OPEN ACCESS

Scholars International Journal of Obstetrics and Gynecology

Abbreviated Key Title: Sch Int J Obstet Gynec
ISSN 2616-8235 (Print) |ISSN 2617-3492 (Online)
Scholars Middle East Publishers, Dubai, United Arab Emirates
Journal homepage: https://saudijournals.com

Original Research Article

Variation in Clinical Presentation and Treatment Modalities of Ectopic Pregnancy

Nondita Paul[1*], Sumana Shifat[2], Shanjida Sultana[3], Sultana Nasreen[4], Taslima Akter[5], Syeda Sharmin Sultana[6], Mst. Sharifa Akter[7]

[1]Medical Officer (Obs and Gynae), Faridpur General Hospital, Faridpur, Bangladesh
[2]OSD, DGHS (Attachment- DMCH), FCPS Subspecialty Trainee, Department of Female Pelvic Medicine and Reconstructive Surgery, Dhaka Medical College Hospital, Dhaka, Bangladesh
[3]Lecturer (Gynae), Government Unani and Ayurvedic Medical College and Hospital, Dhaka, Bangladesh
[4]Medical Officer, Department of Anesthesiology, National Institute of Traumatology and Orthopedics Rehabilitation, Dhaka, Bangladesh
[5]Medical Officer, On deputation-Dhaka Medical College Hospital, Dhaka, Bangladesh
[6]Medical Officer (Obs and Gynae), Harirampur Upazila Health Complex, Manikganj, Bangladesh
[7]Medical Officer (Obs & Gynae), Shaheed Suhrawardy Medical College and Hospital, Dhaka, Bangladesh

DOI: https://doi.org/10.36348/sijog.2025.v08i07.001 | **Received:** 29.04.2025 | **Accepted:** 03.06.2025 | **Published:** 11.07.2025

***Corresponding author:** Nondita Paul
Medical Officer (Obs and Gynae), Faridpur General Hospital, Faridpur, Bangladesh

Abstract

Background: The management of ectopic pregnancy has undergone a revolution in the past few decades. Evidence suggests that the incidence of ectopic pregnancies has been rising. Earlier diagnosis also plays a role by identifying ectopic pregnancies that would have spontaneously resolved. ***Objectives:*** The aim of the present study is to describe the presentation and different modalities of management of ectopic pregnancies admitted to the Gynecology ward over the study period. ***Methods:*** This was a cross-sectional study was done in the Obs & Gynae Department, Shaheed Suhrawardi Medical College Hospital. Fifty patients who were clinically suspicious of ectopic pregnancy and also supported by positive urinary pregnancy tests, beta hCG and no intrauterine gestational sac in ultrasonography was included for the study. Data were collected in a preformed questionnaire and analyzed by SPSS (version 22.0). ***Results:*** Maximum respondents (60.0%) age 21-30 years, mean age 27.71±5.3 years. The past history of pelvic inflammatory disease (PID) forms the major bulk of the risk factors of ectopic pregnancy. Patients had H/O pelvic inflammatory disease was 54% of the study population. Patients had H/O of menstrual regulation 16.0% and history of abortion (spontaneous and induced) 20.0%. Most of the patients 56% having history of < 8 wks. of amenorrhoea, 6% having no history of amenorrhoea and least (4%) having more than 10 weeks amenorrhoea. All (100%) of the patients having history of Abdominal pain; Amenorrhoea was found in (94%), Vaginal bleeding was found in (82%) and general weakness was found in (90%). On the other hand less than 40% had symptoms of fainting attack (36%) and early pregnancy sign-symptoms (38%). Among 50 patients 43(86%) undergone surgical operation,5(10%) receive medical treatment and 2(4%) are managed expectantly, 93.02% cases of ectopic pregnancy occurred in the fallopian tube, 4.6% cornual, 2% ovarian among the study population undergone laparotomy. Right tube was found to be involved more often (55%) than left (45%) and in most of cases (93.02%) the tube was found to be ruptured. Out of 43 cases of laparotomy 37 (86.04%) cases unilateral salpingectomy, 3(6.9%) cases unilateral salpigectomy with contralateral tubectomy and 1(2.3%) cases unilateral salpingo-oophorectomy were done. one case removal of cornu and repair done. Small number of patients had developed minor complications like pyrexia alone 23.25%, Pyrexia with lower abdominal pain (18%), wound gap (2.3%), mild abdominal distension (4.6%), UTI with pyrexia (6.9%) and loose motion (4.6%) among the study population. ***Conclusion:*** Pelvic inflammatory disease and multiple induced abortions and menstrual regulations are the strongest risk factors of ectopic pregnancy. Prevention of PID may not only reduce the ectopic pregnancy but also reduce adverse effects on tubal patency. Child birth in total aseptic conditions by a skilled birth attendant to prevent incidence of pelvic infection.

