Deaths from ectopic pregnancy have doubled in the United States since 2020

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23 September 2026

An ectopic pregnancy occurs when a fertilized egg implants outside the uterine cavity, most commonly within a fallopian tube. Because an extrauterine pregnancy cannot develop into a live birth, the growing embryo will eventually rupture the organ and trigger catastrophic hemorrhage unless medical or surgical treatment is provided.

A national investigation published September 9 by *ProPublica* found that 196 women died with an ectopic pregnancy recorded on their death certificates between 2020 and 2025, compared to 106 in the previous six years. Between 2023 and 2025, the national rate reached 9.8 ectopic-associated deaths per million live births, roughly double the rate of a decade earlier.

In the 18 states that enforced abortion bans at six weeks or earlier, the rate reached 13.1 per million live births. In the 27 jurisdictions that never enacted a ban, it rose to 7.1. Though the increase is national, the abortion bans have accelerated it.

The data assembled by reporters Andrea Suozzo and Agnel Philip show a clear trajectory. States that would later ban abortion already had higher mortality in 2014. Both groups of states jumped sharply in 2020, during the pandemic. After 2023, the states with abortion bans pulled away from the rest of the country.

The historical baseline comes from research led by Dr. Andreea Creanga at the Centers for Disease Control and Prevention (CDC), which used national vital statistics to establish long-term trends. Converted to *ProPublica*'s denominator, the national rate fell from 11.5 deaths per million live births in 1980-1984 to 5.0 in 2003-2007. States that have banned abortion are now reporting mortality higher than the national figure of 40 years ago.

Over those four decades, physicians have standardized effective toolkits to diagnose and treat ectopic pregnancies before they rupture. These deaths stem not from a failure of medical knowledge but from a decaying health care infrastructure, overburdened emergency departments and state policies that impede timely care.

Two facts make these numbers a record of institutional failure. The rise began in 2020, two years before the Supreme Court overturned *Roe v. Wade*. And no federal investigation has been opened, while the maternal mortality review committees of the ban states are not asking whether their laws contribute to the deaths.

Ectopic pregnancies account for 1 to 2 percent of all pregnancies in the United States and rupture in about 15 percent of tubal cases. Ruptured ectopic pregnancy is the leading cause of maternal death in the first trimester. Up to half of the women who develop one have no identifiable risk factor. Among women who arrive at an emergency department with lower abdominal pain or vaginal bleeding in early pregnancy, 6 to 16 percent, roughly one in ten, have an ectopic pregnancy.

Caught early, it is treated with methotrexate, a drug that halts the growth of the pregnancy tissue, provided the patient is stable and can return for repeat blood tests. Otherwise surgery is lifesaving. Once the tube ruptures, the pregnant woman needs transfusion and an emergency operation. Because methotrexate cannot be given after rupture, delay converts an injection into an operation, and an operation can mean the loss of a fallopian tube, impacting future fertility.

Under established clinical standards, no woman should die of an ectopic pregnancy.

Seeing a mass on an ultrasound is not required to diagnose or treat the condition. Early ectopic pregnancies are often invisible on scans and are diagnosed from the trend in pregnancy hormone levels together with pain and bleeding. Demanding visual proof is not a clinical standard but a legal shield, adopted by hospital lawyers and risk managers to protect institutions from prosecution under state abortion bans. The hesitation is now so widespread that Access Bridge, a program of the Public Health Institute that trains emergency physicians, published a protocol in August 2026, *Pregnancy of Unknown Location in the ED*, written for departments operating under abortion restrictions. It tells doctors they need not wait for a visible mass to treat.

Two cases now in the courts show what this means.

In Texas, Kyleigh Thurman, 33, went to Ascension Seton Highland Lakes on February 17, 2023, with pain and bleeding. An ultrasound showed no pregnancy in the uterus. She returned two days later; her hormone level had plateaued, the signature of a failing pregnancy, but the hospital had no ultrasound staff on Sundays, and she was sent home with an appointment eight days away. On February 21, at Ascension Seton Williamson, an ultrasound showed a new structure beside her right ovary; the on-call obstetrician, consulted by telephone, never entered her room, and she was discharged again. On her fourth visit, on February 23, a physician from her own gynecology practice walked into the emergency department and ordered methotrexate. On March 2 her tube ruptured and was removed. Federal inspectors later cited Ascension Seton Williamson for failing to screen her and failing to call in an obstetrician. Ascension has denied the allegations in her lawsuit.

In Arkansas, Leitaea Lowrimore arrived at Mercy Hospital Fort Smith just before noon on February 19, 2026, bleeding and in pain, and told the triage nurse that a hospital had sent her home the day before. Four hours later she returned to the desk because the pain was worse. No one reassessed her. After six hours and thirty-nine minutes she had not been assigned a physician, and her record was closed as "Left Without Being Seen." She drove to Kansas and was treated within hours.

