"MANAGEMENT PRACTICES IN ECTOPIC PREGNANCY – A HOSPITAL BASED STUDY"

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Dissertation

Submitted to the

KAHER, Belagavi, Karnataka

In partial fulfillment

of the requirements for the degree of

MASTER OF SURGERY (M.S.)

In

OBSTETRICS AND GYNAECOLOGY

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APRIL- 2021

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ABBREVIATIONS

CC	-	Contigency coefficent
D and C	-	Dilatation and Curettage
DHFR	-	Dihydrofolate Reductase
ELISA	-	Enzyme Linked Imunosorbant Assay
EP	-	Ectopic pregnancy
hCG	-	Human chorionic gonadotrophin
IUCD	-	Intrauterine contraceptive device
IVF	-	Invitro Fertilization
LCB	-	Last child birth
mIU	-	Milli international units
MTX	-	Methotrexate
N	-	Normal
PID	-	Pelvic inflammatory disease
KLE's	-	Karnataka Lingayat Educational Society
BMI	-	Body Mass Index
PMD	-	Paramesonephric duct
RIA	-	Radio Immuno Assay
SES	-	Socio- economic status
T	-	Tenderness
KLE's	-	Karnataka Lingayat Educational Society

KAHER	-	KLE Academy of Higher Education and Research center
T/M	-	Tenderness with mass
THF	-	Tetrahydrofolate
UPT	-	Urine pregnancy test
TSH	-	Thyroid Stimulating Hormone
CNS	-	Central Nervous System
FHR	-	Fetal Heart Rate
RCOG	-	Royal College of Obstetricians and Gynecologists
DOME	-	Department of Medical Education
GA	-	Gestational age
Sl.No.	-	Serial Number
HTN	-	Hypertension
JNMC	-	Jawaharlal Nehru Medical College
USG	-	Ultrasonography
LMP	-	Last Menstrual Period

ABSTRACT

Background and objectives

Ectopic pregnancy is a global problem and is the most common life-threatening emergency in early pregnancy leading to significant morbidity and fetal loss. It occurs in variable presentations. The rate of ectopic pregnancies has increased from 0.5% in 1970 to 2% today. The aim of this study was to study the management practises associated with ectopic pregnancy and the risk factors associated in the development of ectopic pregnancy.

Methodology

The present study was conducted over a period of one year in the department of obstetrics and gynecology at Dr. Prabhakar Kore Hospital, MRC, Belagavi from January 2019 to December 2019.A total of 50 patients with ectopic pregnancy were analyzed regarding clinical presentation, risk factors, operative findings and treatment modality.

Result

Total number of 50 cases of ectopic pregnancies were admitted during this period. Majority of cases were in the age group of 21-25 years. Several risk factors were identifiable. The classical triad of amenorrhea, pain abdomen and vaginal bleeding was present in 24% of cases only. More than half of case (62%) had ruptured tubal pregnancy on admission. Unruptured tubal pregnancy was seen in 32% cases.

Conclusion

Ectopic pregnancy is still a major challenge in gynaecological practice. In our country most of the cases present late after tubal rupture requiring radical surgical treatment. Early diagnosis and timely intervention in the form of medical treatment or conservative surgery not only reduces maternal morbidity but also preserves future fertility.

Keywords

Ectopic pregnancy, Haemoperitoneum, Salpingectomy

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INTRODUCTION

Ectopic gestation is a pregnancy in which the developing blastocyst becomes implanted at a site other than the endometrium of the uterine cavity.[1]

Ectopic pregnancy is a life threatening condition, it greatly endangers the life of the woman and also her future fertility by causing damage to the fallopian tubes and /orovary. Its oneamong the important causes of maternal death in the 1st trimester of pregnancy worldwide and also in India.

As per the Centre for disease control and prevention, 2 % of all reported pregnancies accountsto Ectopic gestation. Ectopic pregnancy is a condition in which the embryo can attach and embed itself in any other place other than the uterine cavity.

The rate at which it occursworldwide has comparatively lessened to an extent that the incidence cannot be identified in an exact manner.The incidence of ectopic pregnancy varies as fornow as many who reach the emergency department late.Ectopic pregnancy is treated as anoutpatient emergency as people reach way before tubal rupture can occur and may need medical management or laproscopy at the most.

The incidence is expressed as the number of ectopic pregnancies per l000 pregnancies but the denominator is difficult to determine accurately since early pregnancy failures that do not result in delivery or hospitalization are often not counted.[2]

The rate at which ectopic gestations occur in India are still on the rise but comparatively it has been reduced because of early diagnosis and more tertiary care facilitesfordiagnosis and following promptchoiceof treatment depending on the patients condition.

The incidence in which it occurs in India is about l-2 % and the incidence at which ectopic pregnancy occur in Karnataka is almost negligible. Hence the patients reach the hospitals at a very critical stage in India mostof the time therefore surgical procedures are performedmore than medical procedures.[3]

An ectopic gestationoccurringto an individual is almost life threatening to that particular individual as it depends on many characteristics like the periodofgestation at which it was detected the earlier the chances ofcomplications like rupture are less. It also depends on site, risk factors mainly historyof a previous surgery or history of dilatation and curettage or a pelvic infection.

The majorityof Ectopic gestation occurs in fallopian tube: Ampullary(70%), Isthmic(12%), Fimbrial(11.1%), Ovarian(3.2%), Interstitial (2.4%), Abdominal(1.3%).[1]

The clinical appearance includes Amenorrhea, Abdominal pain, bleeding per vagina, Others (breast tenderness, urinary symptoms, dizziness, syncope, shoulder tip pain, gastrointestinalsymptoms). There is a dilemma regarding the best approach of management as there appears to be much controversy surrounding this essential step. The discussion focuses initially on the choice of medical versus surgical treatment. While surgical approaches are the gold-standard treatment, advances in early diagnosis in the 1980s facilitated the introduction of medical therapy with methotrexate. With the routine use of early ultrasound, the diagnosis of ectopic pregnancy can be established early and medical treatment can be administered in many cases. The overall success rate of medical treatment in properly selected women is nearly 90%. With a surgical approach there is a need to address the question of

whether to perform a laparoscopy or a laparotomy. In selected cases of early ectopic pregnancy or pregnancy of unknown location, expectant management is an option.

AIMS AND OBJECTIVES

1. Primary objective –To study the management practices of Ectopic pregnancy atDr. Prabhakar Kore Hospital and MRC, Belagavi.

2. Secondary objective – To study the risk factor associated with Ectopic pregnancy.

REVIEW OF LITERATURE

An accurate portrayal of an extra uterine pregnancy was that of Abulcasis, an Arabian doctor who lived in Spain in the eleventh century. His patient had an abdominal swelling that underwent suppuration and drainage through the abdominal wall with passage of the fetal skeleton. In l693, Busiere lst perceived Ectopic gestation when he was looking at the body of a Prisoner executed in Paris.[4]

Bland- Sutton and Gieles appropriately commented “the mother becomes the grave for her child".

In 1604, Jean Riolan of Paris was the first to report an authentic ruptured tubal pregnancy. In l669, Mauricean precisely recorded an instance of tubal pregnancy.

In l873, Barnes presented the word ’ectopic’ for pregnancy in the interstitial area of the tube in the rudimentary horn of mal developed uterus. Robert lawson Tait proposed the lst reported operation for ruptured tubular ectopic in l884.[4]

Despite the fact that the total number of pregnancies had declined in the course of recent decades, the pace of Ectopic gestation had extended drastically. Goldner and partners depicted changes in Ectopic gestation mortality and described the danger of death for various groups utilizing information on Ectopic gestation recognized by the National Vital Statistics System for the year l970 through l989.[5] The extended proportion of extrauterine to intrauterine pregnancies was identified with the rising occurrence of sexually transmitted infections and to the viability of present day anti-microbial medicines for pelvic inflammatory disease.[4,5] The danger of death from Ectopic gestation declined by 90 percentage.[5] Despite rising incidence, the related morbidity and mortality is declining in the developed countries due to increased awareness and well organized health - care delivery system and availability of

sophisticated techniques for the early recognition and treatment of ectopic pregnancies.

Anatomy of the fallopian tube

The fallopian tubes are hollow muscular tubes about l0cm long. They are normally partitioned into four anatomical segments.

The fallopian tube arise from the uterine corpus posterior and superior to the round ligaments. The broad ligaments support the tubes with a condensation of connective tissue called the mesosalpinx. The lumen of the fallopian tubes communicates with the uterine cavity and the intraabdominal cavity.

Each tube is divided into four distinct portions:

1. The interstitial portion, where the tube passes through the uterine cornu;
2. The isthmus, with a narrow lumen and thick muscular wall;
3. The ampulla, with a larger lumen and mucosal folds; and
4. The fimbria, located at the end of the tube with front-like projections that increase the surface area of the end of the tubes, thereby facilitating contact with ovulated ova.

Vascular Supply: The fallopian tube gets its blood supply from the parts of the ovarian artery. Venous drainage will be into the ovarian veins.

Lymphatic drainage: The fallopian tube drains into two or three main trunks, which are accompanied with the ovarian veins in the infundibulopelvic ligament and pass upwards anterior to the ureter to join the lateral group of lumbar glands.

Histology:

1) Serous layer:Mesothelium of the peritoneum.

2) Subserous layer:Numerous small blood vessels and lymphatics.

3) Muscular layer:

- Outer longitudinal and inner circular fibres.

- Circular fibres are best developed in the isthmus and are thinned out near the fimbriated extremity.

4) Mucous membrane:

- Thrown into folds or plicae.

- Near the isthmus, three folds can be recognized.

- In the ampullary region they become highly complex.

- Each plica consists of stroma which is covered by epithelium. Stroma is cellular and its cells are in some ways similar to those of the endometrium. Blood vessels of the stroma are plentiful and are particularly well marked in the ampullary region.

- Epithelium of the mucous membrane consists of three types of cells:

- Ciliated (columnar or cubical).

- Goblet-shaped cell.

- Peg cells, whose purpose is not known.

Etiology of tubular gestation

Reasons for tubular gestation might be isolated into 3 groups.

I. Conditions that retard the passage of fertilized egg, for example, salpingitis, Congenital malformations, tumors, pelvic adhesions, spasm and past operations on the tube.

II. Conditions which increase tubular receptivity, for example, ectopic endometrium and tubular decidual reactions.

III. Factors characteristic in the conceptus, including transmigration of ovum, delayed ovulation and abnormalites of sperm or ovum.

I. Conditions which retard the passage of the fertilized ovum

l. Pelvic Inflammatory disease

It is one of the commonest cause of Ectopic gestation. Endosalpingits causes desquamation of the epithelium with loss of cilia and during the process of healing, contiguous plicae adhere, forming blind alleys in the tube, thus holding up the migrating ovum. Additionally the ciliary drive of the ovum is lost, so likewise the propulsive power of tubular musculature. Exosalpingitis offers a rise to peritubular attachments, which limits the peristaltic movements of the tube, offering rise to inadequate transportation.

Krohn and his partners also Johnson and Beachman correlated the raised occurrence of tubal pregnancy by antimicrobial management of PID offering a rise to a partial tubular patency. As indicated by ACOG, earlier PID particularly that brought about by Chlamydia Trachomatis is the most widely recognized risk factor. Chlamydia had been cultured from 7 % to 30 % of patients with tubal pregnancy.[7] Halbrecht, Vago and Stallworthy had observed a rising trend of Ectopic gestation following treatment of tubercular salpingitis. The primary disease might be gonococcal, post abortal, puerperal or secondary to an extragenital pelvic infection or operation. Since tubular disease is nearly always bilateral, the danger of intermittent ectopic pregnancy is 40 times more greater than the overall risk of 0.3 %. Levin and partners have shown that the risk of Ectopic gestation is extended in ladies with an essential history of PID[8]. Westrom cited that following one episode of salpingitis, l2.8% scenario showed complete or partially blocked tubes. Following two episodes it rose to 30% and following 3 episodes, 75% showed blocked tubes.[9] Westrom found that 4-5 percentage of patients, accomplishing a gestation resulting in subsequesnt to salpingitis, had an Ectopic gestation.[10]

The etiological impact of the faulty tubes is likewise appeared by the way that Ectopic gestation is preceded by several years of infertility.

2. Congenital abnormalities of fallopian tube

A diverticula, an accessory ostia and atresia of the tube might distort the lumen. Its hard to decide the significance of developmental anomalies in the etiology of tubal pregnancy, since the distortion of the structure of the infected organ causes artifacts, stimulating aberrant pathways.

3. Tumors

Tiny myomas at the opening of the tube and uterus could hinder the entrance of a fertilized egg or through mucous polyp. Other intraluminal lesions be tubular dermoid cyst. Tumors emerging in adjacent organ might cause obstruction leading to the occurrence of ectopic pregnancy: Uterine myoma (Magrath, Kelly and Cullen), ovarian and paraovarian cyst (Brady). But in these cases where an extra or intratubular tumor related with tubular gestation are rare.

4. Psycological casues including ‘spasm’

Ashermann recommended that, as tubular motility is controlled via autonomic sensory system, neuro-endocrine irregularity might direct to tubular dyskinesia, which therefore can delay the fertilized ovum in the oviduct long enough for nidation to happen.

5. Surgical obstruction

Previous procedures on the tube either to reestablish patency or deliberately disturb the continuity can offer mount to Ectopic gestation.[11] The most serious risk of gestation, incorporating ectopic pregnancies happens in the initial two years following sterilization.[12] Most commonly seen following laparoscopic fulguration. Laproscopic

coagulation has a reduced risk of pregnancy compared with mechanical devices but the risk of ectopic is increased nine-fold when a failure does occur.[13,14] It may rarely follow hysterectomy if performed within 48 hours after coitus, if a fertilized ovum gets trapped in the oviduct at the time of hysterectomy.

6. Intra Uterine Contraceptive Device

The utilization of intra uterine contraceptive device had been related with an enlarged frequency of Ectopic gestation. In a few published reports on Ectopic gestation, Tatum and Schmidt saw that 4 percentage of the pregnancies with an intra uterine contraceptive device are ectopic. As indicated by Jain (l976), the enlarged incidence of ectopic gestation following continuos usage of Intra Uterine Contraceptive Device is an artifact of enlarged effectiveness of these devices in preventing uterine pregnancies with their prolonged use. Snowden (l977) revealed prevalence of 2l% of ectopic pregnancies in Progestasert users against 2.5% in other Intra Uterine Contraceptive Device users. This might be due to altered hormonal environment .An increased incidence of ectopic pregnancy has been reported with the use of IUCD with and without progesterone.[15]

7. Hormonal contraception

An altered tubular motility follows change in the serum levels of estrogens and progesterones likely from upregulation of adrenergic receptors of smooth muscle.[16] An extended frequency of Ectopic gestation had been seen with the utilization of progestin only contraceptives[17] and following utilization of postovulatory elevated-dose estrogens to prevent gestation – the "morning following pill".

8. Assisted Reproductive techniques

The rise in ectopic pregnancies with assisted reproduction is likely to be identified with tubular factors that cause infertility. Tubular gestation is enlarged

following gamete intrafallopian transfer (GIFT) and In-vitro fertilization.[18] Abdominal pregnancy has been reported following GIFT and IVF.[19] Cervical pregnancy may be increased after in- vitro fertilization.[20] Ovarian pregnancy also may be increased after IVF.[21]

9. Others

Following one past ectopic, the possibility of an other is 7-l5%.[11,18] Peritubular adhesions following postabortal or puerpeural disease, appendicitis or endometriosis might cause tubular kinking and narrowing of the lumen.[18]

These might be related with the marginally extended danger of Ectopic gestation following past induced abortion.[22]

A previous cesarean delivery had been connected to a small Ectopic gestation risk.[23]

The incidence of tubular gestation had also been found to be enlarged, in patients with luteal phase defects,[24] with cigarette smoking[25,26] and vaginal douching.

II. Conditions which increase tubal receptivity

Rubin et al noted endometrium in the lumina of the intrauterine section of the tube in a few cases of Ectopic gestation. Huffman proposed that “the ovum implants in an aberrant site simply because the site contains cells initially derived from the Mullerian ducts, which return to the original type and require the property of forming decidua.

III. Factors intrinsic in the conceptus

1. Trans migration of the ovum

Delay of the transfer of fertilized egg had been proposed as potential reason for extrauterine gestation. Advocates of external migration generally termed as "transperitoneal migration" happen at the cul-de-sac and the ovum progresses to the blastocyst stage during passage through the tube. Intrinsic transmigration scholars

recommend that the ovum is prepared in one tube and migrates across the uterus to enter the contrary tube.

2. Delayed ovulation

Iffy proposed that unusual implantation brought about by delayed ovulation with late fertilization and insufficient development of secretory endometrium. Due to the late fertilization, the fertilized egg is able to suppress the following menstrual period and the reflux stream of the menstrual flow washes the ovum from the uterus once again into the fallopian tube where the implantation happens.

Pathology

1. Uterine changes

The uterus undergoes a few changes related with an early normal gestation, including softening of the cervix and isthmus and an increase in size. In a study out of ll25 women who were disgnosed with an Ectopic gestation, 75% had a normal sized uterus.[27] In 25% of patients, the uterus enlarges in size because of hormonal stimulation of gestation" (Stabile and GrudZirskar l990). Thus the absence of uterine changes doesn't reject the diagnosis of an Ectopic gestation.

2. Behaviour of uterine mucosa

Decidual change is noted whether gestation is intrauterine or extra uterine, however with fetal death the decidua might gradually be exfoliated. When extrauterine gestation proceeds without interference, uterine deciduas show same features as decidua vera of intrauterine gestation with absence of thinning and atrophy brought about by mechanical pressure of amniotic liquid. When death of foetus happens uterine decidua is thrown either in a huge cast or in smaller particles.

Outcome of tubular gestation

If left untreated, an ectopic pregnancy in the fallopian tube can progress to a tubal abortion or tubal rupture, or it may regress spontaneously.

1. Tubal rupture – Tubal rupture is usually associated with profound hemorrhage, which can be fatal if surgery is not performed expeditiously to remove the ectopic gestation. Ruptured ectopic pregnancy is the major cause of pregnancy-related maternal mortality in the first trimester.[28] Most of these deaths occur prior to hospitalization or proximate to the patient's arrival in the emergency department.

Rupture can be intraligamentary or intraperitoneal:

Intraligamentary (extra peritoneal) rupture: is uncommon and is accounted by rupture of the tube at a juncture where Its joined to the wide ligament. The gestation and the blood are released between the layers of the broad ligament to form a pelvic or a broad ligament haematoma. Eventually one leaf of the broad ligament might give way under the strain of recurrant bleeding and a secondary intraperitoneal rupture occurs.

1. Intraperitoneal rupture: Usually happens into the peritoneal cavity and the blood collects there in a partly solid but mostly liquid structure. Signs in view of acute blood loss might go with it. When the patient survives this without careful surgical intervention, reimplantation might happen. The blood will gather to form a pelvic haematocoele. Once in a while, when the conceptus is big, it might stay in cul-de-sac for long as an encapsulated mass or even become calcified to form a lithopaedian.
2. Tubal abortion – Tubal abortion refers to expulsion of the products of conception through the fimbria. This can be followed by resorption of the tissue or by reimplantation of the trophoblasts in the abdominal cavity (ie, abdominal pregnancy) or on the ovary (ie, ovarian pregnancy). Tubal abortion may be

accompanied by severe intraabdominal bleeding, necessitating surgical intervention, or by minimal bleeding, which would not require further treatment.

3. Spontaneous resolution – Spontaneous resolution of an ectopic pregnancy can occur, although it is difficult to predict which patients will experience uncomplicated spontaneous resolution. This is discussed in more detail separately.In rare instances, gestational products left in the fallopian tube can cause tubal obstruction.
4. Chronic ectopic

In this situation, the gestation dies but a variation of "Death in utero" happens with mild chronic symptoms dominated by anemia. Slow leakage of blood around the adnexa forms a pelvic mass frequently misdiagnosed as inflammatory disease. Resorption mostly takes place but the patient is treated surgically when the mass is discovered.

Tubal pregnancy had also been recognized for three and half centuries, the issue of exact and early diagnosis had not been solved. The manifestations of Ectopic gestation frequently range from inconclusive to an unusual clinical picture.

Clinical Manifestations

(l) **Amenorrhoea**: About 95 % of the patients have a brief period of amenorrhoea of 6-8 weeks and notice different manifestations of early gestation like nausea. The absence of a missed menstrual period by no means can rule out a tubular gestation. About 20 % don’t give a history of ammenorrhea. One explanation is that the patient mistakens uterine bleeding that mostly happens with tubular gestation for a true menstrual period which thus gives a wrong date for the last menses. That is why a carefully obtained history diffrentiates between the two.

(2) **Pain**: Abdominal pain, for the most part which is severe is a constant feature of Ectopic gestation in 95 % cases. It might be unilateral or bilateral, in the lower abdomen or diffuse or in the upper abdomen. The manifestations are identified irrespective of ruptured or not. It might be dull and steady aches related with stretching and slow tearing of the tube before rupture or acute ache as in rupture of the tube. Tenderness of whole of the abdomen because of irritation of the peritoneum is found in the presence of escaped blood. Phrenic or shoulder ache occurs when the blood causes diaphragmatic irritation. Kinins are found in elevated concentration at injury sites and might be involved with the creation of ache in Ectopic gestation. As indicated by Pisarska, patients at elevated risk ought to be screened early and before they become symptomatic.[29]

(3) **Bleeding or spotting**: As long as placental endocrine function continues, uterine bleeding is usually not there, but when endocrine support of the decidua becomes insufficient the uterine mucosa bleeds. The bleeding is usually less, found in 60-80 percentage of people, dark coloured and might be intermittent or continuous. Rarely heavy bleeding happens in tubular gestation. A decidual cast might be seen which is pathognomonic of Ectopic gestation. It had a smooth glittering intrinsic surface and a shaggy maternal surface and chorionic villi are missing.