Keywords: Clinical Presentation, Treatment, Ectopic Pregnancy.

INTRODUCTION

An ectopic pregnancy is one in which the fertilized ovum becomes implanted in a site other than the normal uterine cavity [1]. It is the major cause of maternal mortality during the first trimester of pregnancy which accounts for 10-15% of all maternal deaths [2]. It is a common condition in women of reproductive age group with an incidence of 1-3% [3]. Risk factors of ectopic pregnancy include pelvic inflammatory disease (6-fold increased risk), use of intrauterine contraceptive (3-5% increasedrisk), smoking (2.5%increased risk), assisted reproductive technology, tubal damage, tubal surgery (5.8% increased risk), prior ectopic pregnancy (10 fold increased risk) [3]. Patients with an ectopic pregnancy usually present with amenorrhea, abdominal pain and bleeding per vaginum at first trimester usually [4]. Due to early diagnosis there seems to be an increasing trend in the incidence of ectopic pregnancy but the incidence of maternal morbidity and mortality has declined due to early diagnosis by serial β HCG measurements, transvaginal ultrasonography and minimally invasive surgery (MIS) [5]. Early diagnosis reduces the risk of tubal rupture and allows for conservative medical management [6]. Ectopic pregnancy may occur any time from menarche to menopause. Incidence is maximum between the ages of 20-30 years. The incidence of ectopic pregnancy is three times higher in women aged 35-44 years in comparison to those in the age group 15-24 years [7]. Incorporation of progesterone in the IUCD seems to increase the incidence of tubal pregnancy over than seen with the unmedicated devices [8]. Women who are subfertile are also at increased risk for an ectopic pregnancy because altered tubal integrity (or function) contributes to both conditions [9]. The advent of USG especially transvaginal ultrasonography (TVS), Serum progesterone, B-hCG, direct vision by laparoscopy are important investigations for early diagnosis of ectopic pregnancy. In experienced hands, TVS will detect 75-80% of clinically significant tubal ectopic at the initial examination [10]. TVS, B-hCG monitoring are the standards for evaluation of suspected ectopic pregnancy. Over the past decade the management of ectopic pregnancy has evolved from radical operative approach (salpingectomy) to a more conservative surgical or medical treatment [11]. However, surgical management is still indicated in some patients. Immediate laparotomy and clamping of the bleeding vessels may be the only means of saving the life of a moribund patient. Observational studies suggest that rates of tubal patency (60-90%) and recurrence of ectopic pregnancy (8-15%) are similar after medical and surgical treatment [12]. In the majority of cases, surgery is the mode of treatment. The surgical treatment may either be an open laparotomy or laparoscopic depending on the surgeon′s skill, availability of equipment and clinical state of the patient. The management of ectopic pregnancy has been revolutionized over the past few decades. This has resulted in emergence of several non-surgical options to what had once thought to be a solely surgically treatable condition. An earlier diagnosis can be made with transvaginal ultrasound and quantitative serum βhCG. This increases the chances of success of medical treatment and minimizes its morbidity, mortality and financial burden [13-21]. There have been some visible changes in the diagnosis and treatment of ectopic pregnancy over the past decade at the study center. This study therefore determines the incidence, associated risk factors, the currently available treatment modalities and suggests means of reducing the incidence and morbidity/mortality associated with ectopic pregnancy.

MATERIALS AND METHODS

Study design: This was a cross-sectional observational study.

Place of study: Department of Obst and Gynae, Shaheed Suhrawardi Medical College Hospital, Dhaka Bangladesh.

Study period: Six months from October 2018 to April 2019.

Sample size: Sample size adjusted 50.

Sampling technique: Purposive sampling

Study population:

Patients who were clinically suspicious of ectopic pregnancy and also supported by positive urinary pregnancy tests, beta hCG and no intrauterine gestational sac in ultrasonography was included in this study who admitted in the Department of Obstetrics and Gynaecololgy, Shaheed Suhrawardy Medical College & Hospital, Dhaka.