These filings are rare cases with representation. The *ProPublica* count is the cases with a death certificate. Between them is a larger population that no one is counting.

The abortion bans were imposed on a system that was already unequal. In the *American Journal of Obstetrics & Gynecology*, Dr. Jennifer Hsu and colleagues examined 62,588 women treated for ectopic pregnancy between 2006 and 2015. Medicaid patients were 8 percent less likely and uninsured women 13 percent less likely to receive methotrexate than the commercially insured, and among surgical patients the uninsured were 40 percent less likely to keep their tube.

In *Human Reproduction*, Dr. Debra Stulberg tracked 19.1 million Medicaid enrollees in 14 states between 2004 and 2008 and found 101,892 ectopic pregnancies with an 11 percent complication rate; of 17 deaths, nine were Black women. Stulberg noted that such records show which women are harmed but not why: they record race and insurance, and nothing about income, housing, work or distance to care.

That division converges on the emergency department, where 80 percent of ectopic encounters occur and where Medicaid recipients and uninsured women disproportionately seek care.

An ectopic pregnancy is a 48-hour problem intersecting with a medical system built on multi-hour waits. Dr. Alexander Janke and colleagues, in *Health Affairs*, found that boarding of admitted patients beyond four hours accelerated in mid-2020 and never recovered; a quarter of admitted patients now wait four hours or more in ordinary months, 40 percent in winter. The rate of patients leaving without being seen doubled by 2021. A 2026 review of 226 studies in *Clinical and Experimental Emergency Medicine* found crowding associated with higher mortality at every interval measured.

The connection to ectopic pregnancy has been measured. A meta-analysis in *In Vivo* of 3,122 women found that during the pandemic, in hospitals without a dedicated early-pregnancy unit outside the emergency department, which included every US hospital studied, the odds of arriving with a ruptured ectopic nearly tripled. In the United Kingdom, where such units are standard, rupture did not rise. Since 2020, 116 rural US hospitals have closed their obstetric units, leaving emergency departments with no obstetrician to call. With crowding and ectopic mortality both rising from mid-2020, the timing suggests hospital delay was killing women before *Dobbs*.

The outpatient safety net was dismantled in parallel.

A Title X clinic is where a low-income woman gets her first pregnancy test, treatment for the infections that scar fallopian tubes, and a clinician who tells her to go to the emergency room today. The first Trump administration's 2019 rule cut the network from 3,954 clinics to 3,031 and its users from 4 million to 1.5 million.

In the *New England Journal of Medicine*, Dr. Amanda Stevenson showed that Texas's 2013 exclusion of Planned Parenthood was followed by a 35 percent fall in long-acting contraception and a 27 percent rise in Medicaid-paid births among women who had relied on injectables.

After *Dobbs*, Dr. Suzanne Bell reported in *JAMA* on 22,180 excess births in 14 states with abortion bans, concentrated among Medicaid beneficiaries. The state creates more pregnancies among the women least able to reach early care and removes the clinics that provided it. In 2025 Title X grants were withheld, Congress barred Medicaid payments to Planned Parenthood, 57 of its clinics closed, and Medicaid work requirements due in January 2027 threaten the coverage of millions of women.

When the clinic closes, a woman's first contact with a failing pregnancy moves to the emergency room, and the emergency room is where the abortion bans have their biggest effect.

In a national survey in the *Western Journal of Emergency Medicine*, Dr. Monica Saxena and colleagues found that 24 percent of emergency physicians in restrictive states reported delaying care for suspected ectopic pregnancy since *Dobbs* and 54 percent reported changing it. The reason given most often was a "higher threshold of certainty"; the most common changes were ordering more blood tests and arranging follow-up instead of treating. This is the peer-reviewed version of what happened to Thurman. *ProPublica*'s analysis of Texas hospital data found 310 more women with significant blood loss after an ectopic pregnancy in 2023 and 2024 than in 2018 and 2019, a 29 percent rise.

However, public institutions refuse to look. The Arkansas medical board told *ProPublica* its law is clear enough; boards in 18 other states with abortion bans have issued no guidance or did not respond. The CDC's Division of Reproductive Health has lost most of its staff, its pregnancy surveillance team has been placed on leave, funding to train emergency physicians in obstetric emergencies was ended, federal guidance on emergency abortion care was rescinded and the lawsuit against Idaho was dropped. An HHS spokesperson said maternal health work is "being accelerated across the Department." The division that would investigate these deaths has been gutted.

In a deeper sense, a death from ectopic pregnancy is an indicator of whether a society will defend the lives of working-class women.

The abortion bans are one front in a broader assault on the social right to health care, contraception and education, waged by the same legislatures and the same Congress that have cut Medicaid, defunded the clinics and, from January, will strip coverage from millions through work requirements. That its weight falls first on the poorest working people is not an accident of the market but the class decision of the financial elite.