(4) Other manifestations are of syncope, which varies from fainting to sudden fall and unconsiousness. When there should arise an occurrence of pelvic haematocoele, demonstration of micturition starts a new episode of ache and rectal manifestations like tenesmus and constipation are seen. Retching, backache and rise in temperature are different manifestations of Ectopic gestation. Pleuritic chest ache might happen from diaphragmatic irritation brought about by the hemorrhage. Dorfman and partners

reported that gastrointestinal symptoms (80%) and dizziness or light headedness (58 percentage) was mostly seen with advanced gestation.[27]

Physical examination

While the history is more valuable in diagnosis, the physical findings can also be helpful. In acute cases, the diagnosis is usually evident with clear indications of intraperitoneal hemorrhage and associated vascular breakdown. In the more occult variety, thorough physical assessment is vital.

Fever: The temperature seldom enlarges above l0l.5°F because of absorption of product of degeneration of blood. Fever can be significant in distinguishng a ruptured tubular gestation from certain cases of acute salpingitis.

Blood pressure and pulse: The patient will be normally normotensive or marginally hypotensive. Tachycardia might be a main sign of diminished blood volume. Prior to rupture, vital signs are most often normal. Early response to moderate hemorrhage might go from no change in vital signs to a slight ascent in blood pressure, or a vasovagal reaction with bradycardia and hypotension. Blood pressure will fall and heart rate rise just when bleeding and hypovolemia is significant.

Indeed, even with modern diagnostic strategies, women with a ruptured Ectopic gestation might present with hypovolemia and shock.[27]

Abdominal Examination: Abdominal tenderness is regularly present. Rebound tenderness might be elicited because of generalized peritoneal response in the pelvis. Bowel sounds are typically well heard.

In cases of ruptured ectopic with hemorrhage Infraumbilical distension with a moderately flat hypochondrium is seen which is a proof of intraperitoneal hemorrhage. The distension isn't generally because of free intraperitoneal blood

however to a related ileus of gut brought about by blood. The presence of free fluid in the peritoneal cavity might be shown by dulleness in the flanks.

Vaginal Examination: Pelvic mass is seen in majority of patients with ectopic gestation.The mass might be noted in either adnexal region or as a bulge in the cul-de-sac. Adnexal tenderness is commonly present on palpation. Most patients have tenderness on movement of the cervix.

Diagnosis

Transvaginal ultrasound

The transvaginal ultrasound (TVUS) is the most useful imaging test for determining the location of pregnancy. TVUS should be performed at the time of a suspected ectopic pregnancy, and may need to be repeated, depending on the findings, the hCG level, or subsequent suspicion of rupture.[30]

1. Findings diagnostic of an ectopic pregnancy include

- a gestational sac with a yolk sac or embryo (with or without a heartbeat) outside of the uterus.
- A gestational sac alone (without a yolk sac or embryo) is insufficient for diagnosis.

2. Findings suggestive of ectopic rupture

- A finding of echogenic fluid (consistent with blood) in the pelvic cul-de-sac and/or abdomen with rupture of an ectopic pregnancy

Figure1: Transvaginal scan of an ectopic gestational sac showing a thick hyperechoic rim and a yolk sac (*arrow*) within the anechoic center, but no embryo is seen.

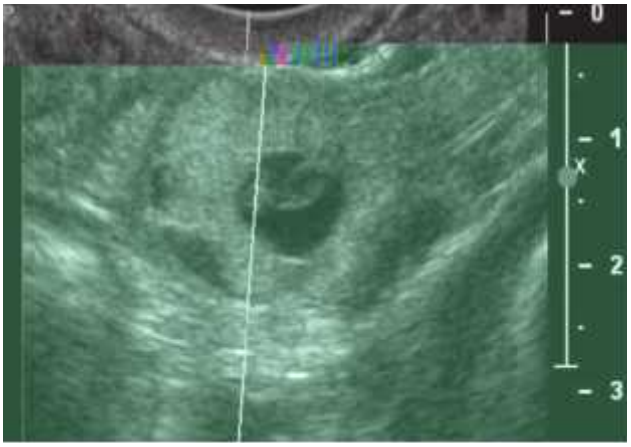

Figure2: Transvaginal scan of an ectopic gestational sac shows a very early embryo with M-mode

Figure3: Transvaginal scan of the adnexa in a patient with an ectopic gestational

sac containing a larger embryo. Cardiac activity was noted on real-time imaging. Note the rhombencephalon (*arrow*) in the posterior fossa. There is a large peri gestational hematoma (*asterisks*) that is less echogenic than the trophoblastic tissue at the periphery of the gestational sac (*arrowhead*).

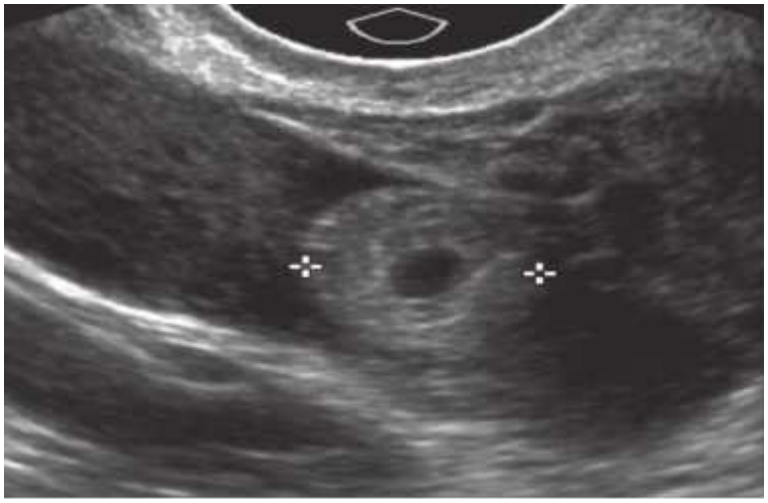

Figure4 : Transvaginal scan shows a typical adnexal tubal ring (*between calipers*), also called a “sugar donut” or “bagel” sign, representing an empty ectopic gestational sac with a round anechoic fluid-filled center surrounded by a thick echogenic rim. Note a small amount of adjacent free pelvic fluid.

Serum Human Chorionic Gonadotrophin :

ELISA for Beta HCG are sensitive to levels of 10 to 20mIU/ml and are positive in >99% cases of ectopic pregnancy.

Levels above the discrimatory zone –indicates failure to visualize an intrauterine pregnancy and indicates that the pregnancy is not alive or is ectopic. An empty uterus with serum beta HCG concentration >/=1500mIU/ml was 100% accurate in excluding a live intrauterine pregnancy.[31]

Levels below the discrimatory zone – indicates pregnancy location is often not technically discernible with TVUS. Thus serial serum Beta HCG is done every 48hours to see if they growing or failing intrauterine pregnancy.

If there is a normal rise – do TVS when serum beta HCG > discrimatory zone- it can be an Intra uterine pregnancy or ectopic pregnancy or non diagnostic or abnormal Intra uterine pregnancy.

Treatment

Expectant Therapy:

Expectant management is a method of conservative strategy, which consists of observation and assessment of whether the ectopic pregnancy is continuing to resolve spontaneously and successfully without any intervention.

Criteria for patient selection includes:

- Decreasing β-hCG levels.
- Pregnancy of unknown location
- An adnexal mass of less than 4 cm without an embryonic heartbeat.
- No evidence of rupture.

Follow-up should be between one to three times weekly with β-hCG measurement and ultrasonography as required. Expectant management is reported to be most useful when the initial β-hCG is <1000 IU/l. A rapidly declining β-hCG level also appears to predict a favourable outcome. Success rates between 47% and 82% are reported, depending on the patient's initial status[32,33].

Medical Treatment

Medical managment stays away from inherent morbidity of anesthesia and surgical procedure and lessens cost . Achievement rates and future reproductive performance are practically identical to those seen with surgical treatment.

MTX, Potassium chloride, Hyperosmolar glucose, Actinomycin, Prostaglandins all have been utilized. MTX had been concentrated broadly and is currently settled as an essential 1st line clinical therapeutic alternative in contrast to careful treatment for Ectopic gestation.

Its a folic acid antagonist that inactivates the enzyme DHFR, in this manner depleting available stores of THF, a basic co-factor in DNA and RNA synthesis during cell multiplication. Rapidly multiplying tissues like trophoblasts are especially vulnerable to its activity.[34]

INDICATIONS

Absolute Indications

- Heamodynamic stability
- No proof of intra abdominal bleed
- Commitment to follow up and comply
- No contraindication to MTX treatment

Preferable indications

- Absent or mild symptoms (pain)
- Serum beta-hCG concentration less than 5,000 IU/L
- Absent embryonic heart activity
- Ectopic mass measuring less than 4 cm in diameter

CONTRAINDICATIONS

- Breastfeeding
- Immunodeficiency states
- Hematologic abnormalities (severe anemia, leukopenia, thrombocytopenia)
- Known sensitivity to methotrexate
- Active pulmonary disease
- Active peptic ulcer disease
- Alcoholism
- Clinically important hepatic or renal dysfunction

Methotrexate Protocols for Tubal pregnancy

REGIMEN	FOLLOW UP
Single dose MTX 50mg/m^2 IM on Day 1	• Measure hCG level on posttreatment day 4 and day 7 o If the decrease is greater than 15%, measure hCG levels weekly until reaching nonpregnant level o If decrease is less than 15%, readminister methotrexate at a dose of 50 mg/m^2 intramuscularly and repeat hCG level o If hCG does not decrease after two doses, consider surgical management • If hCG levels plateau or increase during follow-up, consider administering methotrexate for treatment of a persistent ectopic pregnancy
Multiple dose MTX , 1mg/kg 1M day 1,3,5,7 Leucovorin 0.1mg/kg IM day 2,4,6,8	• Measure hCG levels on methotrexate dose days and continue until hCG has decreased by 15% from its previous measurement • If the decrease is greater than 15%, discontinue administration of methotrexate and measure hCG levels weekly until reaching nonpregnant levels (may ultimately need one, two, three, or four doses) • If hCG does not decrease after four doses, consider surgical management • If hCG levels plateau or increase during follow-up, consider administering methotrexate for treatment of a persistent ectopic pregnancy

Side effects

- Nausea, vomiting, diarrhoea
- Pneumonitis
- Reversible alopecia/Stomatitis
- Hepatotoxicity
- Bone marrow depression

Medical Therapy by Local Injection:

The direct injection of Methotrexate under transvaginal ultrasound guidance into an ectopic gestational sac. They instilled 10 mg of M and observed resolution of the pregnancy within 2 weeks. Direct injection of MTX has theoretic advantages over systemic treatment. The concentration of MTX at the site of implantation is many times higher after local injection than after systemic administration. With less systemic distribution of the drug, a smaller therapeutic dose might be necessary and toxicity would be less.

Surgical Treatment

Conservative Surgical Treatment

Conservative surgery[36]: In younger patients who are bound to have a future intrauterine gestation, conservative surgery to safeguard the affected fallopian tube is mostly appropriate for unruptured, leaking or marginally ruptured ectopics. Frequently even with gross rupture, the vast majority of the tube might be preserved.

In most ectopics, laparotomy is done. In specific situations, the specialist laparoscopist might remove the gestational tissue by a second puncture site suction, forceps or both. This might be feasable with an aborting Ectopic gestation when the whole coagulated mass is being or had been removed from the fimbriated end.

a. Salpingostomy

b. Salpingotomy

The procedures for saving the oviduct include either cutting the tube longitudinally over the implantation site and removing out the products of conception or with more distal implantation, just squeezing the tube in order to abort the products of conception through the ampulla. Salpingotomy is same as for salpingostomy aside

from that the entry point is closed with 7-0 Vicryl or similar suture. As per Tulandi and Saleh, there is no distinction in visualization with or without suturing.

c. Segmental resection and anastomosis

Resection of the mass and tubular anastomosis is utilized for an unruptured isthmic gestation. This procedure is utilized in light of the fact that salpingostomy might cause scarring and resulting in narrowing of the small lumen .Once the tubular fragment is exposed, the mesosalpinx underneath the tube is incised, and the tubular isthmus containing the ectopic mass is resected. The mesosalpinx is stitched, in such a way reapproximating the tubular stumps. The portions of the tube are then paired to one an other in layers with interrupted sutures using 7-0 Vicryl.

Radical Surgical Treatment

a. Salpingectomy: with or without ipsilateral oophorectomy

Removal of part or the entire affected tube is the typical technique. In interstitial gestation, the cornu of the uterus is incised also. Evacuation of the ovary, at the time of salpingectomy, had been proposed by Jeffcoate (l967) as a potential methods for both improving fertility decreasing the probability of an ongoing Ectopic gestation. Ovulation mostly occur from the ovary neighboring to the remaining oviduct and thus there are less chance of outer movement of the ovum, which causes ectopic gestation. Salpingectomy is performed when the fallopian tube is broadly diseased or damaged. This can likewise be performed through the vaginal route. Yet, it doesn't allow appropriate evaluation of the opposite tube and ovary and sufficient peritoneal toileting. As indicated by Moon, interstitial pregnancies can be effectively treated with endoscopic surgery.

In the event that the patient does not want a future pregnancies, tubular sterilization can be performed. Cornual resection is done in an effort to limit the recurrence of

gestation in the tubular stump. Indeed, even with cornual resection, a resulting interstitial gestation might not be prevented.

OVARIAN PREGNANCY

Ovarian pregnancy occurs in 1:7000 pregnancies or approximately 0.5 to 3.0 percent of ectopic pregnancies and is becoming more common. In contrast to tubal pregnancy, a history of pelvic inflammatory disease or the use of an intrauterine contraceptive device does not increase the risk of ovarian pregnancy. Ovarian pregnancy appears to be a random event that is not associated with a history of infertility or recurrent extrauterine pregnancy.

Diagnostic criteria described by Spiegelberg for Ovarian Pregnancy are [34,35]

l. The tube on the affected side have to be intact.

2. The fetal sac have to be seen within the Ovary.

3. It have to be linked with the uterus by the ovarian ligament.

4. Definite ovarian tissue has to be found in its wall.

Findings suggestive of an ovarian ectopic pregnancy on transvaginal ultrasound with an empty uterus are a wide echogenic ring with an internal anechoic area on the ovary. A yolk sac or embryo is seen less commonly.It is not possible to separate the cystic structure or gestational sac from the ovary on gentle palpation (negative sliding organ sign). The corpus luteum should be identified separate from the suspected ovarian pregnancy. Colour Doppler may aid detection of a fetal heart pulsation within the ovary. A complex echogenic adnexal mass with free fluid in the pouch of Douglas can represent a ruptured ovarian ectopic pregnancy.

A single serum b-hCG should be carried out at diagnosis to help with management. In some cases, a repeat serum b-hCG in 48 hours may be useful in deciding further management.

Ovarian ectopic pregnancy can be difficult to diagnose with certainty preoperatively, so the diagnosis should be considered whenever ultrasound findings are suspicious. After surgical treatment, the histopathology result will confirm the diagnosis of ovarian ectopic pregnancy.

Minimal access surgery is now the treatment of choice for ovarian ectopic pregnancy. Removal of the gestational products by enucleation or wedge resection (in the presence of a large ectopic mass) is preferred.Enucleating the products of conception bluntly from the ovary minimises damage to the surrounding ovarian tissue. Haemostasis can be achieved by electrocautery or suturing. Oophorectomy is occasionally required when there is coexisting ipsilateral ovarian pathology or excessive bleeding.

A number of successful and unsuccessful attempts have been made to treat ovarian ectopic pregnancy with systemic methotrexate. In one series,there was a failure rate of 40% using methotrexate alone. However, all the cases successfully treated with methotrexate were diagnosed laparoscopically. There are no defined selection criteria, or treatment or follow-up regimens.

ABDOMINAL PREGNANCY

Abdominal pregnancy refers to a pregnancy that has implanted in the peritoneal cavity, external to the uterine cavity and fallopian tubes. The estimated incidence is 1 per 10,000 births and 1.4 percent of ectopic pregnancies. There are reports of abdominal pregnancy occurring after hysterectomy.

Risk factors for abdominal pregnancy include tubal damage, pelvic inflammatory disease, endometriosis, assisted reproductive techniques, and multiparity. Because of the variable location in the abdomen, abdominal pregnancy is associated with a wide range of signs and symptoms. In contrast to tubal ectopic pregnancies, abdominal

pregnancies may go undetected until an advanced gestational age; some pregnancies go all the way to term. In such cases, fetal movement may be appreciated and may be painful, and the fetus may assume an unusual lie. When the pregnancy implants on bowel, nausea and vomiting may be prominent symptoms. Vaginal bleeding is less frequent than in tubal ectopic pregnancies; however, vaginal bleeding may occur since the endometrium still responds to changes in pregnancy hormones. Some women present with an acute abdomen and shock due to severe intraabdominal hemorrhage from placental separation or rupture of maternal blood vessels or viscera. In rare cases, the pregnancy may be diagnosed after a failed induction due to lack of myometrial response to oxytocin stimulation. Bowel obstruction and formation of fistulae are other rare presentations.

The following ultrasound criteria have been suggested by Gerli et al as being diagnostic of an early abdominal pregnancy[35]:

1. Absence of an intrauterine gestational sac.
2. Absence of both an evident dilated tube and a complex adnexal mass.
3. A gestational cavity surrounded by loops of bowel and separated from them by peritoneum.
4. A wide mobility similar to fluctuation of the sac, particularly evident with pressure of the transvaginal probe toward the posterior cul-de-sac.

In a clinically stable patient where abdominal pregnancy is identified or strongly suspected on ultrasound, MRI can help to confirm the diagnosis and to identify placental implantation over vital structures, such as major blood vessels or bowel.This can help to guide perioperative considerations, such as the surgical team, blood products, preoperative angiographic embolisation, bowel preparation and insertion of ureteral catheters. Ultrasound and/or MRI can be used to precisely map the location of

the placenta prior to laparotomy so as to avoid incising the placenta and the associated risk of uncontrollable haemorrhage.Laparoscopic removal is an option for treatment of early abdominal pregnancy. Possible alternative treatment methods would be systemic methotrexate with ultrasound- guided fetocide. Advanced abdominal pregnancy should be managed by laparotomy. Laparoscopic treatment is a safe and effective option for the management of abdominal pregnancy when the diagnosis is made early and the site of implantation does not involve a vascular area. Laparoscopic management has been associated with reduced operative time, blood loss and length of hospital stay when compared with laparotomy.

Very few cases of nonsurgical management of early abdominal pregnancy have been reported. These include cases managed with intramuscular methotrexate alone and in combination with intrasaccular injection with methotrexate.

Methotrexate has also been used as an adjunctive treatment to surgery.Advanced abdominal pregnancy is associated with significant maternal and fetal morbidity and mortality,and once diagnosed, a laparotomy should be undertaken promptly.The surgical approach should be planned to avoid incision of the placenta. The placenta may be left in situ if the vascular attachment involves major vessels or vital structures, and spontaneous resorption awaited.Preserving the placenta (or 'its retention') is associated with significant morbidity (ileus, bowel obstruction, fistula formation, haemorrhage, peritonitis), but the mortality is lower than with its removal.Adjuvant treatments with methotrexateand selective arterial embolizationhave been described.

CERVICAL PREGNANCY

Possible etiologies include an endometrial lining unreceptive to implantation (as with infection), uterine fibroids, an atrophic endometrium, a septate uterus, current IUD use, endometrial scarring, and use of oral contraceptives. Pregnancies associated

with assisted reproductive technologies (ART) also seem to have a higher incidence.Rubin in 1911, postulated following criteria for the diagnosis of cervical pregnancy

- Cervical glands must be opposite the placental attachment.
- Placental attachment to the cervix must be situated below the entrance of the uterine vessels or below the peritoneal reflection of the anterior and posterior surfaces of the uterus.
- Fetal elements must be absent from the corpus uteri.

Paalman and McElin proposed five more clinically practical criteria for the diagnosis of this condition:

- Uterine bleeding without cramping pain following a period of amenorrhea.
- A soft, enlarged cervix equal to or larger than the fundus (the hourglass uterus).
- Products of conception entirely confined within and firmly attached to the endocervix
- A closed internal cervical os.
- A partially opened external cervical os.

On ultrasound, the uterine cavity will be empty and the cervix may appear barrel shaped. The gestational sac or trophoblastic mass will be present below the level of the internal cervical os. There will be a negative ‘‘sliding organ sign’’ (when pressure is applied to the cervix using the TVS probe, in a miscarriage the gestational sac slides against the endocervical canal but not in an implanted cervical pregnancy). There may also be evidence of sustained peritrophoblastic circulation on color Doppler examination.

The preoperative preparation should include blood typing and cross-matching, establishment of intravenous access, and detailed informed consent. The consent should include the possibility of hemorrhage that may require transfusion or hysterectomy.