Selection criteria

Inclusion criteria:

- All patients diagnosed as ectopic pregnancy as per the above criteria will be subjected to their willingness to participate in the study after informed consent.

Exclusion criteria:

- Pregnancy with other complications such as acute appendicitis, acute pyelonephritis, acute cystitis and bleeding disorder etc.
- Patient who were refuse to be included in the study.

Procedure of data collection:

Data collection will be done for all patients who are diagnosed to have ectopic pregnancys during the study period. Data regarding patient's demographics, clinical presentation, diagnostic modalities, and treatment outcome will be recorded for every patient in a pre-designed data record form. Statistical analysis was done by using SPSS version-22. Results are presented as

mean±standard deviation (SD), frequency and percentage.

Data analysis:

Data will be collected, coded, revised and entered into the statistical package for social science (SPSS) version (22) and the following will be done. The quantitative data will be presented as number and percentages while the qualitative data will be presented as mean, standard deviations and ranges.

RESULTS

This present hospital based cross-sectional observational study included fifty patients who were clinically suspicious of ectopic pregnancy and also supported by positive urinary pregnancy tests, beta hCG and no intrauterine gestational sac in ultrasonography was included in this study who admitted in the Department of Obstetrics and Gynaecololgy, Shaheed Suhrawardy Medical College & Hospital, Dhaka in a period of six months, different observations are shown as below –

Table 1: Sociodemogaphic analysis among the patients of ectopic pregnancy (n = 50)

Patients particulars		No. of Patients	Percentage (%)
Age	<30	30	60.0
litaracy	illiterate	16	32.0
Socioeconomic status	Lower middle class	26	52.0

As shown in Table 1 most of our patients (60%) were of 21-30 years age. About 32% patients are illiterate and most (52%) are belong to lower middle-class group.

Table 2: Predisposing factors associated with the study population (n = 50)

Predisposing factors	No. of Patients	Percentage (%)
Pelvic inflammatory disease (PID)	27	54.0%
Abortion (Spontaneous and induced)	10	20.0%
Menstrual regulation (MR)	8	16.0%
H/O-D & C	3	06.0%
H/O- Infertitity	3	06.0%
H/O-Tubal ligation (Sterilization)	1	02.0%
H/O-IUCD insertion	3	06.0%
H/O-Ectopic Pregnancy	2	04.0%
Had no any predisposing factors	09	18.0%

Total will not correspond to 100 percentage because of multiple response. Table-2 shows the past history of PID tops the list with 54% followed by abortion (Spontaneous and induced) (20%). H/O- M.R. 16%, D&C (6%), Infertility (6%) and IUCD insertion 06% and was found among the study population. Only one case of Tubal ligation (Sterilization), on the other hand in 18% of the patients there was no predisposing factors.

Table 3: Presenting symptoms among the patients with ectopic pregnancy (n=50)

Symptoms	No. of Patients	Percentage (%)
H/O- Amenorrhoea	47	94.0%
Abdominal pain	50	100.0%
Vaginal Bleeding	41	82.0%
Fainting attack	18	36.0%
Early pregnancy S/S	19	38.0%
Generalized weakness	45	90.0%

(Total will not corresponds to 100 percent because of multiple response).

Table-3 shows that all (100%) of the patients having history of Abdominal pain; Amenorrhoea was found in (94%), Vaginal bleeding was found in (82%) and general weakness was found in (90%). On the other hand, less than 40% had symptoms of fainting attack (36%) and early pregnancy S/S (38%).

Table 4: Presenting Signs of ectopic pregnancy

Signs	No. of Patients	Percentage (%)
Anaemia	47	94.0%
Abdominal distension	35	70.0%
Tenderness in lower abdomen	47	94.0%

Signs	No. of Patients	Percentage (%)
Mild P/V Bleeding	41	82.0%

(N.B.: Total will not correspond to 100% percent because of multiple response)

Table-4 reveals that most cases (94%) had tenderness in the lower abdomen. On examination 94% patients were anaemic, 70% had abdominal distension, 82% had mild P/V bleed in

Table 5: Investigation done before laparotomy in ectopic pregnancy patient

Types or procedures of investigation	No. of Patients	Percentage (%)
Blood hemoglobin estimation		
Severe Anaemia	15	30.0%
Moderate Anaemia	24	48.0%
Mild Anaemia	6	12.0%
Ultrasonography detected ruptured ectopic pregnancy	22	44.0%

N.B.- Total will not corresponds to 100 percent because of multiple response.

