© 2026 Jannat F, et al. This is an open access article distributed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License (https://creativecommons.org/licenses/by-nc-sa/4.0/). ISSN 2518-6299 (print), 2520-5048 (online)

Original Article

Incidence, Risk Factors and Clinical Profile of Ectopic Pregnancy in a Tertiary Care Hospital in Bangladesh

Fatematul Jannat[1], Nur Jahan Begum[2], Musammat Shamima Akter[3], Shabera Arzoo[4], Mohammad Ariful Islam[5], Nasrin Afrose[6], Umme Habib Nadia[7]

Abstract

Background: *Ectopic pregnancy is a potentially life-threatening gynecological emergency. In developing countries like Bangladesh, it often presents late with tubal rupture and hemodynamic instability. It is a major cause of maternal morbidity and mortality among women of reproductive age. Globally, the incidence of ectopic pregnancy has increased over the past decades, rising from approximately 0.5% in 1970 to nearly 4% in recent years. The purpose of this study was to determine the incidence, risk factors, and clinical profile of ectopic pregnancy.* ***Materials and Methods:*** *This was a cross-sectional observational study conducted in the Department of Obstetrics and Gynecology at Cumilla Medical College Hospital (CuMCH), Cumilla, from October 2021 to March 2022. A total of 105 patients with ectopic pregnancies were selected by purposive sampling. Ectopic pregnancy was diagnosed by a positive urinary pregnancy test or serum β-hCG, along with ultrasonography. Patients who were clinically suspicious, but laparotomy findings ruled out ectopic pregnancy and who did not give consent were excluded. The collected data were analyzed using SPSS version 23.0, and descriptive statistics were employed to summarize the findings.* ***Results:*** *The overall incidence of ectopic pregnancy in this study was 2.1%. The most affected age group was 21-25 years (43.8%), with a mean age of 26.8 ± 5.6 years. Most patients were multiparous (61.0%), followed by primiparous (26.7%) and nulliparous women (12.4%). Amenorrhea (98.1%), abdominal pain (89.5%), and per-vaginal bleeding (67.6%) were the commonest presentations, with 12.4% presented shock. Previous abortion was the most frequent risk factor (44.8%), followed by pelvic inflammatory disease (26.7%), prior abdominopelvic surgery (25.7%), infertility (20.0%), and previous ectopic pregnancy (18.1%). The ampullary region was the most common site (60.0%), with a higher predominance on the right side (60%).* ***Conclusion:*** *Ectopic pregnancy remains a major gynecological emergency and a significant challenge to women's reproductive health. A high index of suspicion is essential for early diagnosis before rupture, allowing the possibility of conservative management. Prompt diagnosis and timely intervention can reduce morbidity and mortality and improve future reproductive outcomes.*

Keywords: Ectopic pregnancy; Incidence; Risk factors; Clinical profile; Tertiary care hospital.
Received: September 10, 2025; **Accepted:** October 30, 2025
https://doi.org/10.3329/emcj.v11i1.89998

Introduction

The term 'ectopic' originates from the Greek word 'ektopos,' which means 'out of place.' An ectopic pregnancy happens when a fertilized ovum implants outside the endometrial cavity. It poses a life-threatening risk because they can invade maternal blood vessels, potentially leading to severe hemorrhage[1]. It is the most common cause of maternal mortality during the first trimester and is responsible for approximately 10-15% of all maternal deaths[2]. Apart from fetal wastage, maternal mortality and morbidity, ectopic pregnancy is also associated with recurrence and impairment of subsequent fertility[3]. More than 95% of extra-uterine pregnancies occur in the tubes as ampullary 55%, isthmus 25%, fimbrial 17% and interstitial 2%. Remained are found in the ovary, cervix, abdominal cavity or a scar from a caesarean section (<5%)[2]. Ectopic pregnancy may be bilateral and be concurrent with an intra-uterine pregnancy (heterotopic) but these circumstances are rare[4].

True incidence of ectopic pregnancy varies significantly among institutions and countries, depending on the denominator used in calculations and the facilities available for diagnosis. Currently, the overall incidence is increasing worldwide[5,6]. But

[1]Assistant Professor, Department of Obstetrics & Gynecology, Eastern Medical College & Hospital, Cumilla, Bangladesh.
[2]Professor, Department of Obstetrics & Gynecology, Eastern Medical College & Hospital, Cumilla, Bangladesh.
[3]Professor, Department of Obstetrics & Gynecology, Eastern Medical College & Hospital, Cumilla, Bangladesh.
[4]Professor, Department of Obstetrics & Gynecology, Eastern Medical College & Hospital, Cumilla, Bangladesh.
[5]Medical Officer, Department of Surgery, Dhaka Medical College & Hospital, Dhaka, Bangladesh.
[6]Assistant Professor, Department of Biochemistry, Cumilla Medical College, Cumilla, Bangladesh.
[7]Honorary Medical Officer, Department of Skin & VD, Cumilla Medical College, Cumilla, Bangladesh.