Various techniques that can be used to control bleeding include uterine packing, lateral cervical suture placement to ligate the lateral cervical vessels, placement of a cerclage, and insertion of an intracervical 30-ml Foley's catheter in an attempt to tamponade the bleeding. Alternatively, angiographic artery embolization can be used. If laparotomy is required, an attempt can be made to ligate the uterine or internal iliac arteries.

Nonsurgical treatment, including intraamniotic and systemic methotrexate administration.

Cervical pregnancies are rare, accounting for less than 1% of all ectopic gestations. The following ultrasound criteria have been described in the diagnosis of cervical ectopic pregnancy[35]:

1. Empty uterine cavity.
2. A barrel-shaped cervix.
3. A gestational sac present below the level of the internal cervical os.
4. The absence of the 'sliding sign'.
5. Blood flow around the gestational sac using colour Doppler.

The 'sliding sign' enables cervical ectopic pregnancies to be distinguished from miscarriages that are within the cervical canal. When pressure is applied to the cervix using the probe, in a miscarriage, the gestational sac slides against the endocervical canal, but it does not in an implanted cervical pregnancy.A single serum beta-hCG carried out at the time of ultrasound diagnosis is useful in deciding management

options. A serum beta-hCG level greater than 10 000 iu/l is associated with a decreased chance of successful methotrexate treatment.Medical management with methotrexate can be considered for cervical pregnancy.

Surgical methods of management are associated with a high failure rate and should be reserved for those women suffering life-threatening bleeding. Early, accurate diagnosis is the key factor in the conservative management of cervical pregnancies. Gestational age less than 12^{+0} weeks, absence of fetal cardiac activity and lower serum beta-hCG levels are associated with more successful conservative management.A variety of methods have been described in the literature (dilatation and curettage, systemic methotrexate, local injection with potassium chloride or methotrexate). There was, however, no standard protocol of methotrexate used and successful cases required surgical debulking or local injection with methotrexate in addition to systemic therapy. Gestational age more than 9^{+0} weeks, beta-hCG levels greater than 10 000 iu/l, crown–rump length greater than 10 mm and fetal cardiac activity were shown to be associated with a higher risk of primary failure of the treatment of cervical ectopic pregnancy with systemic methotrexate. In addition, combination therapy with intra-amniotic injection seemed to increase the chance of successful treatment in this retrospective study.

A number of adjunctive methods to control haemorrhage in the treatment of cervical ectopic pregnancy have been described; these include uterine artery ligation and uterine artery embolisation (UAE).

Rh-negative women

Anti-D prophylaxis as per national protocolis given to all RhD-negative[35] women who have surgical removal of an ectopic pregnancy, or where bleeding is repeated, heavy or associated with abdominal pain. Alloimmunisation has been reported following

ectopic pregnancy and 25% of cases of ruptured tubal ectopic pregnancy are associated with a significant number of fetal cells in the maternal circulation.

Women who undergo surgical management of ectopic pregnancy may be at higher risk of sensitisation due to mixing of fetal and maternal blood.

There is a paucity of evidence regarding the risk of alloimmunisation associated with medical and expectant management of ectopic pregnancy. However, the risk of mixing of fetal and maternal blood following conservative or medical management is thought to be low.NICErecommend only offering anti-D prophylaxis to those undergoing surgical management, but this is contrary to the British Committee for Standards in Haematology guidance.

Nitesh *et.al* (2020) conducted a study of ectopic pregnancy in a tertiary care centre in department of obstetrics and gynaecology, jhalawar medical college, Jhalawar, Rajasthan, India from January 2019 to October 2019. All patients admitted with diagnosis of ectopic pregnancy, either ruptured or unruptured where included in the study. Total 52 patient of ectopic pregnancy were studies. Majority (63.46%) of patients belong to the age group 21-30 years. Ectopic pregnancy was most commonly noted in nulliparous woman (44.23%) Majority of the case (31%) had no risk factors among remaining (34.61%), previous MTP (17%), (17-30%) previous ectopic (9%) and PID (15-38%) were identified risk factors. Ampulla (75%) was the most common site for ectopic pregnancy. 57% of the cases were on the right side. The common presenting complaints were pain in abdomen (81%) bleeding/ spotting per vaginal (42%). There was no mortality. : Surgical treatment was done more often because of patients reporting late to the hospital screening of high-risk case, early diagnosis and early intervention reduce the morbidity and mortality in ectopic pregnancies.[37]

Vasundara *et.al (2017)conducted a study titled* 'Management of tubal ectopic pregnancy in a tertiary care health center'. 60 women diagnosed with tubal ectopic pregnancy at KIMS Hospital, Secunderabad were selected as the sample of the study. All the patients were managed on outpatient basis, except when the patient was haemodynamically unstable or there were signs of ruptured ectopic pregnancy clinically or on transvaginal scan (TVS). Patients with unruptured tubal pregnancy irrespective of β-hCG levels who were haemodynamically stable, with normal complete blood count (CBC), liver function test (LFT), renal function test (RFT), complied with regular follow up were selected for medical management. Patients were referred for surgical management in cases of tubal rupture and in patients whose β-hCG levels decrease is by ≤15% or a plateau was reached in serum β-hCG after two repeat doses of methotrexate. Success rate was 95.24% (n=40). Two patients (4.76%) with methotrexate administration, had to be taken up for surgery due to poor response, even after 2 doses. Whereas 25% of subjects required surgical management. Surgery was the ultimate option in 25%(n=15). 8.33%(n=5) who underwent laparoscopy on an elective basis, while 11.67%(n=7) underwent emergency surgery (Total =12, 20%). 18. 5%(n=3) underwent laparotomy, one of them being converted from laparoscopy to open surgery. Type of surgery done, in any case was Salpingectomy.[38]

Gaddagi (2012) studied the cases of ectopic pregnancy who were admitted to the Cheluvamba hospital during November 2004 to May 2006. A total of 37 patients who were diagnosed as ectopic pregnancy cases were analyzed between the period from November 2004 to May 2006. All these cases were analyzed after applying the inclusion and exclusion criteria with respect to the 1. History 2. Clinical presentation 3. Investigations and 4. Treatment.Results suggested that the incidence of the ectopic pregnancy in the study was 1:399 pregnancies. A majority of the cases were

multigravidas. In most of the cases, there were no identiable risk factors. However, they did present with pain in the abdomen, amenorrhoea and bleeding per vagina in at least 50% of the cases. Almost half (40%) were in a state of shock at admission. Ultrasound, a urine pregnancy test and culdocentesis were the investigative modalities which were used. All the cases were managed by surgical management. On laparotomy, a majority of the cases were found to be ampullary pregnancies, followed by interstitial pregnancies. The tube was ruptured in almost 80% of the cases and there was a haemoperitoneum. Almost all the patients had intraoperative and/ or postoperative blood transfusions. There was no significant post operative morbidity in these cases. Interpretation And Conclusion- The early diagnosis of an ectopic pregnancy is one of the greatest challenges for a physician. It requires a high index of suspicion i.e to diagnose an ectopic pregnancy, one must be ectopic minded. The importance of an early diagnosis lies in the fact that the lady can be offered a conservative line of management which can definitely have a beneficial effect on her reproductive career.[39]

Arup Kumar (2007) conducted a study titled Ectopic Pregnancy-An Analysis of 180 Cases. This was a prospective study carried out at NRS Medical College, Kolkata, among consecutive 180 patients of ectopic pregnancy admitted from January, 2002 to December, 2004. During this period the incidence of ectopic pregnancy was 1 in 161(0.6%). The peak age of incidence was 26-30 years; primi were the most sufferers. There were 65.0% patients was had identifiable risk factors. Tubectomy (14.4%), history of abortion (26.1%), infertility (12.2%), pelvic inflammatory diseases (12.8%) and history of previous surgery (11.1%) were the important risk factors. Amenorrhoea (76.1%), abdominal pain (86.1%) and vaginal bleeding (42.2%) were the frequent presenting complaints. There were 87.8% patients was had pallor, 9.4% were

admitted with features of shock. Cervical motion tenderness (82.2%) was the most frequent sign. Urinary beta-hCG was positive in 96.1% cases. Ultrasonography revealed diagnosis in 2/3rds cases among 129 patients. Culdocentesis evoked the diagnosis in 73.3% cases out of 135 patients. In 95.0% cases it was of tubal variety, 70.2% ruptured, 19.9% tubal abortion and 9.9% unruptured. Surgery by open method in the form of salpingectomy (81.9%), salpingo-oophorectomy (9.3%) and salpingostomy (5.3%) were the mainstay of management. Expectant management and medical therapy can be offered only in 1.2% and 1.75% respectively. There was no case fatality.[40]

Urooj Mahboob(2006) conducted a study titled 'Management of Ectopic Pregnancy: A Two-Year Study -Fifty two patients diagnosed to have ectopic pregnancy at MCH Center unit II in the year 2004 and 2005 were included in the study. A cross-sectional analytical study was done. Four modes of treatment were given according to patient's condition, ultrasound findings and beta-hCG levels; these were laparotomy, operative laparoscopy, methotrexate injection and conservative management. The outcome measures included success of each treatment modality, need for second mode of treatment in each group and duration of hospital stay.**Results suggested that t**he rate of ectopic pregnancy was 1:100 deliveries. Emergency laparotomy was performed in 30 (57.9%) women, 15 (28.8%) received methotrexate injection. Seven women (13.3%) were managed conservatively and operative laparoscopy was not used as primary treatment in any of the patient. All cases of laparotomy did not require any further procedure. Twelve out of fifteen (80%) cases of medical treatment were successful while one (6.7%) proceeded to emergency laparotomy, one (6.7%) to operative laparoscopy and one (6.7%) to laparoscopy preceding laparotomy. Five out of seven patients (71.4%) on conservative treatment did not require any further

intervention while two (28.6%) of them resolved with methotrexate injection. The duration of hospital stay in laparotomy, medically treated and conservatively managed groups was 6.5, 5.9 and 1.7 days respectively. The study concluded that **in** the institutional setting ectopic pregnancy accounted for 1% of total deliveries. More than half of all women with ectopic pregnancy presented with acute abdomen and required emergency laparotomy. About 40% women could be managed with non-surgical modalities with 80% success for methotrexate injection and 71% for conservative treatment in the present study.[45]

MATERIALS AND METHODS

This study was conducted at Dr. Prabhakar Kore hospital and MRC, Belagavi between January 20l9 and December 20l9 following obtaining clearance from the Hospital Ethical Committee.

Method ofcollectionof data All cases ofdiagnosed Ectopic gestation at Dr. Prabhakar Kore hospital and MRC, Belagavi.over the periodofone year was enrolled in the study. Data was collected in a semi-structured questionnaire which included presenting complaints, history (historyof present illness, menstrual and obstetric, past history, historyofcontraceptive use and family history), examination findings (general examination, vitals and obstetricexamination) and investigations (Haemoglobin, bloodgroup, β-human chorionicgonadotrophins, ultrasonographic findings) and any otherinvestigation that seemed necessary by the treating obstetrician. The treatment modality of each case was also documented.

Statistical analysis

Following statistical methods was utilized in the current study

- Percentages
- Chi-square test.

Chi-square test

The Chi-Square Test method organizes a variable intocategories and provides a chi-square measurement. This integrity of-fit test is tocompare the observed and expected frequencies in every groupshould be tested either that all groupscontain a similar proportionof values or that every groupcontains a user specific proportionof values.

Data was entered intoMicrosoft excel data sheet and was analyzed using SPSS forWindows (Statistical Presentation System Software, SPSS Inc.) version l7.0.Continuous data was represented as mean and standard deviation.

Graphical representationof data: MS Excel and MS word was used toobtainvarious types of graphs such as bar diagram and Pie diagram.

p value (Probability that the result is true) of<0.05 was considered as statistically significant following assuming all the rules of statistical tests.

Statistical software: MS Excel**,** SPSS version l7.0 was used to analyze data.

Inclusion Criteria

All cases ofdiagnosed Ectopic pregnancy at Dr. Prabhakar Kore hospital, Belagavi.

Exclusion Criteria

Patients not willing to give consentfor the study.

RESULTS

The present study was an observational study on managment practises of ectopic pregnancy and was conducted at Dr. Prabhakar Kore hospital and MRC, Belagavi, for a 1-year period, from January 2019 – December 2019.

In this series, 50 cases ofdiagnosed ectopic gestation was observed and treated during a periodofone year from January 2019 to December 2019 atDr. Prabhakar Kore hospital and MRC, Belagavi

Table 1: Incidence of ectopic pregnancy

Total number of deliveries	**4816**
Total number of ectopic pregnancies	50
Incidence	1.03

Out of total 4816 deliveries, the total number of diagnosed ectopic pregnancies were 50. Incidence of total number of diagnosed cases of ectopic pregnancies was 1.03.

Table 2: Age distributionof the sample

Age of the patient (years)	Total number of cases	Percentage (%)
20-30years	3l	62 %
30-40years	l8	36 %
>40years	l	2 %
Total	50	100%

In the present study 31 pregnant women diagnosed with Ectopic pregnancy were in the age group of 20-30 years contributing to 62% and 18 of them were in the age group 30-40 years (36%) and ≥40 years (2%) as shown in Table 1. The average maternal age was 24.6years.

Graph 1: According to age

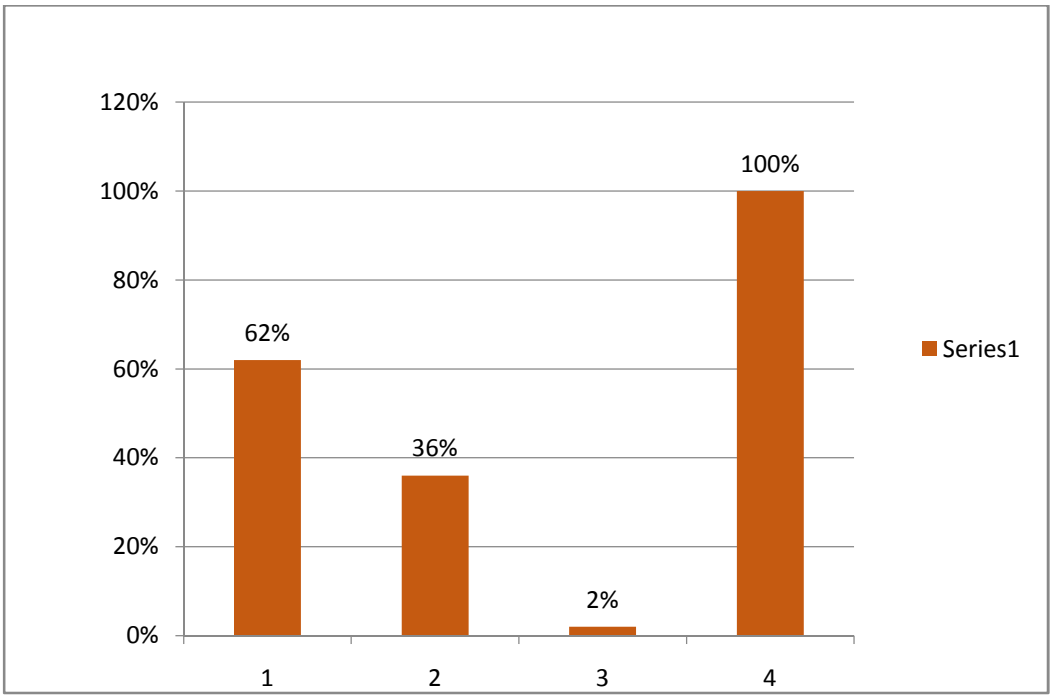

Table 3: Distribution according to Gravidity

Gravida	Number	Percentage(%)
Primigravida	l4	28 %
Multigravida	36	72 %
Total	50	100%

The maximum incidence of ectopic gestation (72%) was noticed among multigravidas more commonly the second gravida. In 14 out of 50 patients, ectopic pregnancy was the first conception.

Graph 2: Distribution according to gravidity

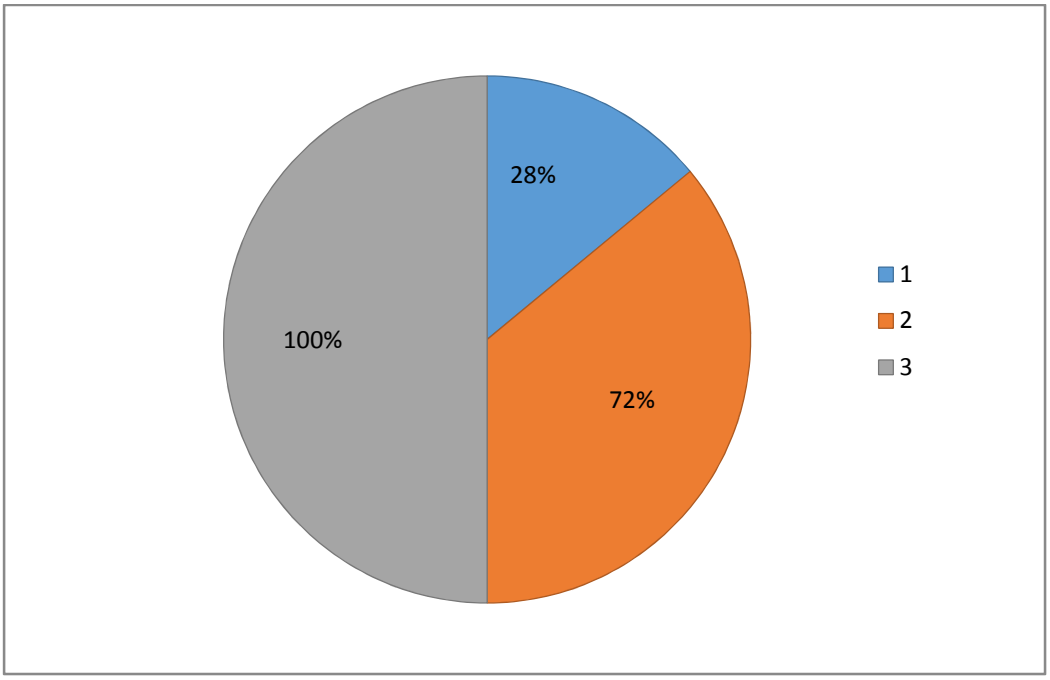

Table 4:Distribution according to risk factors

Risk factor	Frequency	Percentage(%)
Previous LSCS	21	42 %
Age > 35 years	2	4%
Past historyof Endometriosis	3	6 %
PID	7	l4 %
Intra uterine contraceptive device	3	6 %
Previous history of dilatation and currettage	l0	20 %
Tubectomy	2	4 %
Prvious ectopic	2	4 %
Total	50	100%

A previous lower segment caesarean section was found to be the most common risk factor in my study accounting for nearly 42% cases. A previous history of dilatation and curettage being the sole factor in 20% cases. 7 patients gave history of Pelvic inflammatory disease which contributed to 14% and had undergone treatment for the same with abtibiotics. 3(6%) patients had a history of endometriosis and had taken treatment for it. 2(4%) patinets had been operated previously for an ectopic pregnancy.

Graph 3:Distributionof cases according to risk factors

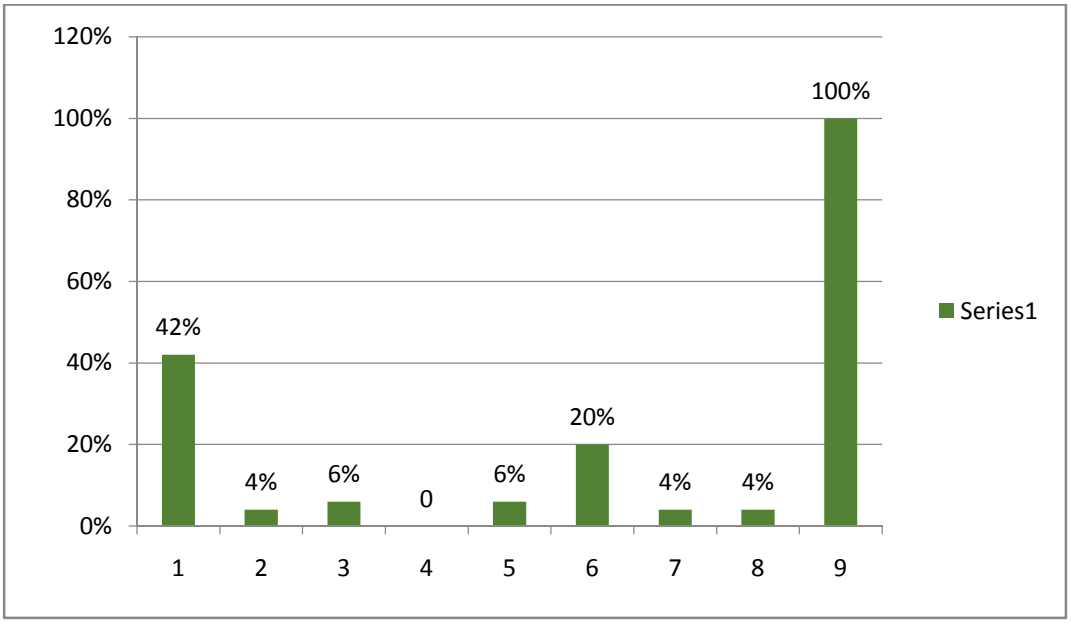

Table 5:Modeof presentation

Symptoms	No. of cases	Percentage(%)
Amenorrhea, Pain abdomen, PV bleed (Triad of symptoms)	l2	24 %
Triad ofsymptoms + syncope	ll	22 %
Amenorrhea + Pain abdomen	l0	20 %
Amenorrhea + Pain abdomen + syncope	7	l4 %
Amenorrhea	3	6 %
Ammenorrhea + PV bleed	l	2 %
Pain abdomen + others	3	6 %
Pain abdomen + PV bleed + Vomiting	3	6 %
Total	50	100%

The typical triad of amenorrhea, pain abdomen and bleeding was observed in 24% cases only. 20% of the cases presented with a history of pain abdomen and amenorrhea. Abdominal pain maybe a dullaching pain or a radiating pain or a pricking type of pain. It may be continuous or intermittent Those cases in which rupture was suspected had symptoms of persistent abdominal pain along with other symptoms in view of ongoing blood loss like feel like faint or loss of consciousness.