Table 5 shows that out of total (50) study population 30% had severe, 48% had moderate and 12% had mild grade of anaemia found by Hb estimation. Thirty percent of patients were found pregnancy test positive by urgent laboratory test and 44% of patients were diagnosed as ruptured ectopic pregnancy by ultrasonogram (USG).

Table 6: Treatment options of the study patients

Treatment Options	No. of Patients	Percentage (%)
Expectant	02	4.0%
Medical	05	10.0%
Surgical	43	86.0%
Total	**50**	**100.0%**

Table-6 shows that among 50 patients 2(4%) receive expectant management, 5(10%) receive medical treatment,43(86%) receive surgical management.

Table 7: Sites of ectopic pregnancy (n = 43)

Sites	No. of Patients	Percentage (%)
Tubal	40	93.02%
Cornual	02	4.6%
Ovarian	01	2.0%
Total	**43**	**100.0%**

Table 7 shows that in 92% cases of ectopic pregnancy occurred in the fallopian tube, 2% ovarian, 4.6% cornual among the study population.

Table-8: Peroperative findings in tubal pregnancy (n= 40)

	Laparotomy finding	No. of Cases %
Condition of the affected tube	(a) Ruptured	36 (90%)
	(b) Unruptured	01 (2.5%)
	(c) Tubal abortion	03 (7.5%)
Condition of the other tube	(a) Healthy looking	34 (85%)
	(b) Inflamed	2 (5%)
	(c) Peritoneal adhesion	2(5%)
	(d) Tubal ligation	1 (2.5%)
	(e) Endometriotic deposits	1 (2.5%)
Tube affected	(a) Right	22 (55%)
	(b) Left	18(45%)
Free blood in peritoneal cavity and pouch of doglus		28 (70%)
Old clotted blood with adhesion at the site of implantation		12 (30%)

Table-8 shows that laparotomy was done in all cases and right tube was more (55%) affected than the left (45.10%) and in most of the cases (90%) the tube was found to be ruptured. Only in 2.5% cases tubes were

found to be distended and no rupture was found. Out of 40 cases, 7.50% were diagnosed as tubal abortion, where the tubes were inflamed and distended but gestational sac could be detected inside the tube. There was oozing of blood from the luminal side of the tube into the peritoneal cavity.

Regarding condition of the tube, opposite tube was healthy looking in 85% of patients and inflamed in 5% cases, peritoneal adhesion 2 cases (6.8%), tubal ligation 1 case (2.5%) and endometrial deposits in one case (2.5%) was found as peroperative findings (Table-3.13). In 28 (70%) cases there was fresh blood inside the peritoneal cavity and rest 12 (30%) cases had old clotted blood indicating features of old ectopic pregnancy.

Table 9: Operation performed in ectopic pregnancy (n = 43)

Types of operation	No. of Patients	Percentage (%)
Unilateral salpingectomy	36	83.72%
Unilateral sapingectomy with contra- lateral tubectomy	03	6.9%
Unilateral salpingo-oophorectomy	01	2.3%
Salpingostomy	01	2.3%
Cornu repair	02	4.6%
Total	**43**	**100.0%**

Table-9 shows that out of 50 cases of laparotomy 36(83.72%) cases unilateral salpingectomy, 4(6.9%) cases unilateral salpigectomy with contralateral tubectomy and 1 (2.3%) cases unilateral salpingo-oophorectomy,1(2.3%) salpingostomy and 2(4.6%) cornu repair were done.

Table 10: Post operative complications after laparotomy (n =43)

Complication	Frequency	Percentage (%)
Hypovolumic shock with oliguria	2	4.6%
Pyrexia	5	11.62%
Lower abdominal pain with pyrexia	2	4.65%
UTI with pyrexia	3	6.9%
Wound gap with pyrexia	1	2.3%
Mild abdominal distension	2	4.6%
Loose Motion	2	4.6%

Table-10 shows that small number of patients had developed minor complications like pyrexia alone 11.62%, Pyrexia with lower abdominal pain (4.65%), wound gap (2.31%), mild abdominal distension (4%), UTI with pyrexia (6.4%) and loose motion (4%) among the study population. In 2 (4.6%) cases of hypovolumic shock with oliguria was found as a major complication.

Table 11: Outcome of operation (n = 43)

Outcome	No. of Patients	Percentage (%)
Smooth and uneventful	26	60.0%
complications	17	39.0%
Total	**43**	**100.0%**

Table-11 shows that about half (60%) of the patients had smooth uneventful recovery and 39% having minor complications. There was no death among the study population.

Table 12: Hospital stay of post operative patient (n = 43)

Days	No. of Patients	Percentage (%)
0-7	40	93.02%
8-14	2	4.6%
15-21	1	02.3%
>21	0	00.0%
Total	**43**	**100.0%**

Table-12 showed that out of 43%patients 40 (93.02%) stayed in the hospital for 7-14 days. One patient stayed for longer period, (2.3%) required due to wound gap with infection.

DISCUSSION

Ectopic pregnancy (EP) means a pregnancy that develops outside the uterus, usually in one of the fallopian tubes, but might also occur in the cervix, ovary

or the abdominal cavity. The increasing incidence of this condition is concerning because of an associated increase in pregnancy-related morbidity and mortality rates during the first trimester in women of childbearing age [19, 22]. Prevalence of ectopic pregnancy is increasing all over the world. With this rising incidence of ectopic pregnancy and its considerable impact on the reproductive health of an individual, attention should be directed towards improved diagnosis and its management [25]. Ectopic pregnancy may occur at any age during the reproductive period. In the present study the majority (60.0%) of the patients belonged to the age group 21-30 years. This is similar to the study by Palve *et al*., [16] and Patel *et al*., [25] in which the peak age incidence was 20-30 years. Yeasmin *et al*., [18] reported majority of the patients (63.83%) belonged to the age group of 20-30 years in the study. Shukla *et al*., [26] showed in a study majority of the cases (37) (36.27%) were noted between 21 to 25 years of age group followed by the age group 26 to 30 years All the above studies indicate that highest incidence of ectopic pregnancy in highly fertile period. In my study, most of the patients (52.0%) were of lower middle class followed by 36.0% respondents middle class and 10.0% patients come from higher class. It indicates that highest incidence of ectopic pregnancy among the poor people. Soren *et al*., [17] noted among 41 patients (57%) belonged to low socio-economic status and 31 patients (43%) belonged to medium socio-economic status and none belonged to high socio-economic status.