Table 6: Clinical presentation

Sign	Number	Percentage(%)
Pallor	33	66 %
Tachycardia	42	84 %
Hypotension	26	52 %
Shock	9	l8 %
Abdominal Tenderness	43	86 %
Guarding	6	l2 %
Abdominaldistension	2	4 %
Enlarged uterus (8 weeks size)	4	8 %
Cervical motion tenderness	27	54 %
Forniceal tenderness	32	64 %

Out of 50 patients, Abdominal tenderness was found to be a significant finding in 43 (86%) cases. Only 9 were admitted in a state of shock. However other symptoms like distension and guarding was seen in 4% and 12%of cases respectively.

Majority of the cases had normal uterine size. It was found increased in around 8 % of casesA painful cervical movement was seen in 54% of cases. This sign along with a suggestive history and mass or fullness of the posterior fornix was most helpful in arriving at the correct diagnosis of ectopic gestation.

Majority of the cases have forniceal tenderness. About 64% of cases had tenderness with mass in the fornix.

Table 7: Anemia (according to ICMR) onadmission

Degree of anemia	No. of cases	Percentage(%)
Mild anemia (8 – l0.9g/dl)	20	40 %
Moderate anemia (5 - 7.9g/dl)	7	l4 %
Severe anemia (<5g/dl)	3	6 %
Normal (>llg/dl)	20	40 %
Total	50	100%

Anemia was seen in 61% of cases in which 40 % had mild anemia, 14% had moderate anemia, 6%had severe anemia.

Table 8: USG findings

USG features	Number	Percentage(%)
Extrauterine gestational sac seen with free fluid	16	32 %
Complex adnexal mass separate from the ovary with free fluid	26	52%
Significant free fluid in POD	8	16 %
Total	50	100%

68% of cases were ruptured and 32% of cases were found to be unruptured on ultrasound.

Graph 4: USG Findings

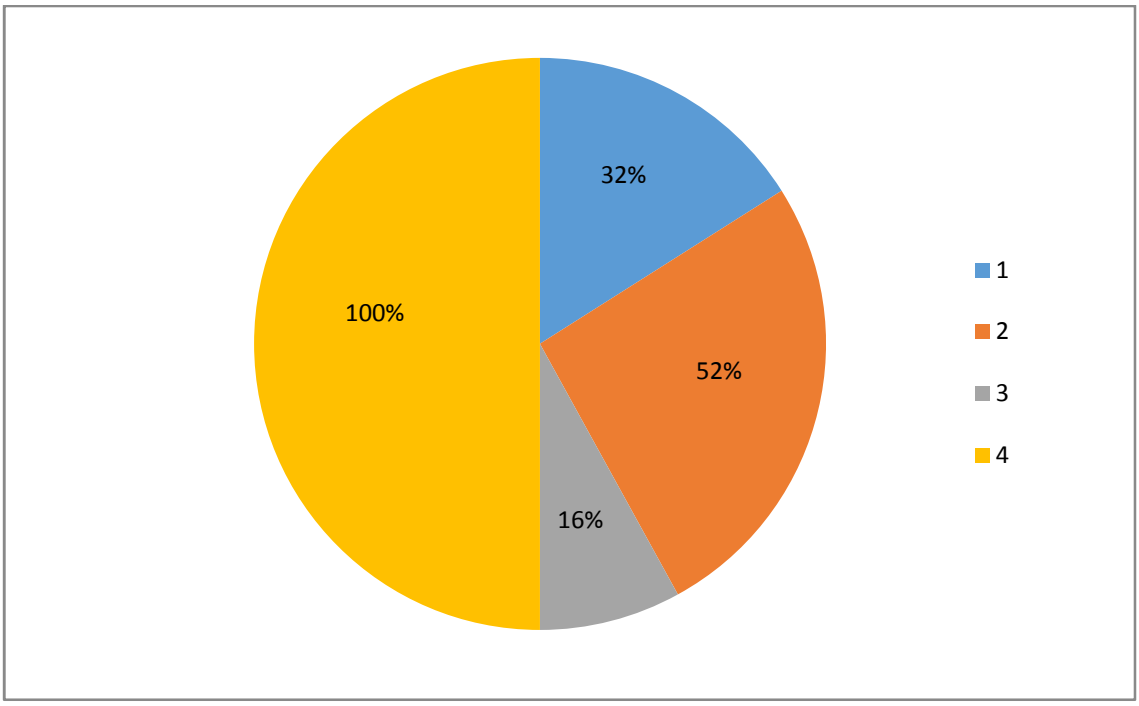

Table 9:Distributionof cases according to site

Site	Number	Percentage(%)
Ampullary	29	58 %
Cornual	ll	22 %
Fimbrial	4	8 %
Isthumus	6	l2 %
Total	50	100%

Significantly more number of cases had ampullary (58%) pregnancy, followed by cornual (22%) and isthmal (12%) and least in the fimbrial part (8%) of the fallopian tube.

Graph 5: Distribution of cases according to site

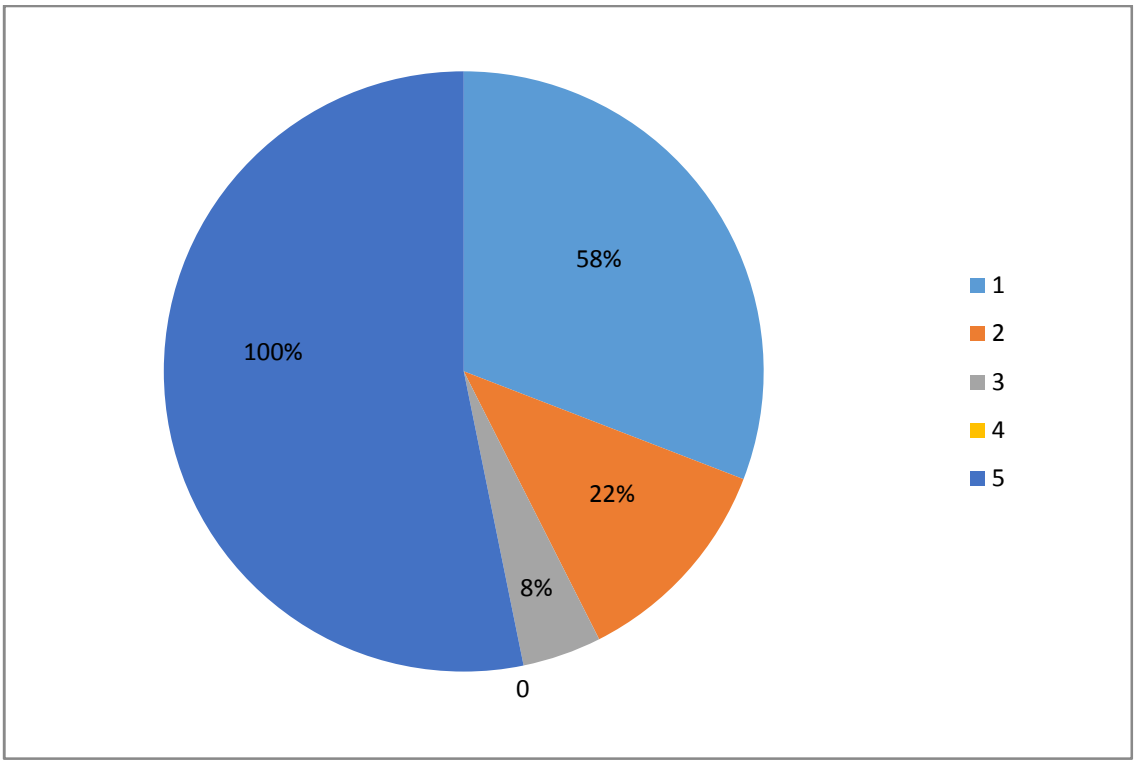

Table 10 :Intraoperative finding

Intra op finding	Number	Percentage(%)
Ruptured	29	58 %
Unruptured	l6	32 %
Tubal abortion	4	8 %
Chronic ectopic	l	2 %
Total	50	100%

Significantly more cases had rupture (58%) followed by tubal abortion (8%)and unruptured ectopic (32%).

Graph 6:Intraoperative finding

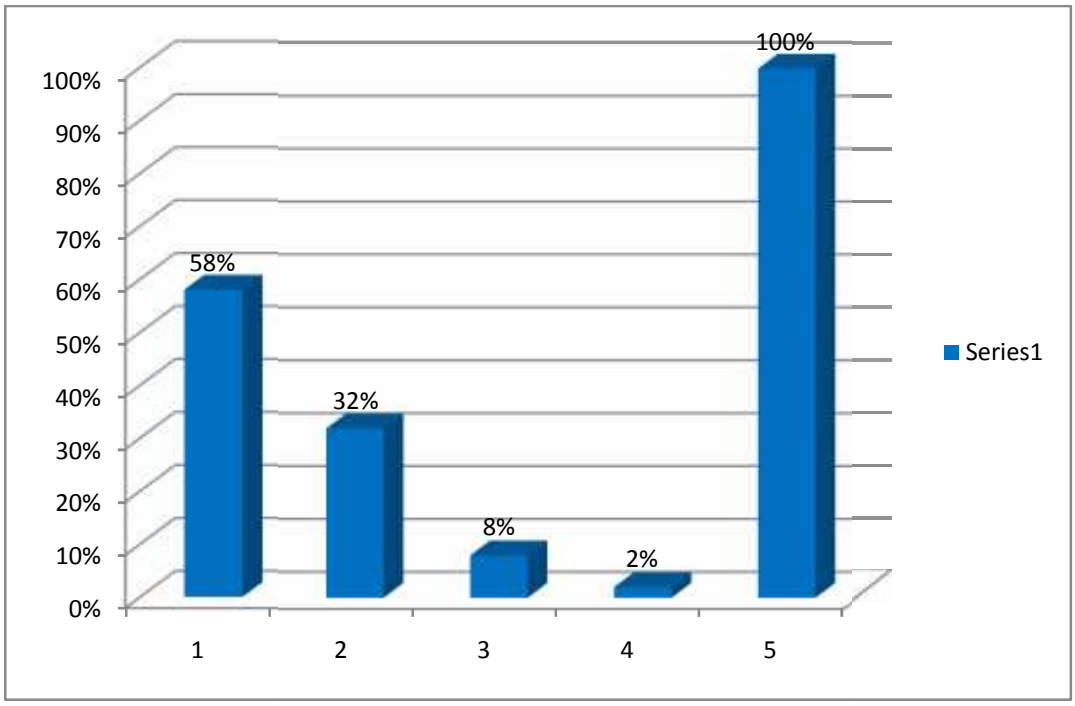

Table 11 :Correlationof shock with presentation of ectopic

			Conditionof tube				P-value
			Chronic ectopic	Ruptured	Tubal abortion	Unruptured	
SHOCK	ABSENT	N	l	21	3	l6	0.l63
		%	l00.0 %	72.4 %	75 %	l00.0 %	
	PRESENT	N	0	8	l	0	
		%	0.0 %	27.6 %	25 %	0.0 %	

In the present study, the comparison between shock with presentation of ectopic was made as shown in Table 11.

8 patients in ruptured ectopic group had presented with shock and 1 patient with tubal abortion presented with shock which was not statistically significant as shown in Table 11.

Table 12: Correlation of surgery done with presentation of ectopic

			Condition of tube				P-value
			Chronic ectopic	Ruptured	Tubal abortion	Unruptured	
Procedure	**USCT	N	0	l	0	0	0.446
		%	0.0 %	3.l %	0.0 %	0.0 %	
	****LUSCT	N	0	2	0	0	
		%	0.0 %	6.2 %	0.0 %	0.0 %	
	***LUSE	N	0	3	2	6	
		%	0.0 %	9.4 %	50.0 %	37.5 %	
	*USE	N	l	23	2	l0	
		%	l00.0 %	8l.2 %	50.0 %	62.5 %	

- Unilateral Salphingectomy (USE)*
- Unilateral salphingectomy with contralateral tubectomy (USCT)**
- Laprascopic Unilateral Salphingectomy (LUSE)***
- Laprascopic unilateral salphingectomy with contralateral tubectomy with falope rings (LUSCT)***

In the present study the most common procedure done was laparotomy with unilateral salphingectomy and most of the patients in my study presented as ruptured ectopic which did not show any statistical significance as show in Table 12.

Table l3: Procedure done

Procedure	No. of scenario	Percentage(%)
Unilateral Salphingectomy	35	70 %
Unilateral salphingectomy with contralateral tubectomy	l	2 %
Laprascopic Unilateral Salphingectomy	l2	24 %
Laprascopic unilateral salphingectomy with contralateral tubectomy with falope rings	2	4 %
Total	50	100%

Significantly more number of cases had undergone unilateral salphingectomy (70%). 2% of cases had undergone unilateral salphingectomy with contralateral tubectomy as they had completed their families. 14 out of 50 patients had undergone laproscopic procedure of which laproscopic unilateral salphingectomy was the most commonly performed procedure, thus preserving the fertility status.

Graph 7: Procedure done

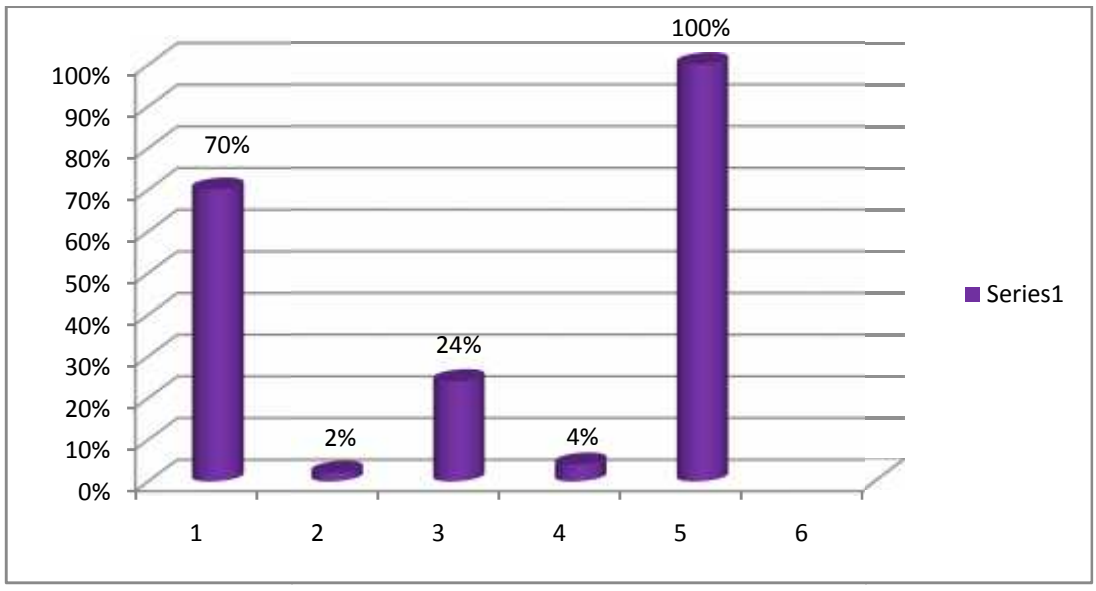

Table l4: Total Blood loss

Amount	Number	Percentage (%)
<500 ml	l6	32 %
500 – l000 ml	24	48 %
l000 - l500 ml	7	l4 %
>1500ml	3	6 %
Total	50	100%

In the present study the total blood loss was noted highest in 24 patients which had been seen to be around 500-1000ml.

In only 3 patients a blood loss of more than 1500ml were noted as shown in Table 14

Table 14: Blood transfusion

Procedure	Frequency	Percentage(%)
Done	34	68 %
Not done	16	32 %
Total	50	100%

Blood transfusion was given in 68% of cases. Patients who were brought in shock were managed with both blood transfusions as well as plasma expanders.

DISCUSSION

The one-year hospital-based study was directed between period of January 2019 to December 2019 to all diagnosed cases of ectopic pregnancy Dr. 'Prabhakar Kore' hospital, Belagavi. In this study, 50 cases ofdiagnosed ectopic gestation were observed and treated.

In table 1, Out of 4816 deliveries, the incidence of ectopic pregnancy is 1.03%. This wasnearly same as the study conducted by Hoover KW done et al where the incidence was 6.4%.[47]

In a similar study done by Van Den Eeden SK et al at Northern California between 1997- 2007 : a large health network study of 126,451 deliveries, around 2617 ectopic pregnancies were identified and the incidence was 20.7%.[48]

In a related study of Medicaid recipients from 2004 to 2008 a multicentric study reported a rate of 14.7%.[49]

Maternal characteristics:

1. Maternal age(Table 2)

Ectopic pregnancy may occur at any time from menarche to menopause. In the present study 31 pregnant women diagnosed with Ectopic pregnancy were in the age group of 20-30 years contributing to 62% and 18 of them were in the age group 30-40 years (36%) and ≥40 years (2%). In a similar study conducted by Van Den Edeen SK et al at a large health network at northern california during 1997 to 2000 the ectopic pregnancy rates between 15-19, 20-29,30-39, and 40 to 49 years were 12.5%, 16.6%, 25.3% and 42.5% [50]respectively.

2. Gravidity(Table 3)

The present study, the maximum incidence of ectopic in multigravidas was 72%, Munro Kerr and Eastman are of the opinion that there is no specific relation between parity and ectopic. But in the study by Rose et al, as parity increases there is a decrease in the incidence of ectopic pregnancy[49]. According to ICMR Multicentric Case Control Study of ectopic pregnancy, majority of women were young and had low parity.

Risk factors (Table 4)

1. Previous lower segment caesarean section

In the present study the number of cases with history of a previous caesarean section who developed an ectopic pregnancy in the subsequent pregnancy were 42%. In a similar study by Zachary S Bowman et al in the state of Utah during 1996 to 2011 was 29.9%.

2. Pelvic Inflammatory Disease

In the present study, 7 patients gave a history of PID which contributes to 14 %. Literature shows that PID is an important factor predisposing to the development of ectopic pregnancy. According to other studies done by March Banks (1998), In a study done by Savitha Devi et al (2000) and Rose et al. (2002), the incidence of PID as a risk factor was 4.25% and 34.4% respectively. PID following gonococcal, chlamydial and other bacterial infection is responsible for 3.3- 6 fold increased risk of ectopic pregnancy.

3. Dilatation and Curettage

Patients who aborted and underwent dilatation and curettage in their previous pregnancy within the past two years had an incidence of ectopic in 20 % of the patients. Rose et al. (2002) reported previous abortion as a risk factor in 25.8%. Tubal dysfunction or damage following abortion induced or otherwise appears to be a chief factor in these cases.

4. Previous ectopic gestation

In the present series 2 (4 %) cases had been operated for previous ectopic gestation, which is in concurrence with the studies of R. Narayanan et al. (2014) and Rose et al. (2002) who reported 3.2% of repeat ectopic pregnancy.

5. Use of Intrauterine Contraceptive Device

In the present series IUCD was used by three patients (6 %). Throughout literature there are reports linking the use of various types of IUCDs with the occurrence of ectopic pregnancy. March Banks (1998) quotes 1.6% incidence of ectopic pregnancy in patients who were on progestin-only contraceptive. An incidence of 11.9%, 7.69% and 33% ectopic pregnancy were quoted in relation to the use of intrauterine devices by March Banks et al. (1998), Savitha Devi (2000) and Wills and Mohanambal (1991) respectively.

Mode of presentation (Table 5)

In the present study the typical triad of amenorrhea, Pain abdomen, per vaginal bleeding was observed in 24% cases. In a retrospective study of 2026 patients who presented to the emergency department at the university of Pennsylvania with first

trimester vaginal bleeding and /or abdominal pain, 376 (18%) were diagnosed with Ectopic pregnancy. Of these 376 patients, 76% had vaginal bleeding and 66% had abdominal pain[52]. Oumachigui et al. (1976) reported shoulder pain in 8%, fainting attacks in 18%, vomiting in 31% and urinary symptoms in 12.5%.

Clinical Presentation (Table 6)

Most of the patients in the present study had abdominal tenderness (86%) followed by guarding(12%) and rigidity (4%) similar to the study done by Pendse in the year 2011 where the incidence of Abdomian tenderness , Guarding and rigidity were found to be 89%, 5.4% and 16.3% respectively.In the present study cervical motion tenderness and forniceal tenderness were noted in 54% and 64% of cases respectively similar to the studies done by Rose et al 55% and 46% respectively and Pendse 86% and 54 % respectively.

USG findings (Table 8)

The most common Ultrasonographic finding seen in our study was complex adnexal mass separate from the ovary with free fluid in 52% cases .Ultrasonography reported 68% of them as ruptured, 32% of them as unruptured. Presence of anadnexal mass, most likely an ectopic pregnancy, was found in 66.6% in a study done by Rose Jophyet al[34]. Most of our patients were referred from outside with diagnosis of ruptured ectopic pregnancy. So our treatment modality was mainly surgical.