In this series the highest (54%) incidence of ectopic pregnancy among those women suffering from pelvic inflammatory diseases (PID), then those patients suffering from history of spontaneous and induced abortion (20%). Out of 50 patients 16% of them having the history of menstrual regulation (MR), H/O-D&C (6%), H/O- infertility (6%), H/O-IUCD insertion (6%), H/O ectopic pregnancy (s4%) and only one (2%) having the tubal ligation (Sterilization). Iqwegbe *et al*., [13] reported the commonest associated aetiological factor associated with ectopic pregnancy in previous induced abortion followed by pelvic infections. Similar to reports was noted Mukul [30] and Nahar *et al*., [7] reported PID identified as the risk factors of ectopic pregnancy- 42% patients had history of previous abortion or MR, period of infertility 22%, pelvic infection 12%, IUCD users 16%. Pranathan and Madhavib [22] found that among the risk factors, previous abortion (30.95%) and pelvic surgery (33.33 %) were common. Tahmina *et al*., [19] found previous pelvic surgery (37.5%), followed by previous abortions (36.1%) as their risk factors. However, most of the studies reported previous abortions as risk factors [27,31,32]. History of amenorrhoea (94%) was found among the study population with majority 56% having the short period (6-8 weeks) of amenorrhoea. In a study by Pranathan and Madhavi [22] the suspicion of an ectopic pregnancy should be raised from the history of risk factors and triad of symptoms: Pain in lower abdomen, amenrrhea, and vaginal bleeding. The classic triad was present in 17 (40.47%) cases. It was found a history of preceding amenorrhea in 37(88.09%) women. Tahmina *et al* [19] found the triad of symptoms in 40.3% of their cases. Other similar studies have reported this triad to be present in 28–95% women, clearly indicating that this is not a presenting feature in most cases. Tahmina *et al* [19] found amenorrhea in 93.1% of their cases, which correlate the present study. All of the patients (100%) in my study having history of abdominal pain. Shahab *et al*.[24] study showed it was 92.5%, Mishra *et al*. most of the cases presented with lower abdominal pain (93.54%) followed by amenorrhea (79.03%).[33] In the study by Shivakumar HC *et al*, of the symptoms 95% had pain abdomen, 80% had amenorrhea, 70% had bleeding per vaginum, 30% had vomiting and 5% had urinary complaints.[34] So, almost cent percent patients of ectopic pregnancy having the complaints of abdominal pain. In this study 94% of patients were found to be anaemic. Almost all patient need blood transfusion. Akhter S [35] have shown 92% cases needed blood transfusion. Another study by Shahab *et al* [24] noted out of 40 patients studied 30(75%) needed blood transfusion. Regarding treatment modalities 2(4%) patient improved by expectant measures,5(10%) patient needed medical management and43 (86%) patient undergone surgery. Out of 43 operation, 40 (93.02%) were diagnosed as tubal pregnancy, 2 (4.6%) cornual, and 1 (2.3%) was ovarian. After opening the abdomen 70% patients having free intraperitoneal haemorrhage including fullness of pouch of douglas and 30% patients having old clotted blood with adhesion among the study population. Akhter S [35] have shown 84% patients having fullness of pouch of douglas and Jesmin S [38] have shown 70% having free blood in the peritoial cavity which are almost similar to my study. Laparotomy findings shows that the right tube (55.70%) was affected more than the left (45%). Most of the patients (90%) had ruptured tubal pregnancy which reflects lack of health facilities in the community level and delay in the diagnosis takes our patients to tertiary level of hospital in the moribund state. Almost similar observation has been made by Suseela *et al*. [20] and Zabin [36] studies. The opposite tube was examined and in 85% of cases, it was found normal looking and in rest (15%) of the cases, it was pathological (that is inflamed 11.3%, peritubal adhesion 5%, tubal ligation 2.5% and endometriotic deposits 2.5%). Almost similar observation has been made by Parvin R [39] and Kusum SW [40]. In this study, out of 43 operative cases unilateral salpingectomy was done in 37 (86.04%) patients, unilateral salpingo-oophorectomy in 1 (2.3%) patients, unilateral salpingectomy with contralateral tubectomy in 3(6.9%) patients,2 (4.6%) corneal repair. Akhter S [35] and Jesmin S [38] studies have shown almost similar observation. However, the type of operation varied as revealed in different studies conducted by different workers. Sindhura *et al*., [15] reported 63.29% cases underwent laparotomy in which the common procedures done were unilateral complete salpingectomy (36.70%), bilateral salpingectomy

(8.86%), salpingo-oopherectomy (5.06%), fimbrectomy (3.79%), cornual resection (3.79%), partial salpingectomy (2.53%) and laproscopic partial salpingectomy (2.53%). In this study, I have found that 2 (4.6%) patients suffered from signs and symptoms of hypovolumic shock with oliguria. As most of the patients in our country are poor and anaemic even mild to moderate bleeding may cause decreased renal output and shock. Jesmin S [38] have shown 9(15%) patients were suffered from like these complications. It may be due to timely and proper treatment were given in my study places. Small number of patients had developed minor complications like pxrexia alone 5(11.62%), Pyrexia with lower abdominal pain (4.65%), wound gap with infection (2.3%), mild abdominal distension (4.6%), UTI with pyrexia (6.9%), Loose motion (4.6%) among the study population. Jesmin S38 have shown almost similar observation. The outcome of immediate operation in my study 60% was smooth and uneventful and some sorts of minor complication was found in 39% of cases. There is no death in my study population. Due to malnutrition and poverty most of the patients complained of general weakness both before and after operation. All of them were treated by vitamins and hematinics. Jasmin S38 have shown that 45% patients having the smooth and uneventful outcome which is almost similar to my study. In my study, out of 43 postoperative 40(93.02) patients stayed in the hospital for below 7 days and about 4.6% left the hospital within 8-14 days of their surgery. Only one patient stayed for longer period (21 days) and needed secondary stitches due to wound gap with infection. Jesmin S38 have shown no patients left hospital within 7 days of surgery and 96.67% patients left hospital within 8-14 days. Most of the patients were treated by laparotomy. Post operative follow-up evaluation was not performed because of time limitation. Among them 2 patients (4%) suffered from hypovolumic shock with oliguria and one patients stayed in longer period (21 days) in the hospital due to wound gap with infection. There is an increase in the incidence of ectopic pregnancy but a decrease in maternal mortality during the past two decades. Although the early diagnostic tools were available, we had to manage most of our patients as surgical emergencies, as they were brought late in the trial, with established diagnosis of ruptured ectopic pregnancy. Physicians should be sensitive to the fact that in the reproductive age group any women presenting with pain in the lower abdomen, diagnosis of ectopic pregnancy should be entertained irrespective of the presence or absence of amenorrhoea, whether or not she has undergone sterilization.