Site of ectopic pregnancy (Table 9)

In the present study the most common location of ectopic gestation was seen in the ampullary region 58% , cornual 22%, isthumus 12%, fimbrial 8% similar to the study

done by Bouyer J et al between 2010 to 2015 where ampullary (70%), cornual (2.4%), isthmic (12%), fimbrial (11.1%)[53].

Management Practises (Table 12)

In the present study out of 50 patients, 70% underwent unilateral salpingectomy, 2% underwent unilateral salphingectomy with contralateral tubectomy, 24% had Laproscopic unilateral salphingectomy and 4 % underwent Laproscopic unilateral salphingectomy with contralateral tubectomy. 14 out of 50 patients underwent laporoscopic procedure. This was similar to the study done by Hajenius PJ a Cochrane Database system review 2007.

Most of our patients (90%) were referred from outside with diagnosis of ruptured ectopic pregnancy. So our treatment modality was mainly surgical.Laprascopy was performed in those patients who were hemodynamically stable. Patients who were not hemodynamically stable were taken up for emergency laparotomy. The most common procedure done was salphingectomy whether laparoscopy or laparotomy. For those who have completed their family tubectomy was also done. We had 8 patients who presented in a state of shock which needed ICU admission and massive blood transfusions. Blood transfusions were given to 32 patients both intraoperatively and postoperatively.

CONCLUSION

1. This study was undertaken to provide a better understanding of ectopic gestation, its clinical presentation and various risk factors associated with this condition.
2. 50 cases were studied during a 1 year study period between January 2019 and December 2019 at Dr Prabhakar Kore Hospital and MRC, belagavi. During this study time the incidence of ectopic pregancy was found to be 1.03%.
3. Maximum incidence of tubal gestation occurred between the age group of 20 - 30 years (62%).
4. Greater incidence was noted in multigravidas accounting for 72% that is 36 out of 50 cases.
5. History of endometriosis in the previous pregnancy was seen in 3 cases which accounted for 6%.
6. Risk factors seen were tubectomy (4%), D & C (20%), PID (14%), endometriosis (6%), previous ectopic (4%), IUCD (6%), Previous LSCS (42%).
7. The typical triad of amenorrhoea, pain abdomen and bleeding was observed in 24% of cases. 21 patients had other associated symptoms such as giddiness, Nausea, vomiting and syncopal attacks. 9 patients were brought in shock (18%).
9. Tenderness on cervical movement was seen in 27 cases (54%).
10. Ultrasonography diagnosed complex adnexal mass in 68% of the patients and intra operatively 99% were true ectopics.
11. Anemia was seen in 61% of cases in which 40 % had mild anemia , 14% had moderate anemia, 6%had severe anemia.
12. Most of our patients (90%) were referred from outside with diagnosis of ruptured ectopic pregnancy. So our treatment modality was mainly surgical.

13. The commonest site of tubal gestation was in the ampullary region – 58%. Isthmal pregnancy was seen in 12% of the cases and the other 22% had cornual pregnancy, 8% had fimbrial pregnancy
14. Commonest mode of termination was tubal rupture-29 cases (58%).
15. Out of the 50 patients, 70% underwent unilateral salpingectomy, 2% underwent unilateral salphingectomy with contralateral tubectomy, and 24% had Laproscopic unilateral salphingectomy 4 % underwent Laproscopic unilateral salphingectomy with contralateral tubectomy. 14 out of 50 patients underwent laporoscopic procedure.
16. Among the 50 cases, 49 were true ectopic pregnancies, 1 was chronic ectopic.
17. Blood transfusion was given for 34 patients both intra operatively and post operatively.
18. Postoperative period was uneventful in 41 patients. 9 patients required ICU admission.

SUMMARY

The present study was undertaken to provide a better understanding of ectopic gestation, its clinical presentation and various risk factors and different treatment modalities associated with this condition.

The one – year hospital based study was done in study period of January 2019 December 2019 at Dr Prabhakar Kore Hospital, Belagavi. The primary objective of this study was to study the managment practices of Ectopic pregnancy at Dr. Prabhakar Kore hospital, Belagavi. Secondary objective was to study the risk factorassociated with Ectopic pregnancy. During one year period , out of a total of 4816 deliveries conducted in our hospital 50 were diagnosed to have Ectopic pregnancy . Data was analysed using 'SPSS software' and the statistical variables used were percentages and chi- square test. There is an increase in the incidence of ectopic pregnancy and a decrease in maternal mortality due to ectopic pregnancy, during the past two decades. The treatment modality also has evolved from radical to conservative surgery and even to medical and expectant management. But the paradox noted in this institution, is that even though 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. The incidence in the present study was calculated to be 1.03%. The risk factors seen were tubectomy (4%), D & C (20%), PID (14%), endometriosis (6%), previous ectopic (4%), IUCD (6%), Previous LSCS (42%). Most of our patients (90%) were referred from outside with diagnosis of ruptured ectopic pregnancy. So our treatment modality was mainly surgical out of which 70% underwent unilateral salphingectomy (open method). Ultrasonography diagnosed complex adnexal mass in 66% of the patients

and intra operatively 99% were true ectopics. Commonest mode of termination was seen to be tubal rupture. Postoperative period was uneventful in 42 patients. 8 patients required ICU admission.

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ANNEXUREI

ETHICAL CLEARANCE CERTIFICATE

K.L.E. ACADEMY OF HIGHER EDUCATION AND RESEARCH
(Deemed – to- be- University)
Accredited 'A' Grade by NAAC (2nd Cycle) Placed in Category 'A' by MHRD (GoI)
JAWAHARLAL NEHRU MEDICAL COLLEGE,
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Ref: MDC/DOME/48 **Date: 24/11/2018**

To,
REG. NO. BJ0118007
PG student in Obstetrics and Gynaecology,
J.N.Medical College,
BELAGAVI.

Sub: Institutional Ethical Clearance for the study.

With reference to the above, we wish to inform you that your proposed research project titled **"MANAGEMENT PRACTICES IN ECTOPIC PREGNANCY – A HOSPITAL BASED STUDY"**, is ethical and justifiable. The proposed research project has been cleared by the JNMC Institutional Ethics Committee on Human Subjects Research.

(Dr. Arathi Darshan)
Member Secretary
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi.

(Dr. Roopa M Bellad)
Chairman,
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi.

ANNEXURE II

CONSENT FOR PARTICIPATION IN RESEARCH STUDY

Mrs. _____ we are requesting you to enroll yourself in study titled **"Management Practises in Ectopic pregnancy – A hospital based study"**conducted by REG. NO. BJ0118007, Post Graduate in M.S. Obstetrics and Gynaecology under the guidance of DR. _____, Department of Obstetrics and Gynaecology, J.N. Medical College, Belgaum under KLE university, Belgaum.

Objectives /purpose of study:

Respected Madam we request you to participate in our study as you are eligible for participating and your participation in this study is important as it helps u to study how risk factors and management practices of ectopic pregnancy.

Your participation in research is voluntary. Your decision whether to participate in the study or not will not change present or future health care services offered to you and will not affect your relationship with J.N. Medical College. If you decide to participate you are free to withdraw at any time. All diagnosed cases of ectopic pregnancy will be recruited in our study.I will be the investigator for our study. This study is not being funded.

Procedure Involved:

If you agree to enroll yourself in my study, you will be interviewed regarding your present, past and family history, then you will be clinically examined in detail and investigated which may or may not cause pain. The procedures don't cause any temporary or lasting problems to you. Your co-operation is necessary as the investigation may be repeated number of times as required.

Risks and Benefits:

There are no potential risks and discomforts associated with any procedure involved in our study. The benefits of taking part in this research is your participation being valuable contribution to medical research to improvise treatment currently practiced.

Alternative:

There are no other options of treatment. If you decline to participate it will affect the results of our study and you will get the routine line of management. You will be informed about any new information that may affect your decision to participate in the study.

Withdrawal from study:

You can withdraw at any time from the study. There will be no penalty for withdrawal. You can be removed from the study if necessary.

Privacy and Confidentiality:

The only people who will know that you are the research subject will be the members of the research team. No information about you or information provided by you during the research will be disclosed to others without your written permission except:

1. In emergency to protect your rights and welfare.
2. If required by law.

Institutional/sponsor's policy:

In the event of any injury related to the study, treatment will be made available through KLE's Hospital & MRC, Belgaum. There is no compensation or payment for such medical treatment by law. If you are injured you may contact REG. NO. BJ0118007, Post graduate student, Department of Obstetrics and Gynaecology, KLE's Hospital& MRC.

Financial Incentives for participation:

No financial incentives are being offered to enrolled patients. It is purely being done with the idea of research and all the cost of the study will be borne by the investigator. You will not be reimbursed for any expenses for participation in this research.

Contact details:

In case you have any questions related to the study, in future or in case of study related injury or illness, you can contact REG. NO. BJ0118007, Post graduate student, Department of Obstetrics and Gynaecology, KLE's Hospital and MRC, Ph. No:_____or Dr_____, Professor, Dept. Of Obstetrics and Gynaecology, KLE's Hospital and MRC, Belgaum, Ph. No:_____.

If you have any queries about your rights as a study participant, you may contact Dr. Roopa M Bellad, Prof. of Pediatrics as Chairman of J. N. Medical College Institutional Ethics Committee on Human Subjects Research, Phone No.0831 2473777 ext-1527 at J. N. Medical College, Belgaum.

Authorization to Publish Results:

When the results of the research are published or discussed, in a conference, no information will be displayed that would disclose your identity. Any information that is obtained in connection with this study and that can be identified with you will remain confidential. Results of the study will be used to improve maternal and perinatal outcome.

Consent statement:

I, _____ voluntarily agree for participating in this study. By signing this consent form I am not giving up any of my legal rights, I may withdraw from the study anytime. I am signing the consent form after having read or been read form in my own vernacular language, including the risks and the benefits and having all my questions answered.

Participant Name : _____

Signature or the Left Thumb Print of Participant : _____

Investigators Name: _____ Signature: _____

Witness Name : _____ Signature: _____

Date: _____

ಸಂಶೋಧನಾಅಧ್ಯಯನದಲ್ಲಭಾಗವಹಿಸುವಿಕಗಒಪ್ಪಿಗ

ಶ್ರೀಮತಿ. __ ನಾವು "ಎಕ್ಟೋಪಿಕ್ಪ್ರೆಗ್ನೆನ್ಸಿನಿರ್ವಹಣಾಆಚರಣೆಗಳು - ಆಸ್ಪತ್ರೆಯಆಧಾರದಅಧ್ಯಯನ" ಎಂಬಶೀರ್ಷಿಕೆಯಅಧ್ಯಯನದಲ್ಲಿನಿಮ್ಮನ್ನುಸೇರಿಸಿಕೊಳ್ಳಬೇಕೆಂದುನಾವುಮನವಿಮಾಡುತ್ತೇವೆ. ಡಾ. REG. NO. BJ0118007, ಎಂಎಸ್ಸೆಬ್ಸ್ಟ್ರಿಕ್ಸ್ತತ್ತುಗೈನೆಕಾಲಜಿಪದವಿಡಾ. _____, ಪ್ರಸೂತಿಮತ್ತುಸ್ತ್ರೀರೋಗಶಾಸ್ತ್ರವಿಭಾಗ, ಕೆಎಲ್ಇವಿಶ್ವವಿದ್ಯಾಲಯ, ಬೆಳಗಾವಿನ ಜೆಎನ್ಮೆಡಿಕಲ್ಕಾಲೇಜ್ಮಾರ್ಗದರ್ಶನದಲ್ಲಿಪದವೀಧರರುನಡೆಸಿದಸಂಶೋಧನೆ.

ಉದ್ದೇಶಗಳು / ಉದ್ದೇಶದಉದ್ದೇಶ:

ಗೌರವಾನ್ವಿತಮ್ಯಾಡಮ್ನಮ್ಮಅಧ್ಯಯನದಲ್ಲಪಾಲ್ಗೊಳ್ಳಲುನಾವುನಮ್ಮನ್ನುವಿನಂತಿಸುತ್ತೇವಮತ್ತುಈಅಧ್ಯಯನದಲ್ಲಿನ ಮ್ಮಪಾಲ್ಗೊಳ್ಳುವಿಕೆಯುಮಹತ್ವದ್ದಾಗಿದ,
ಇದುಅಪಸ್ಥಾನೀಯಗರ್ಭಧಾರಣೆಯಪ್ರಭುತ್ವವನ್ನುಅಧ್ಯಯನಮಾಡಲುಸಹಾಯಮಾಡುತ್ತದ,
ಅಪಾಯಕಾರಿಅಂಶಗಳನ್ನುಗುರುತಿಸಲುಮತ್ತುಸರಿಯಾದನಿರ್ವಹಣೆಗೆನಿರ್ಧರಿಸಲುಅಪಸ್ಥಾನೀಯಗರ್ಭಧಾರಣೆಯ ತಾರ್ಕಿಕತೆ.

ಸಂಶೋಧನೆಯಲ್ಲಿನಮ್ಮಭಾಗವಹಿಸುವಿಕೆಸ್ವಯಿಂಪ್ರೇರಿತವಾಗಿರುತ್ತದ.
ಅಧ್ಯಯನದಲ್ಲಪಾಲ್ಗೊಳ್ಳಬೇಕೆಅಥವಾಇಲ್ಲವೇಎರಿದುನಮ್ಮನಿರ್ಧಾರವುನಮಗಪ್ರಸ್ತುತಪಡಿಸುವಪ್ರಸ್ತುತಿಅಥವಾಭವಿಷ್ಯದಆರೋ ಗ್ಯಸೇವೆಗಳನ್ನುಬದಿಲಸುವುದಲ್ಲಮತ್ತುಜಿಎನ್ಎಂವೈದ್ಯಕೀಯಕಾಲೇಜ್.
ನೊಂದಿಗಿನನಿಮ್ಮಸಂಬಂಧದಮೇಲೆಪರಿಣಾಮಬೀರುವುದಿಲ್ಲ.
ನೀವುಭಾಗವಹಿಸಲುನಿರ್ಧರಿಸಿದಲ್ಲಿನೀವುಯಾವುದೇಸಮಯದಲ್ಲಿಹಿಂಪಡೆಯಲುಸ್ವತಂತ್ರರಾಗಿರುತ್ತಾರ.
ಸೇರಿಸುವಮಾನದಂಡಗಳನ್ನುಪೂರೈಸುವಎಲ್ಲಾಗರ್ಭಿಣಿಮಹಿಳೆಯರುನಮ್ಮಅಧ್ಯಯನದಲ್ಲಿನೇಮಕಗೊಳ್ಳುತ್ತಾರೆ.

ರೋಗಿಗಳಪರಿಸ್ಥಿತಿಗಅನುಗುಣವಾಗಿಅಪಸ್ಥಾನೀಯಗರ್ಭಧಾರಣೆಯಪ್ರಾಬಲ್ಯ,
ಅಪಾಯಕಾರಿಅಂಶಗಳನ್ನುಗುರುತಿಸುವುದುಮತ್ತುಸರಿಯಾದನಿರ್ವಹಣೆಯಬಗ್ಗೆನಿರ್ಧರಿಸಲುಸಂಶೋಧನಾಉದ್ದೇಶದಉದ್ದೇಶ ವಾಗಿದೆ. ನಮ್ಮಅಧ್ಯಯನಕ್ಕೆನಾನುಶೋಧಕನಾಗಿರುತ್ತೇನೆ. ಈಅಧ್ಯಯನಕ್ಕೆಹಣಇಲ್ಲ.

ಕಾರ್ಯವಿಧಾನಕ್ಕೆಒಳಪಟ್ಟದ:

ನನ್ನಅಧ್ಯಯನದಲ್ಲಿನಿಮ್ಮನ್ನುತೊಡಗಿಸಿಕೊಳ್ಳಲುನೀವುಒಪ್ಪಿಕೊಂಡರ, ನಿಮ್ಮಪ್ರಸ್ತುತ, ಹಿಂದಿನಮತ್ತುಕುಟುಂಬದಇತಿಹಾಸದಬಗ್ಗೆನಿಮ್ಮನ್ನುಸಂದರ್ಶಿಸಲಾಗುವುದು,
ನಂತರನೀವುಪ್ರಾಯೋಗಿಕವಾಗಿವಿವರವಾಗಿಪರಿಶೀಲಿಸಲಾಗುವುದುಮತ್ತುನೋವುಉಂಟುಮಾಡದಿರಬಹುದುಅಥವಾತನಿಖ ಮಾಡಲಾಗುವುದು. ಕಾರ್ಯವಿಧಾನಗಳುನಿಮಿಗಯಾವುದೇತಾತ್ಕಾಲಿಕಅಥವಾಶಾಶ್ವತಸಮಸ್ಯೆಗಳನ್ನುಉಂಟುಮಾಡುವುದಲ್ಲ. ಅಗತ್ಯವಿದ್ದಾಗತನಿಖಪುನರಾವರ್ತಿಸಿಯಾಗುವರೆತೆನಿಮ್ಮಸಹಕಾರಅವಶ್ಯಕವೆಂಗದ.

ಅಪಾಯಗಳುಮತ್ತುಲಾಭಗಳು:

ನಮ್ಮಅಧ್ಯಯನದಲ್ಲಒಳಗೊಂಡಿರುವಯಾವುದೇಕಾರ್ಯವಿಧಾನಕ್ಕೆಸಂಬಂಧಿಸಿದಯಾವುದೇಸಂಭವನೀಯಅಪಾಯಗಳುಮ ತ್ತುತೊಂದರೆಗಳುಇಲ್ಲ.
ಈಸಂಶೋಧನೆಯಲ್ಲಿಪಾಲ್ಗೊಳ್ಳುವಪ್ರಯೋಜನಗಳನ್ನುಪ್ರಸ್ತುತಅಭ್ಯಾಸಮಾಡುವಚಿಕಿತ್ಸೆಯನ್ನುಸುಧಾರಿಸುವಲ್ಲಿವೈದ್ಯಕೀಯಸಂ ಶೋಧನೆಗೆನಮ್ಮಪಾಲ್ಗೊಳ್ಳುವಿಕೆಯುಮಹತ್ವದಕೊಡುಗೆಯಾಗದ.

ಅಧ್ಯಯನದಿಂದಹಿಂತೆಗೆದುಕೊಳ್ಳುವಿಕೆ :

ಅಧ್ಯಯನದಿಂದನೀವುಯಾವುದೇಸಮಯದಲ್ಲಿಹಿಂಪಡೆಯಬಹುದು. ವಾಪಸಾತಿಗೆಯಾವುದೇದಂಡವಿಲ್ಲ.
ಅಗತ್ಯವಿದ್ದರೆನೀವುಅಧ್ಯಯನದಿಂದತೆಗೆದುಹಾಕಬಹುದು.

ಗೌಪ್ಯತೆಮತ್ತುಗೋಪ್ಯತೆ :

ನೀವುಸಂಶೋಧನಾವಿಷಯವಿಂದುತಿಳಿಯುವವಿಕ್ಕೆಕಜನರುಸಂಶೋಧನಾತಂಡದಸದಸ್ಯರಾಗಿದ್ದಾರೆ.
ಹೊರತುಪಡಿಸಿನಿಮ್ಮಲಿಖಿತಅನುಮತಿಯಿಲ್ಲದೆಯೇಸಂಶೋಧನೆಯಸಮಯದಲ್ಲಿನಿಮಗೆಅಥವಾಮಾಹಿತಿಯಬಗ್ಗೆಯಾವುದೇ
ಮಾಹಿತಿಯುಬಹಿರಂಗಗೊಳ್ಳುವುದಿಲ್ಲ :

1. ನಿಮ್ಮಹಕ್ಕುಗಳನ್ನುಮತ್ತುಕಲ್ಯಾಣವನ್ನುರಕ್ಷಿಸಲುತುರ್ತುಪರಿಸ್ಥಿತಿಯಿಲ್ಲ.
2. ಕಾನೂನಿನಿಂದಅಗತ್ಯವಿದ್ದರೆ.

ಸಾಂಸ್ಥಿಕ / ಪ್ರಾಯೋಜಕರನೀತಿಗಳು:

ಅಧ್ಯಯನಕ್ಕೆಸಂಬಂಧಿಸಿದಯಾವುದೇಗಾಯದಸಂದರ್ಭದಲ್ಲಿ, ಕಎಲ್ಇಜಿಸ್ವತ್ರಮತ್ತುಎಂಆರ್ಸಿ,
ಬೆಳಗಾವಿಮೂಲಕಚಿಕಿತ್ಸೆಲಭ್ಯವಾಗುತ್ತದೆ.
ಕಾನೂನಿನಮೂಲಕಇಂತಹವೈದ್ಯಕೀಯಚಿಕಿತ್ಸೆಗಾಯಾವುದೇಪರಿಹಾರಅಥವಾಪಾವತಿಇಲ್ಲ.
ನೀವುಗಾಯಗೊಂಡರೆನೀವುREG. NO. BJ0118007, ಪೋಸ್ಟ್ದವೀಧರವಿದ್ಯಾರ್ಥಿ,
ಪ್ರಸೂತಿಮತ್ತುಸ್ತ್ರೀರೋಗಶಾಸ್ತ್ರವಿಭಾಗ, ಕೆ.ಎಲ್.ಇ.
ಹಾಸ್ಪಿಟಲ್&ಎಮ್ಆರ್ಸಿಅಥವಾದೂರವಾಣಿಸಂಖ್ಯೆ.:_____.