CONCLUSION

An ectopic pregnancy in one in which the fertilized ovum becomes implanted in site other than the normal uterine cavity. Ectopic pregnancy is an emergency health problem among the female population in our country. It is common in 21-30 years age and lower middle-class group. PID is the commonest predisposing factor of ectopic pregnancy. Obstetric events of these patients showed that majority were nulliparous. Almost every patient presents with abdominal pain associated with amenorrhoea and vaginal bleeding The recovery of majority patients was smooth and uneventful. There was no death in this study. Small portion of this study population showing some sorts of minor complication. Majority of the patients left hospital within 8 to 14 days after surgical treatment. It can be concluded that much of the morbidity and mortality of the patients of ectopic pregnancy can be prevented by early diagnosis and proper intervention.

REFERENCES

1. Kumar P, Malhotra N, Ectopic Pregnancy. In: Jeeffcote's Principle of Gynaecology, 8th edition, Jaypee Brothers Medical Publishers, New Delhi, Chapter-9; 2014; 142-144.
2. Mahboob U, Mazhar SB. Management of ectopic pregnancy: a two-year study. J Ayub Med Coll Abbottabad. 2006;18(4):34-7.
3. Farquhar CM. Ectopic pregnancy. Lancet. 2005; 366:583-91.
4. Walker JJ. Ectopic Pregnancy. Clin Obstet Gynecol. 2007; 50:89-99.
5. Timmerman D. Predictive models for the early diagnosis of ectopic pregnancy. VerhandelingenKoninklijke Academie voor Geneeskunde van Belgie. 2003;66(2):155-71.
6. Barnhart KT. Ectopic pregnancy. N Engl J Medicine. 2009;361(4):379-87
7. Nahar K, Talukder T, Sultana S, Hossain MA. Study on Risk Factors, Clinical Presentation & Operative Management of Ectopic Pregnancy. Bangladesh Journal of Obstetrics & Gynaecology. 2016 Oct 23;28(1):9-14.
8. Luikko p, Erkkola R, Laakso L. Ectopic pregnancies during use of low dose progesterone for oral contraception 1977; 16: 575
9. Clayton HB, Schieve LA, Peterson HB, Jamieson DJ, Reynolds MA and Wright VC. Ectopic pregnancy risk with assisted reproductive technology procedures. Obstet Gynaecol 2006; 107: 595-604.
10. Dewhurst's Text book of obstetric and Gynaecology for post graduates. Edited by D. Keith Edmonds 7th ed. Black well Publishing 2007; 106-115.
11. Peter S. uzelac, Sara H. Garmel. Current Obstetric and Gynaecologic Diagnosis and Treatment 10th ed. McGraw- Hill companies 2007; 265-270.
12. Mol F, Mol BV, Ankam WM, Vansder Veen F, Hajenius PJ. Current evidence on surgery, systemic MTX and expectant management in the treatment of tubal ectopic pregnancy: a systemic review and metaanalysis. Hum report Update 2008; 14 : 309-19.
13. Igwegbe AO, Eleje GU, Okpala BC. An appraisal of the management of ectopic pregnancy in a Nigerian tertiary hospital. Annals of medical and health sciences research. 2013;3(2):166-70.