ಭಾಗವಹಿಸುವಿಕೆಗಾಗಿಹಣಕಾಸಿನಉತ್ತೇಜಕಗಳು :

ನೋಂದಾಯಿತರೋಗಿಗಳಿಗೆಹಣಕಾಸಿನಉತ್ತೇಜನನೀಡಲಾಗುವುದಿಲ್ಲ.
ಇದುಕೇವಲಸಂಶೋಧನೆಯಿಪರಿಕಲ್ಪನೆಯಿಂದಗಮನಿಸಿಲ್ಪಟ್ಟದೆಮತ್ತುಅಧ್ಯಯನದವಿಲ್ಲಾವಚ್ಚವನ್ನುತನಖದಾರರುಹೂಂದಿತ್ತಾ
ರೆ. ಈಸಂಶೋಧನೆಯಲ್ಲಿಪಾಲ್ಗೊಳ್ಳಲುಯಾವುದೇಖರ್ಚುಗಳಿಗಾಗಿನೀವುಮರುಪಾವತಿಮಾಡಲಾಗುವುದಿಲ್ಲ.

ಸಂಪರ್ಕವಿವರಗಳು :

ಭವಿಷ್ಯದಲ್ಲಿಅಥವಾಅಧ್ಯಯನದಸಂಬಂಧತಗಾಯಿಅಥವಾಅನಾರೋಗ್ಯದಸಂದರ್ಭದಲ್ಲಿನೀವುಅಧ್ಯಯನಕ್ಕೆಸಂಬಂಧಿಸಿದಯಾ
ವುದೇಪ್ರಶ್ನೆಗಳನ್ನುಹೊಂದಿದ್ದರೆ, REG. NO. BJ0118007, ಪೋಸ್ಟ್ದವೀಧರವಿದ್ಯಾರ್ಥಿ,
ಪ್ರಸೂತಿಮತ್ತುಸ್ತ್ರೀರೋಗಶಾಸ್ತ್ರವಿಭಾಗ, ಕ.ಎಲ.ಇ. ಹಾಸ್ಪಟಲ್ಮತ್ತುಎಮ್ಆರ್ಸಿ,ದೂರವಾಣಿಸಂಖ್ಯೆ:
_____ಅಥವಾ_____, ಪ್ರೊಫೆಸರ್, ಪ್ರಸೂತಿಮತ್ತುಸ್ತ್ರೀರೋಗಶಾಸ್ತ್ರವಿಭಾಗ,
ಕ.ಎಲ.ಇ. ಹಾಸ್ಪಟಲ್ಮತ್ತುಎಮ್ಆರ್ಸಿ,ಬೆಳಗಾವಿ, ದೂರವಾಣಿಸಂಖ್ಯೆ.

ಅಧ್ಯಯನದಪಾಲ್ಗೊಳ್ಳುವವರಂತೆನಿಮ್ಮಹಕ್ಕುಗಳಕುರಿತುನೀವುಯಾವುದೇಪ್ರಶ್ನೆಗಳನ್ನುಹೊಂದಿದ್ದರೆ,
ನೀವುಜೆಎನ್ಎಂಮೆಡಿಕಲ್ಕಾಲೇಜ್ಸಂಸ್ಥೆಯಮಾನವಶಾಸ್ತ್ರಸಂಶೋಧನೆಸಮಿತಿಯಅಧ್ಯಕ್ಷರಾಗಿಡಾ. ರೂಪಾಎಂಬೆಲ್ಲಾಡ್,
ಪ್ರೊಫೆಸರ್, ಪೀಡಿಯಾಟ್ರಿಕ್ಸ್ಇಲಾಖೆ, ಜೆಎನ್ಎಂಸಿಮಾನವಸಂಶೋಧನೆಗಾಗಿನೈತಿಕಸಮಿತಿ, ದೂರವಾಣಿಸಂಖ್ಯೆ
0831-247135.

ಫಲಿತಾಂಶಗಳನ್ನುಪ್ರಕಟಿಸಲುಅಧಿಕಾರ :

ಸಂಶೋಧನೆಯಫಲಿತಾಂಶಗಳನ್ನುಪ್ರಕಟಿಸಿದಾಗಅಥವಾಚರ್ಚಿಸಿದಾಗ, ಒಂದುಸಮ್ಮತಿಯನ ,
ನಿಮ್ಮಗುರುತನ ಬಹಿರಂಗಪಡಿಸುವಯಾವುದೇಮಾಹಿತಿಯನ್ನುಪ್ರದರ್ಶಿಸಲಾಗುವುದಿಲ್ಲ.

ಈಅಧ್ಯಯನಕ್ಕಸಂಬಂಧಸದಂತಪಡದಮತ್ತುನಮ್ಮಂದಗಾರುತಸಬಹುದಾದಯಾವುದೇಮಾಹಿತಗೌಪ್ಯವಾಗಿರುತ್ತದ.
ತಾಯಿಯಫಲಿತಾಂಶವನ್ನುಸುಧಾರಿಸಲುಅಧ್ಯಯನದಫಲಿತಾಂಶಗಳನ್ನುಬಳಸಲಾಗುತ್ತದೆ.

ಒಪ್ಪಿಗಹೇಳಿಕ

ನಾನು, _____ ಈಅಧ್ಯಯನದಲ್ಲಿಪಾಲ್ಗೊಳ್ಳುವ್ಯಯಿಂಪ್ರೇರಿತಯಿಂದಒಪ್ಪುತ್ತೇನ.

ಈಸಮ್ಮತಿಯನಮೂನಯಿಲ್ಲಸಹಿಹಾಕುವಮೂಲಕನನ್ನಯಾವುದೇಕಾನೂನುಹಕ್ಕುಗಳನ್ನುನಾನುಬಿಡುತ್ತಿಲ್ಲ,

ನಾನುಯಾವಸಮಯದಲ್ಲಾದರೂಅಧ್ಯಯನವನ್ನುಹಿಂತಗದುಕೊಳ್ಳಬಹುದು.

ನನ್ನಸ್ವಂತದೇಶೀಯಭಾಷಯಿಲ್ಲಒದದನಂತರಅಥವಾಫಾರ್ಮ್ಅನ್ನುಒದದನಂತರನಾನುಒಪ್ಪಿಗಫಾರ್ಮ್ಗಸಹಿಹಾಕುತ್ತಿದ್ದೇನ, ನ,

ಅಪಾಯಿಗಳುಮತ್ತುಪ್ರಯೋಜನಗಳನ್ನುಒಳಗೊಂಡಂತಮತ್ತುನನ್ನಎಲ್ಲಪ್ರಶ್ನಗಳಿಗಉತ್ತರಿಸದ.

ಭಾಗವಹಿಸುವಹಸರು: _____

ಪಾಲ್ಗೊಳ್ಳುವವರಎಡತಮ್ಮುದ್ರಣದಸಹಿ: _____

ತನಖಾಧಿಕಾರಿಗಳುಹಸರು: _____ ಸಹಿ: _____

ಎಟ್ನಸ್ಥಸರು: _____ ಸಹಿ _____

ದನಾಂಕ: _____

संशोधनअभ्यासातसहभागघेण्यासाठीमंजूरी

श्रीमती _____ आम्ही "एक्टोपिकगर्भधारणेतीलव्यवस्थापनपद्धती - हॉस्पिटलआधारितअभ्यास"
नावाच्याअभ्यासामध्येस्वतःलानावनोंदणीकरण्यासविनंतीकरतो._____,
एमएसऑब्स्टेट्रिक्सआणिगायनॉकॉलॉजीमधीलपोस्टग्रॅज्युएट, डॉ. _____प्राध्यापक ओबस्टेट्रिक्सअँडगायनॉकॉलॉजीविभाग, जेएनमेडिकलकॉलेज, केएलईयुनिव्हर्सिटी, बेळगावयेथीलबेलगामयांच्यामार्गदर्शनाखाली.

अभ्यासाचेउद्दिष्ट / उद्देश:

आदरणीयमॅडमआम्हीसहभागीहोण्यासाठीपात्रआहोतम्हणूनआपणआमच्याअभ्यासातसहभागीहोण्याचीविनंती करतोआणियाअभ्यासातआपलासहभागमहत्वाचाआहेकारणतेअस्थानिकगर्भधारणेचाप्रसारकरण्यास, जोखमीचेघटकओळखण्यासाठीआणियोग्यव्यवस्थापनावरनिर्णयघेण्यासाठीमदतकरते.
एक्टोपिकगर्भधारणेचेतर्क.
संशोधनमध्येआपलेसहभागस्वैच्छिकआहे.
अभ्यासातसहभागीव्हायचेआहेकिंवानाहीहेआपल्यानिर्णयामुळेआपल्यालादिलेलीवर्तमानकिंवाभविष्यातीलआरोग्यसेवासेवाबदलणारनाहीतआणिजे.एन.शीआपल्यानातेसंबंधावरत्याचापरिणामहोणारनाही.
वैद्यकीयमहाविद्यालयआपणभागघेण्याचानिर्णयघेतल्यासआपणकोणत्याहीवेळीमागेघेण्यासमोकळेआहात.
सर्वगर्भवतीमहिलांनीसमावेशकरण्याच्यानिकषांशीजुळवूनघेतल्यासआमच्याअभ्यासातभरतीकेलीजाईल.

संशोधनाच्याअभ्यासाचाउद्देशम्हणजेएक्टोपिकगर्भधारणेचाप्रसार,
जोखीमघटकओळखणेआणिरुग्णाच्यास्थितीनुसारयोग्यव्यवस्थापनावरनिर्णयघेणे.
मीआमच्याअभ्यासासाठीचौकशीकरणारआहे. हाअभ्यासनिधीजातनाहीआहे.

प्रक्रियासमाविष्ट

आपणमाझ्याअभ्यासामध्येस्वत: लानावनोंदणीकरण्याससहमतअसल्यास, आपल्याविद्यमा , भूतकाळातीलआणिकौटुंबिकइतिहासाबद्दलमुलाखतघेतलीजाईल,
त्यानंतरआपल्यासवैद्यकीयदृष्ट्यातपासणीकेलीजाईलआणितपासणीकेलीजाईलजेकदाचितवेदनाहोऊशकतेकिंवाहोऊशकतनाही. याप्रक्रियेमुळेआपल्यालातात्पुरतीकिंवाकायमस्वरूपीसमस्यायेतनाहीत.
आवश्यकतेनुसारतपासणीचीसंख्यावारंवारकेलीजाऊशकतेम्हणूनआपलासहकार्यआवश्यकआहे.

धोकेआणिफायदे

आमच्याअभ्यासातसमाविष्टअसलेल्याकोणत्याहीप्रक्रियेशीसंबंधितकोणतेहीसंभाव्यजोखीमआणिअपंगतानाही त.
यासंशोधनामध्येभागघेण्याचेफायदेहासध्याचासरावकरणारीउपचारसुधारण्यासाठीवैद्यकीयसंशोधनातमौल्यवा नयोगदानआहे.

अभ्यासपासूनपैसेकाढणे:

आपणकोणत्याहीवेळीअभ्यासपासूनमागेघेऊशकता. पैसेकाढण्यासाठीकोणतीहीदंडहोणारनाही.
आवश्यकअसल्यासआपणअभ्यासपार काढलेजाऊशकते.

गोपनीयताआणिगुप्तता:

केवळआपणचसंशोधनविषयआहातहेचलोकशोधसंघाचेसदस्यअसतील.
आपल्याबद्दलकोणतीहीमाहितीकिंवासंशोधनदरम्यानआपल्याद्वारेप्रदानकेलेलीमाहितीआपल्यालिखितपरवान गीशिवायइतरांनाप्रकटकेलीजाणारनाही.

1. आपल्याअधिकारांचेआणिकल्याणाचेरक्षणकरण्यासाठीआणीबाणीमध्ये.
2. कायद्यानुसारआवश्यकअसल्यास.

संस्थात्मव / प्रायोजकधोरण:

अभ्यासाशीसंबंधितअसलेल्याकोणत्याहीदुखापतीझाल्यास, केएलईहॉस्पिटलआणिएमआरसी, बेळगावयांच्याद्वारेउपचारकेलेजातील.
कायद्याद्वारेअशावैद्यकीयउपचारांसाठीकोणतेहीनुकसानभरपाईकिंवापेमेंटनाही.
जरआपणजखमीअसालतरआपण_____, पोस्टग्रेजुएटविद्यार्थी, ओबस्टेट्रिक्सआणिगायनकोलॉजीवि ,
केएलईहॉस्पिटलआणिएमआरसीकिंवाफोननंबर:_____वरसंपकेसाधूशकता.

सहभागासाठीआर्थिकप्रोत्साहन:

नामांकितरुग्णांनाआर्थिकप्रोत्साहनदिलेजातनाही.
हेपूर्णपणेसंशोधनसंकल्पनेसहकेलेजातआहेआणिसवेखचोचीतपासणीकरणायांकडूनकेलीजाईल.
यासंशोधनातसहभागीहोण्यासाठीआपल्यालाकोणत्याहीखचोसाठीपरतफेडकेलेजाणारनाही.

संपर्कोचीमाहिती:

जरभविष्यातीलकिंवाअभ्याससंबंधितजखमकिंवाआजारांच्याबाबतीतआपणकाहीप्रश्नअसल्यास, आपणREG. NO. BJ0118007, पोस्टग्रेजुएटविद्यार्थी, ओबस्टेट्रिक्सआणिगायनॉकॉलॉजीविभाग, केएलईहॉस्पीटलआणिएमआरसी, फोननं. शीसंपकेसाधूशकता: _____डॉ. _____, प्राध्यापक, ओबस्टेट्रीक्सआणिगायनॉकॉलॉजीविभाग, केएलईहॉस्पीटलआणिएमआरसी, बेळगाव, फोननं.

अभ्याससहभागीम्हणूनआपल्याअधिकारांबद्दलआपल्याकडेकाहीशंकाअसल्यास, आपणडॉ. रुपाएमबेलेंडशीसंपकेसाधूशकता,
पीएचडीमेडिकलकॉलेजचेइंस्टीट्यूशनलएथिक्सकमिटीऑनमानवीविषयकमिटीचेअध्यक्षम्हणूनबालरोगचिकित्साचेप्राध्यापक, फोननं. 0831 2473777 एटी-1527 जेएनमेडिकलमध्येकॉलेज, बेळगाव.

परिणामप्रकाशितकरण्यासाठीअधिकृतता:

जेव्हाशोधपरिणामांचेप्रकाशनकिंवाचचोकेलीजातेतेव्हाकॉन्फरन्समध्येकोणतीहीमाहितीप्रदर्शितकेलीजाणारनाही जीआपलीओळखउघडकरेल.
याअभ्यासाशीसंबंधितकोणतीहीमाहितीआणिआपल्यासहओळखलीजाऊशकतेतीगोपनीयराहील.
अभ्यासाच्यानिकालांचामातृपरिणामसुधारण्यासाठीवापरकेलाजाईल.

मंजूरीविधानः

मी, _____ याअभ्यासातसहभागीहोण्यासाठीस्वेच्छेनेसहमतआहे.

यासंमतीफॉर्मेवरस्वाक्षरीकरुनमीमाझेकोणतेहीकायदेशीरअधिकारसोडूनदेतनाही.

मीकोणत्याहीवेळीअभ्यासमागेघेऊशकते. मीमाझ्यास्वत:

च्यास्थानिकभाषेतीलवाचनकिंवावाचनकेल्यानंतरजोखमीआणिफायदेआणिमाझ्यासर्वप्रश्नांचीउत्तरेघेतल्यानंत

रसंमतीफॉर्मेवरस्वाक्षरीकरीतआहे.

सहभागीनाव: _____

सहभागीच्याडाव्याथंबप्रिंटचीस्वाक्षरी: _____

तपासकर्त्याचेनाव: _____ स्वाक्षरी: _____

साक्षीदारांचीनावे: _____ स्वाक्षरी: _____

तारीख: _____

अनुसंधानअध्ययनमेंभागीदारीकेलिएसहमति

श्रीमती _____ हमआपको "एक्टोपिकगर्भावस्थामेंप्रबंधनप्र - एकअस्पतालआधारितअध्ययन" नामकअध्ययनमेंखुदकोनामांकितकरनेकाअनुरोधकररहेहैं।REG. NO. BJ0118007, एमएसओबस्टेट्रिक्सऔरगायनकोलॉजीमेंपोस्टग्रेजुएटद्वाराआयोजितडॉ_____ ____, ओबस्टेट्रिक्सएंडगायनकोलॉजीविभाग, जेएनमेडिकलकॉलेज, बेलगामकेएलईयूनिवर्सिटी, बेलगामकेतहतबेलगामकेमार्गदर्शनमें।

उद्देश्य / अध्ययनकाउद्देश्य:

सम्मानितमैडमहमआपकोहमारेअध्ययनमेंभागलेनेकाअनुरोधकरतेहैंक्योंकिआपभागलेनेकेयोग्यहैंऔरइसअध्ययनमेंआपकीभागीदारीमहत्वपूर्णहैक्योंकियहहमेंएक्टोपिकगर्भावस्थाकेप्रसारकाअध्ययनकरने, जोखिमकारकोंकीपहचानकरनेऔरसहीप्रबंधनपरनिर्णयलेनेमेंमददकरताहै।एक्टोपिकगर्भावस्थाकातर्क।

शोधमेंआपकीभागीदारीस्वैच्छिकहै।आपकानिर्णयहैकिअध्ययनमेंभागलेनाहैयानहीं, आपकोवर्तमानयाभविष्यकीस्वास्थ्यदेखभालसेवाओंकोनहींबदलेगाऔरजेएनकेसाथआपकेरिश्तेकोप्रभावितनहीं करेगा।चिकित्सामहाविद्यालय।यदिआपभागलेनेकाफैसलाकरतेहैंतोआपकिसीभीसमयवापसलेनेकेलिएस्वतंत्रहैं। समावेशनमानदंडोंकोपूराकरनेवालीसभीगर्भवतीमहिलाएंहमारेअध्ययनमेंभर्तीकीजाएंगी।

शोधअध्ययनकाउद्देश्यएक्टोपिकगर्भावस्थाकेप्रसार, जोखिमकारकोंकीपहचानकरनाऔररोगीकीस्थितिकेआधारपरसहीप्रबंधनपरनिर्णयलेनाहै।मैंअपनेअध्ययनकेलिए जांचकर्ताबनूंगा।इसअध्ययनकोवित्तपोषितनहींकियाजारहाहै।

प्रक्रियाशामिल :

यदिआपअपनेअध्ययनमेंखुदकोनामांकितकरनेकेलिएसहमतहैं, तोआपकेवर्तमान, अतीतऔरपारिवारिकइतिहासकेबारेमेंसाक्षात्कारकियाजाएगा, फिरआपकोचिकित्सकीयरूपसेविस्तारसेजांचकीजाएगीऔरजांचकीजाएगीकिदर्दहोसकताहैयानहीं।प्रक्रियाओंसेआपकोकोईअस्थायीयास्थायीसमस्यानहींआतीहै।आपकासहयोगआवश्यकहैक्योंकिजांचकीआवश्यकताकेअनुसार बार-बारदोहरायाजासकताहै।

जोखिमऔरलाभ:

हमारेअध्ययनमेंशामिलकिसीभीप्रक्रियासेजुड़ेकोईसंभावितजोखिमऔरअसुविधानहींहैं।इसशोधमेंभागलेनेकेलाभ यहहैकिवतेमानमेंअभ्यासमेंसुधारकेलिएचिकित्साअनुसंधानमेंआपकीभागीदारीमहत्वपूर्णयोगदानहै।

अध्ययनसेनिकासी:

आपअध्ययनसेकिसीभीसमयवापसलेसकतेहैं।वापसीकेलिएकोईदंडनहींहोगा।यदिआवश्यकहोतोआपकोअध्ययन सेनिकालदियाजासकताहै।

गोपनीयताऔरगोपनीयता:

एकमात्रलोगजोजानतेहोंगेकिआपशोधविषयहैं,
वेशोधदलकेसदस्यहोंगे।शोधकेदौरानआपकेद्वाराप्रदानकीगईजानकारीयाजानकारीकेबारेमेंकोईजानकारीआपके लिखितअनुमतिकेबिनादूसरोंकोप्रकटनहींकीजाएगी: 1. अपनेअधिकारोंऔरकल्याणकीरक्षाकेलिएआपातकालमें। 2. यदिकानूनद्वाराआवश्यकहै।

संस्थागत / प्रायोजककीनीति:

अध्ययनसेसंबंधितकिसीभीचोटकीस्थितिमें, उपचारकेएलईअस्पतालऔरएमआरसी, बेलगामकेमाध्यमसेउपलब्धकरायाजाएगा।कानूनद्वाराइसतरहकेचिकित्साउपचारकेलिएकोईमुआवजायाभुगतान नहींहै।यदिआपघायलहोगएहैंतोआपडॉ।सुसानसैमवर्गेस, पोस्टग्रेजुएटछात्र , ओबस्टेट्रिक्सऔरगायनकोलॉजीविभाग, केएलईअस्पतालऔरएमआरसीयाफोननंबर 7736592412 सेसंपकेकरसकतेहैं।

भागीदारीकेलिएवित्तीयप्रोत्साहन :

नामांकितमरीजोंकोकोईवित्तीयप्रोत्साहननहींदियाजारहाहै।यहपूरीतरहसेशोधकेविचारसेकियाजारहाहैऔरअध्ययन कीसभीलागतजांचकर्तोद्वारालीजाएगी।इसशोधमेंभागलेनेकेलिएआपकोकिसीभीखर्चकेलिएप्रतिपूर्तिनहींकीजाएगी।

संपकेविवरण:

यदिआपकेपासअध्ययनसेसंबंधितकोईप्रश्नहैं, भविष्यमेंयाअध्ययनसेसंबंधितचोटयाबीमारीकेमामलेमें, आपREG. NO. BJ0118007, स्नातकोत्तरछात्र, प्रसूतिएवंस्त्रीरोग विभाग, केएलईअस्पतालऔरएमआरसी, फोननंबरसेसंपकेकरसकतेहैं। : _____या_____, प्रोफेसर, ओब्स्टेट्रिक्सएंडगायनकोलॉजीविभाग, केएलईअस्पतालऔरएमआरसी, बेलगाम, पीएचसंख्या:।

यदिअध्ययनअध्ययनकेरूपमेंआपकेअधिकारोंकेबारेमेंआपकेकोईप्रश्नहैं,
तोआपजेएनमेडिकलरिसर्चपरजेएनमेडिकलकॉलेजइंस्टीट्यूशनलएथिक्सकमेटीकेअध्यक्षकेरूपमेंबालचिकित्सा केप्रोफेसरडॉरूपाएमबेलदसेसंपकेकरसकतेहैं, फोननंबर 0831 2473777 एक्सटी -।527

परिणामप्रकाशितकरनेकेलिएप्राधिकरण :

जबशोधकेपरिणामप्रकाशितहोतेहैंयाचर्चाकरतेहैं, एकसम्मेलनमें, कोईजानकारीप्रदर्शितनहींकीजाएगीजोआपकीपहचानकाखुलासाकरेगी।इसअध्ययनकेसंबंधमेंप्राप्तकीगईकोईभी

जानकारीऔरआपकेसाथपहचानाजासकताहैगोपनीयरहेगा।अध्ययनकेनतीजेमातृपरिणाममेंसुधारकेलिएइस्तेमा लकिएजाएंगे।

सहमतिकथन :

मैं, _____

स्वेच्छासेइसअध्ययनमेंभागलेनेकेलिएसहमतहूं।इससहमतिफॉर्मपरहस्ताक्षरकरकेमैंअपनेकिसीभीका

नूनीअधिकारकोनहींछोड़रहाहूं,

मैंकिसीभीसमयअध्ययनसेवापसआसकताहूं।मैंअपनेस्वयंकेस्थानीयभाषामेंपढ़नेयापढ़नेकेबादसहमति

फॉर्मपरहस्ताक्षरकररहाहूं, जिसमेंजोखिमऔरलाभशामिलहैंऔरमेरेसभीसवालोंकेजवाबदिएगएहैं।

भागलेनेवालेकानाम : _____

प्रतिभागीकेबाएंथंबप्रिंटकाहस्ताक्षर : _____

जांचकर्ताकानाम : _____ हस्ताक्षर : _____

साक्षीकानाम : _____ हस्ताक्ष : _____

दिनांक: _____

ANNEXURE III

PROFORMA

"MANAGEMENT PRACTISES IN ECTOPIC PREGNANCY- A HOSPITAL BASED STUDY".

Chief complaints:

History of presenting illness: duration:

- H/o amenorrhea - yes/no …….
- H/o PV bleeding/spotting -yes/no…….
- H/o Pain abdomen - yes/no …….
- H/o associated symptoms -yes/no…….
  (nausea, vomiting, syncopal attack, fever)
- H/o other symptoms -yes/no ……
  (Dysuria /frequency of micturition / Retention of urine/rectal symptoms)

OBSTETRICS HISTORY

G P L D A

Age at marriage: Age at coitus: Married life:

H/o no. Of abortions: yes/no H/o septic abortion : yes/no

H/o check curettage : yes/no H/o puerperal sepsis: yes/no

H/o Contraceptive used (mention):

Tubectomised /not Tubectomised: H/o PID:

MENSTRUAL HISTORY

Age of menarche:

Past menstrual cycles: regular/ irregular: duration of flow:

Duration of cycle: heavy/mod/less:

Dysmenorrhea: Last menstrual period:

PAST HISTORY

H/o white discharge: yes/no

H/o infertility : yes/no

H/o treatment for infertility: (OI/ART/IUI, others): yes/no

Previous history of ectopic :(Y/N, if yes take details):

Past history of medical illness/blood transfusion/surgeries

Habits: smoking: alcohol: others:

PHYSICAL EXAMINATION

PR/min	BP (mm Hg)	RR/min	TEMP(^{0}C)	Ht(cm)	Wt(kg)	BMI(kg/m^2)	PALLOR	EDEMA	CYANOSIS	CLUBBBING

Breast, Spine, Thyroid :

R/S: CVS:

P/A:

	tenderness	guarding	rigidity	Lump/mass	Free	distension

					fluid	
Present+						
Absent-						

Percussion: dullness +/- Auscultation: BS +/-

P/S: cervix : congestion: **+/-** White discharge: **+/-**

P/V: uterus: position- AV/RV Size-normal/bulky

Cervical movements: tender/non tender fornices -mass +/-

PROVISIONAL DIAGNOSIS:

INVESTIGATIONS

Blood group & Rh typing	HB(g/dl)	TLC Cells/ml	DC (%)	ESR (mm/1st Hr)	Beta hCG (IU/ml)
			N E L B		

Special: UPT: positive/negative Culdocentesis: positive/negative

TVS/TAS: UTERUS

OVARIES right: left:

ADNEXA

POD

Impression on USG:

Doppler:

Laparoscopy:

PROVISIONAL DIAGNOSIS:

TREATMENT TAKEN : Expectant management:

Medical:

Surgical: Laparotomy /Laparoscopy

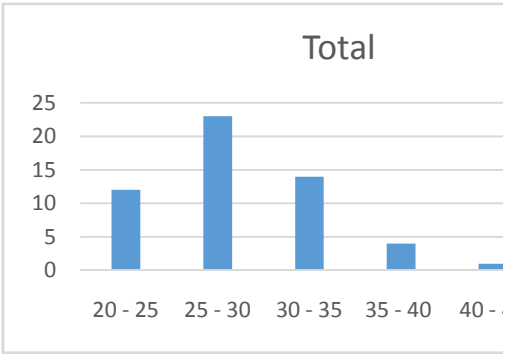
Findings:

Key to Master Chart

Ip.No.	-	Inpatient Number
ML	-	Married Life
IVF	-	InVitro Fertilization
LMP	-	Last Menstrual Period
EDD	-	Expected Date of Delivery
POG	-	Period of Gestation
C-EDD	-	Corrected Expected Date of Delivery
C-POG	-	Corrected Period of Gestation
BM	-	Body Mass Index
Wt.	-	Weight
PR	-	Pulse Rate
BP	-	Blood Pressure
FH	-	Fundal Height
SFH	-	Symphysio Fundal Height
AG	-	Abdominal Girth
Hb	-	Hemoglobin
LSCS	-	Lower segment Caesarean Section
MOP	-	Mode of presentation
GPE	-	General physical examination
P/S	-	Per speculam
	-	Vaginal Exam Vaginal examination
USG	-	Ultrasonogram
RU	-	Ruptured
UR	-	Unruptured
CRL	-	crown Rump Length
HP	-	Hemoperitoneum
BT	-	Blood transfusion

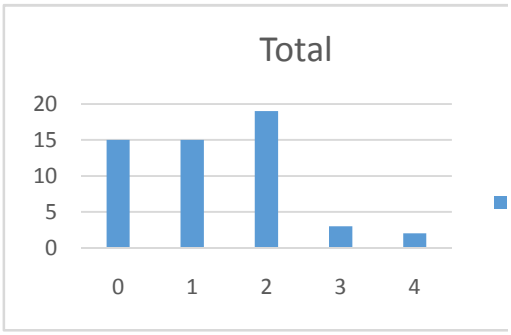
CASES IN RELATION TO AGE

Row Labels	Count of IP.NO.	
20 - 25	12	22%
25 - 30	23	43%
30 - 35	14	26%
35 - 40	4	7%
40 - 45	1	2%
Grand Total	**54**	



DISTRIBUTION OF CASES BASED ON PARITY

Row Labels	Count of IP.NO.	
0	15	28%
1	15	28%
2	19	35%
3	3	6%
4	2	4%
Grand Total	**54**	



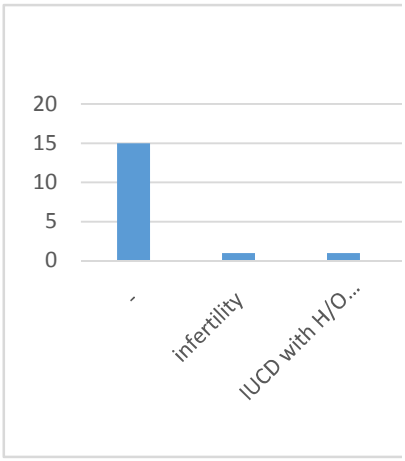
CORRELATION BY AGE AND PARITY

Count of IP.NC	Column Labels					
Row Labels	0	1	2	3	4	Grand To
20 - 25	3	7	2			12
25 - 30	7	4	9	1	2	23
30 - 35	4	4	5	1		14
35 - 40	1		3			4
40 - 45				1		1
Grand Total	**15**	**15**	**19**	**3**	**2**	**54**

	PARITY
AGE	0
20 - 25	25%
25 - 30	30%
30 - 35	29%
35 - 40	25%
40 - 45	
Grand Total	28%

CASES SHOWING RISK FACTORS

Row Labels	Count of IP.NO.	
-	15	28%
infertility	1	2%
IUCD with H/O	1	2%
IUI	2	4%
OCP	4	7%
previous abort	8	15%
previous ectop	1	2%
previous scar	19	35%
tubectomized	2	4%
tubectomy	1	2%



Grand Total	54

DISTRIBUTION BASED ON SITE AND RISK FACTORS

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-	1	4	2	1		7		15
infertility						1		1
IUCD with H/O Right saphingect		1						1
IUI				1		1		2
OCP		2		1	1			4
previous abortion		5	1			1	1	8
previous ectopic		1						1
previous scar		12	3			4		19
tubectomized		1				1		2
tubectomy		1						1
Grand Total	**1**	**27**	**6**	**3**	**1**	**15**	**1**	**54**

DISTRIBUTION BY RISK FACTORS & CONDITION OF THE TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	8	6		15
infertility		1			1
IUCD with H/O Right saphingectomy			1		1
IUI		2			2
OCP		2	1	1	4
previous abortion		5	3		8
previous ectopic		1			1
previous scar		6	8	5	19
tubectomized		1	1		2
tubectomy				1	1
Grand Total	**1**	**26**	**20**	**7**	**54**

Count of IP.N	Column
Row Labels	-
-	100%
infertility	
IUCD with H/O Right saphingecto my	
IUI	
OCP	
previous abortion	
previous ectopic	
previous scar	
tubectomized	
tubectomy	
Grand Total	1

MODE OF PRESENTATION AMENORRHEA

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-			1	1			3	5
+	1	26	5	3	1	12	1	49
Grand Total	**1**	**27**	**6**	**3**	**1**	**15**	**1**	**54**

MODE OF PRESENTATION BLEEDING PV

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-			11	3	2		7	23
+	1		16	3	1	1	8	1	31
Grand Total	**1**		**27**	**6**	**3**	**1**	**15**	**1**	**54**

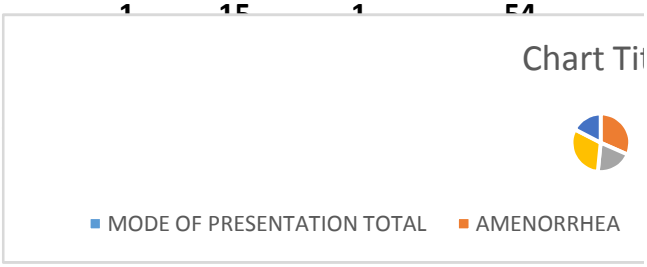
MODE OF PRESENTATION PAIN ABDOMEN

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-			5	1				6
+	1		22	5	3	1	15	1	48
Grand Total	**1**		**27**	**6**	**3**	**1**	**15**	**1**	**54**

MODE OF PRESENTATION OTHERS

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-	1		17	1	1	1	5	1	27
+			10	5	2		10		27
Grand Total	**1**		**27**	**6**	**3**				

MODE OF PRESENTATION TOTAL		
AMENORRHEA	49	91%
BLEEDING PV	31	57%
PAIN ABDOME	48	89%
OTHERS	27	50%



DISTRIBUTION OF SAMPLE BY SITE AND MOP

-	A	C	F	IN	IS	Ovarian
AMENORRHEA	1	26	5	3	1	12	1
BLEEDING PV	1	16	3	1	1	8	1
PAIN ABDOME	1	22	5	3	1	15	1
OTHERS		10	5	2		10	

DISTRIBUTION BY MOP AMENORRHEA & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-		5			5
+	1	21	20	7	49
Grand Total	**1**	**26**	**20**	**7**	**54**

DISTRIBUTION BY MOP BLEEDING PV & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-		15	5	3	23

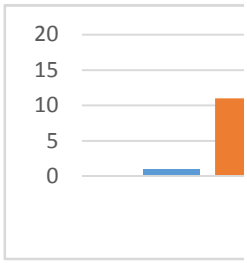
+	1	11	15	4	31
Grand Total	**1**	**26**	**20**	**7**	**54**

DISTRIBUTION BY MOP PAIN ABDOMEN & CONDITION OF TUBE

Count of IP.NC	Column Labels			
Row Labels	-	RU	TA	U	Grand Total
-		2	2	2	6
+	1	24	18	5	48
Grand Total	**1**	**26**	**20**	**7**	**54**

DISTRIBUTION BY MOP OTHERS & CONDITION OF TUBE

Count of IP.NC	Column Labels			
Row Labels	-	RU	TA	U	Grand Total
-	1	11	9	6	27
+		15	11	1	27
Grand Total	**1**	**26**	**20**	**7**	**54**



DISTRIBUTION BY MOP TOTAL & CONDITION OF TUBE

	-	**RU**	**TA**	**U**	
AMENORRHEA	1	21	20	7	
BLEEDING PV	1	11	15	4	
PAIN ABDOME	1	24	18	5	
OTHERS		15	11	1	

GENERAL PHYSICAL EXAMINATION PALLOR & SITE

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-	1	12		2	1	4		20
+		15	6	1		11	1	34
Grand Total	**1**	**27**	**6**	**3**	**1**	**15**	**1**	**54**

GENERAL PHYSICAL EXAMINATION SHOCK & SITE

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-	1	24	1	3	1	14	1	45
+		3	5			1		9
Grand Total	**1**	**27**	**6**	**3**	**1**	**15**	**1**	**54**

GENERAL PHYSICAL EXAMINATION NONE & SITE

Count of IP.NC	Column Labels							
Row Labels	-	A	C	F	IN	IS	Ovarian	Grand Total
-	1	27	5	3	1	15	1	53
+			1					1
Grand Total	**1**	**27**	**6**	**3**	**1**	**15**	**1**	**54**

GENERAL PHYSICAL EXAMINATION		
PALLOR	34	
SHOCK	9	
NONE	1	
TOTAL	**44**	THIS LOOKS WRONG

GENERAL PHYSICAL EXAM PALLOR & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	6	10	3	20
+		20	10	4	34
Grand Total	**1**	**26**	**20**	**7**	**54**

GENERAL PHYSICAL EXAM SHOCK & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	19	18	7	45
+		7	2		9
Grand Total	**1**	**26**	**20**	**7**	**54**

GENERAL PHYSICAL EXAM NONE & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	25	20	7	53
+		1			1
Grand Total	**1**	**26**	**20**	**7**	**54**

ABDOMINAL FINDINGS TENDERNESS & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	5	4		10
+		21	16	7	44
Grand Total	**1**	**26**	**20**	**7**	**54**

ABDOMINAL FINDINGS GUARDING & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	24	16	7	48
+		2	4		6
Grand Total	**1**	**26**	**20**	**7**	**54**

ABDOMINAL FINDINGS DISTENTION AND CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	24	20	7	52
+		2			2
Grand Total	**1**	**26**	**20**	**7**	**54**

ABDOMINAL FINDINGS MASS & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	26	20	7	54
Grand Total	**1**	**26**	**20**	**7**	**54**

ABDOMINAL FINDINGS NAD AND CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1	26	20	7	54
Grand Total	**1**	**26**	**20**	**7**	**54**

TOTAL ABDOMINAL FINDINGS	
TENDERNESS	44
GUARDING	6
DISTENTION	2
MASS	0
NAD	0
TOTAL	**52** THIS LOOKS WRONG

PER SPECULUM EXAMINATION

Row Labels	Count of IP.NO.	
-	17	31%
+	37	69%
Grand Total	**54**	

UTERINE SIZE

Row Labels	Count of IP.NO.	
↑	4	7%
normal	50	93%
Grand Total	**54**	

CERVICAL TENDERNESS

Row Labels	Count of IP.NO.	
-	26	48%
+	28	52%

Grand Total	**54**

FORNICEAL TENDERNESS

Row Labels	Count of IP.NO.	
-	21	39%
+	33	61%
Grand Total	**54**	

URINE PREGNANACY TEST & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-		1			1
+	1	25	20	7	53
Grand Total	**1**	**26**	**20**	**7**	**54**

Count of IP.N	Column
Row Labels	-
-	
+	100%
Grand Total	1

ULTRASONOGRAPHY

Row Labels	Count of IP.NO.	
RU	36	67%
U	18	33%
Grand Total	**54**	

SIDE OF USG

Row Labels	Count of IP.NO.	
L	22	41%
R	32	59%
Grand Total	**54**	

SITE

Row Labels	Count of IP.NO.	
-	1	2%
A	27	50%
C	6	11%
F	3	6%
IN	1	2%
IS	15	28%
Ovarian	1	2%
Grand Total	**54**	

CONDITION OF TUBE

Row Labels	Count of IP.NO.	
-	1	2%
RU	26	48%

TA	20	37%
U	7	13%
Grand Total	**54**	

SITE & CONDITION OF TUBE

Count of IP.NC	Column Labels				
Row Labels	-	RU	TA	U	Grand Total
-	1				1
A		8	13	6	27
C		4	2		6
F		2		1	3
IN		1			1
IS		10	5		15
Ovarian		1			1
Grand Total	**1**	**26**	**20**	**7**	**54**

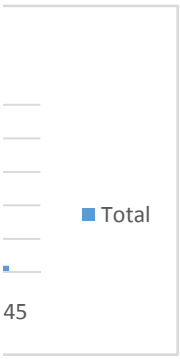
Count of	Column Labels	
Row Lab	-	RU
-	100%	
A		31%
C		15%
F		8%
IN		4%
IS		38%
Ovarian		4%
Grand Tc	1	26

PROCEDURE DONE

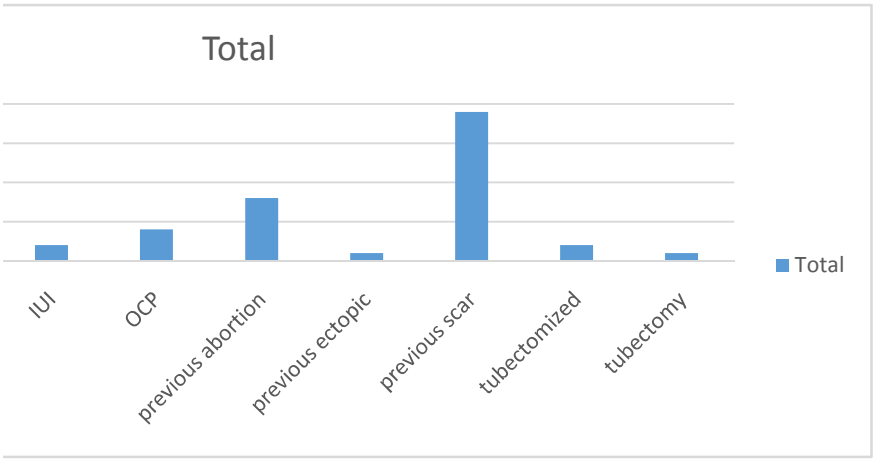
Row Labels	Count of IP.NO.	
B/LSE	1	2%
BSE	1	2%
LB/LSE	2	4%
LUSE	11	20%
medical manag	1	2%
ovariotomy + B	1	2%
USE	35	65%
USE + fimbrect	2	4%
Grand Total	**54**	

BLOOD TRANSFUSION

Row Labels	Count of IP.NO.	
-	14	26%
+	40	74%
Grand Total	**54**	

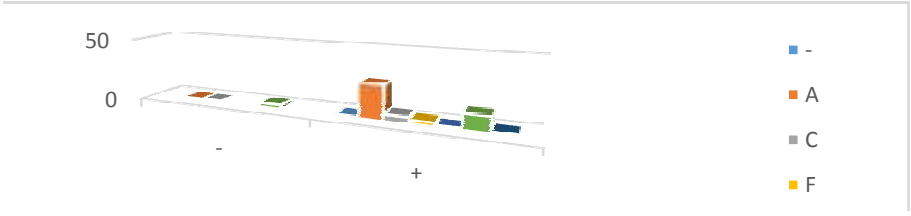


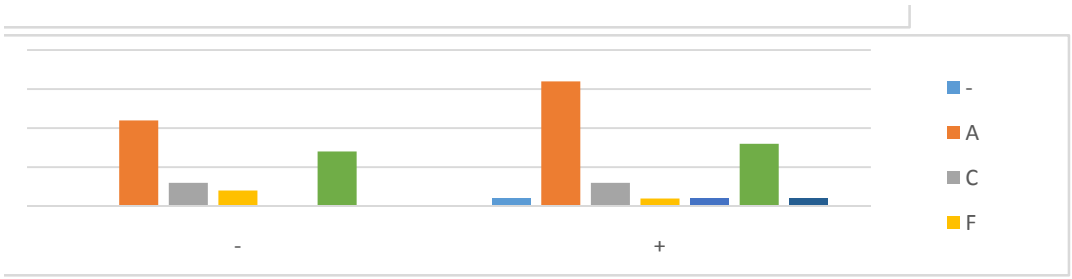
1	2	3	4	Grand Total
58%	17%			12
17%	39%	4%	9%	23
29%	36%	7%		14
	75%			4
		100%		1
28%	35%	6%	4%	54