14. Alpana T, Nagarathnamma R, Prasad N. Management and Outcome of Ectopic Pregnancy in a Tertiary Care Center. J Med Sci 2016;2(3):45-47.
15. Sindhura M, Sailatha R, Famida AM, Vijayalakshmi K, Sathiya S, Renuka S. Trends in ectopic pregnancy: a retrospective clinical study of 79 cases. International Journal of Reproduction, Contraception, Obstetrics and Gynecology. 2017 Jun 24;6(7):3009-13.
16. Palve TT, Bhattacharya R, Magtangi V. Ectopic pregnancy: clinical features, management and complications. International Journal of Reproduction, Contraception, Obstetrics and Gynecology. 2018 Mar 27;7(4):1484-9.
17. Soren M, Patnaik R, Sarangi BK. A clinical study on ectopic pregnancy. Int J Res Med Sci 2017;5:4776-82.
18. Yeasmin MS, Uddin MJ, Hasan E. A clinical study of ectopic pregnancies in a tertiary care hospital of Chittagong, Bangladesh. Chattagram Maa-O-Shishu Hospital Medical College Journal. 2014;13(3):1-4.
19. Tahmina S, Daniel M, Solomon P. Clinical analysis of ectopic pregnancies in a tertiary care centre in Southern India: a six-year retrospective study. Journal of clinical and diagnostic research: JCDR. 2016 Oct;10(10): QC13.
20. Suseela TL, Gunakala KC. A study on management, morbidity and mortality of ectopic pregnancy attending a tertiary care centre at Rajiv Gandhi Institute of Medical Sciences General Hospital, Kadapa, Andhra Pradesh, India. Int J Reprod Contracept Obstet Gynecol 2016; 5:3736-9
21. Chowdhury S, Ferdous A, Bhuiyan AH, Nandy A. Laparoscopy versus Conventional Laparotomy for the Management of Tubal Ectopic Pregnancy A Randomized Controlled Trial. Bangladesh Journal of Endosurgery. 2013;1(2):35-8.
22. Pranathi L, Madhavi Y. A clinical analysis of ectopic pregnancies in a tertiary care hospital in Hyderabad. Asian Pac. J. Health Sci., 2018; 5(1):20-24.
23. Ayaz A, Emam S, Farooq MU. Clinical course of ectopic pregnancy: A single-center experience. Journal of human reproductive sciences. 2013 Jan;6(1):70.
24. Shabab U, Hashmi HA. Different pattern of presentation of ectopic pregnancy and its management. Journal of surgery Pakistan (international). 2013 Jan;18(1): 1-5.
25. Patel M, Chavda D, Prajapati S. A retrospective study of 100 cases of ectopic pregnancy: clinical presentation, site of ectopic and diagnosis evaluation. Int J Reprod Contracept Obstet Gynecol 2016; 5:4313-6
26. Hoover KW, Tao G, Kent CK. Trends in the diagnosis and treatment of ectopic pregnancy in the United States. Obstetrs Gynecol. 2010;115(3):495-502.
27. Singh S, Mahendra G, Vijayalakshmi S, Pukale RS. Clinical study of ectopic pregnancy in a rural setup: a two year survey. Nat J Med Res. 2014;4(1):37-9.
28. Panchal D, Vaishnav G, Solanki K. Study of management in patient with ectopic pregnancy. NJIRM. 2011; 2(3):91-3
29. ICMR- task free project- Multicentric case control study of ectopic pregnancy in India. J Obstet Gynaecol India. 1990; 40:425-30.
30. Mukul LV. Current Management of Ectopic Pregnancy- Obstet Gynecol Clin North Am - September 2007; 34(3); 403-419
31. Khaleeque F, Siddiqui RI, Jafarey SN. Ectopic pregnancies: A three-year study. J Pak Med Assoc 2001; 51:240-42.
32. Baria D, Thaker R, Patel M, Shah S, Shah P, Jani S. Analysis of ectopic pregnancy at a tertiary care hospital: One year study. Int J Reprod Contracept Obstet Gynecol 2013; 2:621.
33. Mishra S, Chaudhary V, Kaul Rajesh. Analysis of 62 cases of ectopic pregnancies in a rural medical college set up at Nalgonda Telangana, India. Int J Sci Study. 2015;3(6):103-6.
34. Shivakumar HC, Umashankar KM, Ramaraju HE. Analysis of forty cases of ectopic pregnancies in tertiary care hospital in South India. Indian J Basic Appl Med Res. 2013;3(1):235-41.
35. Akhter S "Study of Ectoopic Pregnancy A prospective study of 100 cases" Dept. of Obs. & Gynae, BSMMU, Dhaka-2006.
36. Zabin F. Study on clinical presentations, management and operative findings of ectopic pregnancy, IPGMR, Dhaka 1998.
37. Khatoon MR. Clinical presentation and management of ectopic gestation, IPGMR, Dhaka 1987.
38. Jesmin S "An analysis of 60 cases of tubal pregnancy in Rajshahi Medical College Hospital" Rajshahi. January 2003. 55-62. BSMMU, Dhaka
39. Perveen R. Clinicopathological study of tubal ectopic pregnancy. A study of 60 cases, IPGMR, Dhaka 1992
40. Kulsum SW. Study on ectopic pregnancy. A prospective study of 100 cases. Department of Obstet and Gynaecology, BSMMU, Dhaka-2001.