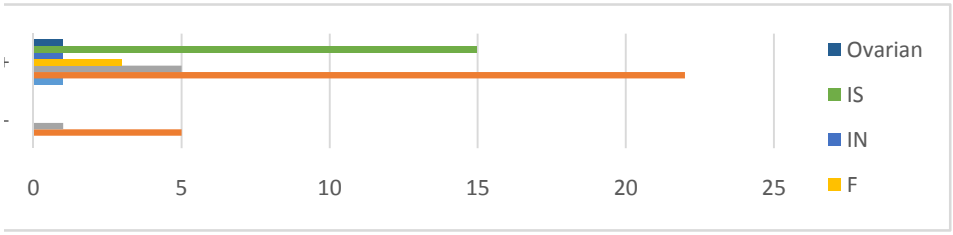


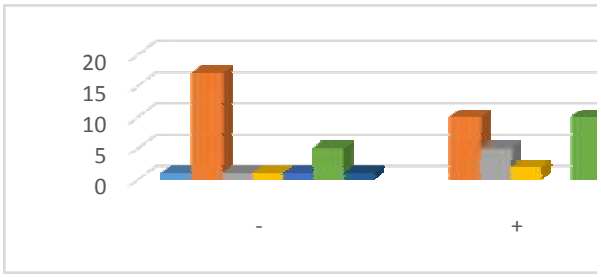
Count o	Column Labels							
Row Lal	-	A	C	F	IN	IS	Ovarian	Grand Tota
-	100%	15%	33%	33%		47%		28%
infertility						7%		2%
IUCD with H/O F		4%						2%
IUI				33%		7%		4%
OCP		7%		33%	100%			7%
previous abortic		19%	17%			7%	100%	15%
previous ectopic		4%						2%
previous scar		44%	50%			27%		35%
tubectomized		4%				7%		4%
tubectomy		4%						2%
Grand T	1	27	6	3	1	15	1	54

ı Labels			
RU	TA	U	Grand Total
31%	30%		28%
4%			2%
	5%		2%
8%			4%
8%	5%	14%	7%
19%	15%		15%
4%			2%
23%	40%	71%	35%
4%	5%		4%
		14%	2%
26	20	7	54




-
A
C
F
-
+


Ovarian
IS
IN
F
0
5
10
15
20
25


20
15
10
5
0
-
+


tle
BLEEDING PV
PAIN ABDOMEN
OTHERS

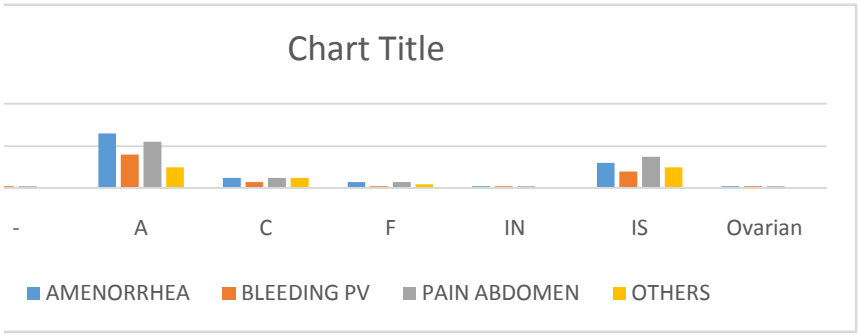
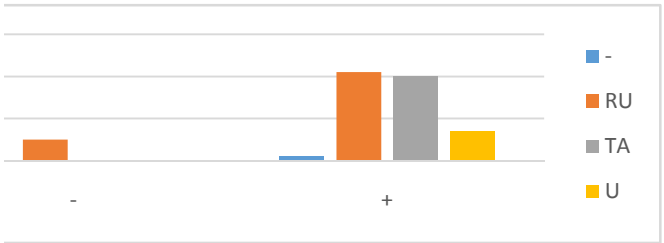
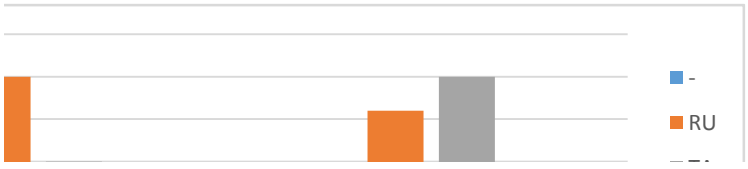
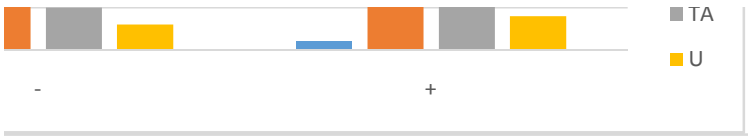
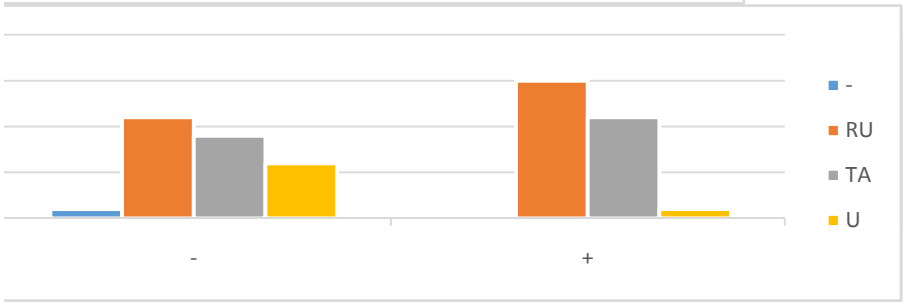


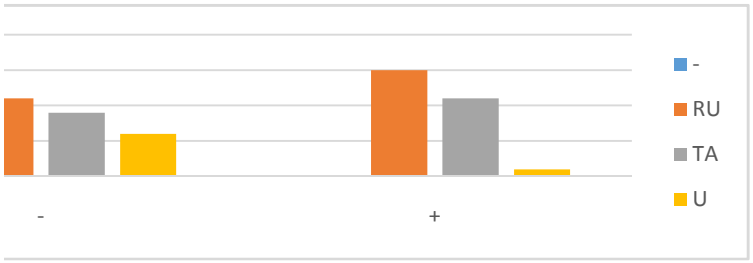
Chart Title
-
A
C
F
IN
IS
Ovarian
AMENORRHEA
BLEEDING PV
PAIN ABDOMEN
OTHERS


-
RU
TA
U
-
+


-
RU


TA
U
-
+


-
RU
TA
U
-
+


-
RU
TA
U
-
+

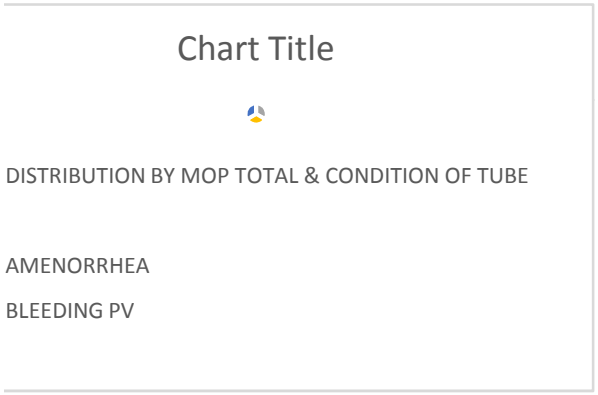
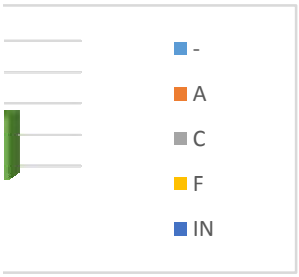


Chart Title
DISTRIBUTION BY MOP TOTAL & CONDITION OF TUBE
AMENORRHEA
BLEEDING PV

ı Labels			
RU	TA	U	Grand Total
4%			2%
96%	100%	100%	98%
26	20	7	54

TA	U	Grand Total
		2%
65%	86%	50%
10%		11%
	14%	6%
		2%
25%		28%
		2%
20	7	54


-
A
C
F
IN

MASTER CHART

SL.NO.	IP.NO.	PARITY	AGE	AGE RANGE	RISK FACTORS	MOP				GPE			ABDOMINAL EXAMINATION					P/S	VAGINAL EXMN.			HB	UPT	USG									PROCEDURE	INTRA OP				BT	P/O	Beta HCG	GESTATIONAL AGE
SL.NO.	IP.NO.	PARITY	AGE	AGE RANGE	RISK FACTORS	AMENORRHEA	BLEEDING PV	PAIN ABDOMEN	OTHERS	PALLOR	SHOCK	NONE	TENDERNESS	GUARDING	DISTENSION	MASS	NAD		UTERINE SIZE	CERVICAL TENDERNESS	FORNICES	HB	UPT	SIDE	RU	UR	GESTATIONAL SAC	YOLK SAC	CARDIAC ACTIVITY	CRL	OTHERS	FLUID	PROCEDURE	SIDE	SITE	TUBE	HP	BT	P/O	Beta HCG	GESTATIONAL AGE
1	921570	1	33	30 - 35	previous ectopic	+	-	+	-	+	-	-	+	-	-	-	-	-	normal	-	+	11.6	+	L	-	+	+	-	-	-	-	-	USE	L	F	TA	-	+	-	2946	6 + 1
2	921029	2	27	25 - 30	IUCD	+	-	+	+	+	-	-	+	-	-	-	-	-	normal	-	+	9.3	+	R	+	-	-	-	-	-	+	+	USE	R	A	RU	+	+	-	2468	4 + 1
3	922530	1	22	20 - 25	Previous surgery	+	+	+	+	+	-	-	+	-	+	-	-	+	↑	-	+	9.6	+	L	+	-	-	-	-	-	+	+	USE	L	A	RU	+	+	-	4794	10 + 1
4	920209	0	27	25 - 30	Previous surgery	+	-	-	-	-	-	-	-	-	-	-	-	-	normal	-	-	12	+	R	-	+	-	-	-	-	+	-	USE	R	A	RU	+	+	-	917	7 + 0
5	921106	0	31	30 - 35	IUI	+	+	+	+	-	-	-	-	-	-	-	-	+	normal	-	-	11.7	+	R	-	+	-	-	-	-	+	-	LUSE	R	A	UR	-	+	-	1009	5 + 5
6	928623	1	30	25 - 30	advanced age	-	+	+	+	+	-	-	+	-	-	-	-	+	normal	-	+	10.8	+	R	+	-	+	+	+	+	-	+	USE	R	A	RU	+	+	-	2682	7 + 0
7	930799	2	32	30 - 35	advanced age	+	-	+	-	+	+	-	+	-	-	-	-	-	normal	-	+	5.8	+	R	+	-	-	-	-	-	+	+	USE	R	C	RU	+	+	-	2028	7+ 1
8	930591	0	27	25 - 30	previous abortion	+	-	+	+	+	+	-	+	-	-	-	-	-	normal	-	-	2.8	+	L	+	-	-	-	-	-	+	+	USE	L	C	RU	+	+	-	987	6 + 0
9	934943	3	34	30 - 35	previous abortion	+	-	+	-	-	-	-	-	-	-	-	-	+	normal	+	+	9.4	+	R	-	+	+	+	-	-	-	-	USE	R	A	UR	+	+	-	41344	7 + 6
10	936263	2	26	25 - 30	IUCD	-	+	+	-	+	-	-	-	-	-	-	-	+	normal	-	-	9.6	+	R	+	-	-	-	-	-	+	+	USE	R	C	RU	+	+	-	2482	8 + 2
11	936476	2	32	30 - 35	tubectomy	+	+	+	-	-	-	-	+	-	-	-	-	+	normal	+	+	10.2	+	L	-	+	+	-	-	-	-	-	USE	L	A	UR	+	-	-	412	6 + 1
12	938369	1	30	25 - 30	previous scar	-	-	+	+	-	+	-	+	-	-	-	-	+	normal	+	+	5.3	-	L	+	-	-	-	-	-	+	+	USE	L	A	RU	+	+	-	1638	8 + 2
13	936094	1	32	30 - 35	previous scar	+	-	+	+	+	+	-	+	+	-	-	-	-	normal	-	-	3.8	+	R	+	-	+	-	-	-	-	+	USE	R	C	RU	+	+	-	8795	6 + 1
14	937107	2	35	30 - 35	OCP	+	+	+	-	-	-	-	-	-	-	-	-	+	normal	-	-	11.7	+	R	+	-	-	-	-	-	+	-	USE	R	A	RU	+	+	-	1203	10 + 2
15	931449	1	25	20 - 25	Previous surgery	+	+	+	+	-	-	-	+	-	-	-	-	+	normal	-	+	13	-	L	-	+	+	-	-	-	-	+	USE	L	A	Chronic ectopic	+	-	-	156.3	9 + 0
16	932906	1	29	25 - 30	Previous surgery	+	+	-	-	-	-	-	-	-	-	-	-	+	↑	+	-	13.6	+	R	-	+	+	-	-	-	-	-	LUSE	R	A	UR	-	-	-	194	5 + 5
17	939247	1	22	20 - 25	endometriosis	+	-	+	-	-	-	-	-	-	-	-	-	-	normal	-	-	10.3	+	R	+	-	-	-	-	-	+	+	LUSE	R	C	RU	+	+	-	1664	7 + 4
18	945331	0	25	20 - 25	-	+	-	+	-	+	-	-	+	-	-	-	-	-	normal	-	-	11.7	+	R	+	-	-	-	-	-	+	+	USE	R	C	RU	+	+	-	3369	7 + 5
19	947465	0	26	25 - 30	endometriosis	+	-	+	-	-	-	-	+	-	-	-	-	-	normal	-	-	13.2	+	L	-	+	+	+	+	+	-	-	USE	L	A	UR	-	-	-	4029	5 + 5
20	952439	2	25	20 - 25	Previous surgery	+	-	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	10.6	+	R	+	-	-	-	-	-	+	+	USE	R	A	RU	+	+	-	2146	9 + 0
21	950417	0	31	30 - 35	-	+	-	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	11.2	+	R	+	-	-	-	-	-	+	+	USE	R	A	RU	+	+	-	1260	6 + 2
22	950127	0	27	25 - 30	previous abortion	+	+	+	-	-	-	-	-	-	-	-	-	+	normal	-	-	12.5	+	L	+	-	-	-	-	-	-	+	USE	L	A	RU	-	+	-	1608	6 + 0
23	958211	0	26	25 - 30	TB	+	-	+	+	+	-	-	+	-	-	-	-	-	normal	+	+	8.1	+	L	+	-	-	-	-	-	+	+	USE	L	C	RU	+	+	-	32953	6 + 3
24	957771	1	23	20 - 25	Previous surgery	+	-	-	+	+	-	-	+	-	-	-	-	-	normal	+	+	9	+	R	+	-	-	-	-	-	+	+	USE	R	A	RU	+	+	-	1283.5	5 + 4
25	957696	2	27	25 - 30	-	-	+	-	+	+	+	-	-	-	-	-	-	+	normal	+	-	4.4	+	R	+	-	-	-	-	-	+	+	USE	R	C	RU	+	+	-	42048	7 + 2
26	957689	1	32	30 - 35	Previous surgery	+	+	+	+	-	-	-	+	-	-	-	-	-	normal	-	-	14	+	R	-	+	+	+	-	-	-	-	USE	R	C	UR	-	-	-	5371	5 + 2
27	955877	0	29	25 - 30	IUI	+	+	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	8.6	+	R	-	+	+	-	-	-	-	-	LUSE	R	C	UR	-	+	-	2061	7 + 6
28	964422	2	29	25 - 30	Previous surgery	+	+	+	+	+	+	-	+	+	-	-	-	+	normal	-	+	7.7	+	L	+	-	-	-	-	-	-	+	USE	L	F	TA	+	+	-	1222	6 + 2
29	969179	3	29	25 - 30	Previous surgery	+	+	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	8.2	+	L	-	+	+	+	-	-	-	+	USE	L	C	UR	+	+	-	35500	6 + 5
30	968248	4	28	25 - 30	-	+	-	+	-	+	-	-	+	-	-	-	-	+	normal	-	+	8.9	+	R	+	-	-	-	-	-	+	+	BSE	R	IS	RU	+	+	-	181.6	5 + 0
31	971782	2	40	35 - 40	OCP	+	+	+	-	+	+	-	+	-	-	-	-	+	normal	+	+	6.3	+	L	+	-	-	-	-	-	+	+	USE	L	A	RU	+	+	-	7848	5 + 0
32	974707	1	24	20 - 25	Previous surgery	+	-	+	+	+	+	-	+	+	-	-	-	+	normal	+	+	6.8	+	L	+	-	+	-	-	-	+	+	USE	L	A	RU	+	+	-	12404	7 + 6
33	975361	2	30	25 - 30	Previous surgery	+	-	+	-	-	-	-	+	-	-	-	-	+	normal	-	-	13.4	+	L	-	+	+	+	-	+	+	+	USE	L	A	UR	+	-	-	28278	13 + 3
34	976348	0	26	25 - 30	IUI	+	+	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	8.9	+	R	+	-	-	-	-	-	+	+	USE	R	IS	RU	+	+	-	480	6 + 1
35	977434	0	33	30 - 35	IUI	+	-	+	-	-	-	-	+	-	-	-	-	+	normal	+	+	12.3	+	L	+	-	-	-	-	-	+	+	USE	L	A	RU	+	-	-	6113	5 + 4
36	978408	0	36	35 - 40	previous abortion	+	+	+	-	-	-	-	+	-	-	-	-	+	normal	+	+	10.9	+	R	+	-	+	-	-	-	-	+	USE	R	A	RU	+	-	-	2085	6 + 4
37	979588	2	29	25 - 30	tubectomy	+	+	+	-	+	-	-	+	-	-	-	-	+	normal	-	-	8.8	+	L	-	+	+	+	+	+	-	+	USE	L	A	UR	+	+	-	4620	6 + 1
38	989188	2	29	25 - 30	tubectomy	+	-	+	+	+	-	-	+	-	+	-	-	+	normal	+	+	7.2	+	R	+	-	+	-	-	-	-	+	LB/LSE	R	IS	RU	+	+	-	1295	6 + 2
39	988897	3	42	40 - 45	Previous surgery	+	-	-	-	+	-	-	+	-	-	-	-	+	normal	+	-	10.2	+	L	-	+	+	-	-	-	-	-	LUSE	L	A	UR	-	+	-	6514	5 + 0
40	926213	2	28	25 - 30	OCP	+	+	+	+	-	-	-	+	-	-	-	-	+	normal	-	-	12.6	+	L	-	+	+	-	-	-	-	-	LUSE	L	A	UR	-	-	-	2910	5 + 4
41	934389	2	35	30 - 35	Previous surgery	+	+	-	-	-	-	-	+	-	-	-	-	+	normal	-	-	12.6	+	R	-	+	+	+	-	-	-	-	USE	R	A	UR	-	-	-	1287	8 + 2
42	936499	1	35	30 - 35	Previous surgery	-	+	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	12.4	+	R	+	-	-	-	-	-	+	+	LB/LSE	R	IS	RU	+	-	-	3526	4 + 4
43	974559	2	25	20 - 25	tubectomy	+	+	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	10.7	+	R	+	-	-	-	-	-	+	+	LUSE	R	F	TA	+	-	-	3153	4 + 5
44	976985	0	33	30 - 35	previous abortion	+	+	+	+	+	-	-	+	-	-	-	-	+	normal	+	+	12.6	+	L	+	-	-	-	-	-	+	+	LUSE	L	A	RU	+	-	-	1044	6 + 5
45	988118	1	21	20 - 25	-	+	-	+	+	+	-	-	+	+	-	-	-	+	normal	+	+	9.2	+	R	+	-	+	-	-	-	-	+	LUSE	R	A	RU	+	+	-	704	4 + 5
46	993365	1	25	20 - 25	Previous surgery	+	+	+	+	-	-	-	+	-	-	-	-	+	normal	+	+	10.7	+	R	+	-	-	-	-	-	+	+	LUSE	R	F	TA	+	+	-	393	10 + 6
47	994198	0	24	20 - 25	-	+	+	+	-	-	-	-	-	-	-	-	-	+	normal	-	-	10.1	+	L	-	+	-	-	-	-	+	-	LUSE	R	IS	UR	-	-	-	1119	4 + 5
48	994931	2	37	35 - 40	Previous surgery	+	-	+	-	+	-	-	+	-	-	-	-	+	normal	-	-	12	+	R	-	+	+	+	-	+	-	+	USE	R	A	UR	+	+	-	2047	6 + 3