Adress of Correspondence: Dr. Fatematul Jannat, Assistant Professor, Department of Obstetrics & Gynaecology, Eastern Medical College & Hospital, Cumilla, Bangladesh. Email: jannatimc@gmail.com

the case fatality rate has decreased[7]. The associated mortality has decreased mainly because of early diagnosis and treatment before rupture[8]. The overall incidence of ectopic pregnancy is approximately 1-2% in the general population, rising to about 2-5% among women who have undergone assisted reproductive techniques (ART)[9]. The incidence of ectopic pregnancy in our country was 7.4/1000 deliveries[10]. In South-East Asia region, the incidence of ectopic pregnancy varies between 0.25-1.9%[11]. In developing countries, many hospital-based studies have reported EP case fatality rates of around 1%-3%, 10 times higher than those reported in developed countries[12].

Other etiological risk factors include a history of tubal or pelvic surgery, endometriosis, in utero exposure to diethylstilbestrol (DES), chromosomally abnormal embryos, use of progestogen-only pills, cigarette smoking, conception following ovulation induction, in vitro fertilization and embryo transfer (ART), previous abortion, previous ectopic pregnancy, infertility, and maternal age above 35 years[13]. Other etiological risk factors include a history of tubal or pelvic surgeries, endometriosis, in utero exposure to diethylstilbestrol (DES), chromosomally abnormal embryos, the use of progestogen-only pills, cigarette smoking, conception following ovulation and in vitro fertilization and embryo transfer (ART), history of previous abortion, previous ectopic pregnancy, history of infertility, age above 35 years[14]. However, 50% of women diagnosed with ectopic pregnancies have no identifiable risk factors[15].

The postulated mechanism includes anatomic obstruction, abnormalities in tubal motility or ciliary function, abnormal conceptus and chemotactic factors stimulating tubal implantation[16]. Approximately 95% of ectopic pregnancies occur in the Fallopian tube, followed by the cornual region, ovary, cervix, cesarean scar, and abdomen[15]. The classic triad of symptoms of ectopic pregnancy includes abdominal pain, bleeding per vagina and amenorrhoea[15]. These classic presentations occur at around 6 to 8 weeks of gestation, but the clinical presentations can range from asymptomatic to secondary amenorrhea, abdominal pain, bleeding per vagina, syncope, vomiting, and hypovolemic shock depending at the time of diagnosis and hospital admission[17]. Clinically it may be acute, unruptured, sub-acute or chronic or old[18].

Ectopic pregnancy is diagnosed through detailed history, thorough clinical examination, and appropriate investigations, including urine pregnancy testing, measurement of serum β-human chorionic gonadotropin (β-hCG) levels, transabdominal and transvaginal ultrasonography, and, in doubtful cases, diagnostic laparoscopy[19]. Ruptured ectopic pregnancy often causes abdominal pain, vaginal bleeding and internal haemorrhage which is a very serious condition requiring immediate resuscitation and surgical intervention[20]. Early diagnosis reduces the risk of tubal rupture, morbidity and mortality, allows more conservative management, and preserves the future fertility. Management of ectopic pregnancy is by expectant, medical and surgical based upon clinical presentation and condition of woman[21].

Ectopic pregnancy is an important cause of hospital admission resulting in morbidity and mortality among woman of reproductive age. The aim of this study is to appraise all the cases of ectopic pregnancy managed at Cumilla medical college hospital over a period of 6 months and to determine the incidence, risk factors, clinical presentation, management, and outcome associated with ectopic pregnancy.

Materials and Methods

Study Design: This was a cross-sectional observational study conducted in the Department of Obstetrics and Gynecology at Cumilla Medical College Hospital (CuMCH), Cumilla, from October 2021 to March 2022, to determine the incidence, risk factors, and clinical profile of ectopic pregnancy. A total of 105 ectopic pregnancy cases were included in the study using purposive sampling. ***Sample size:*** The sample size was calculated using the formula $n = Z^2pq/d^2$, taking a prevalence of 7.4%[10] with a 5% allowable error, and a Z-value of 1.96, yielding a sample size of 105. ***Data Collection Procedure:*** Data was collected through a pre-tested structured questionnaire. A total of 105 patients with ectopic pregnancy were admitted to the Department of Obstetrics and Gynecology of CuMCH during the study period were included in the study. Ectopic pregnancy was diagnosed by a positive urinary pregnancy test or serum β-hCG, along with ultrasonography (USG). A systematic method was used for the clinical examination of the patient. After stabilizing the patient, the following data was studied: sociodemographic details, history and clinical examination include general examinations, per-abdominal and per-vaginal examinations. Other investigations such as blood grouping, CBC, LFT and RFT were carried out. The type of operative intervention performed and the clinical outcome of the patient at discharge were also recorded. All records were stored securely providing the unique study ID of each participant. ***Inclusion Criteria:*** Patients with suggestive history and clinical presentation related to ectopic pregnancy admitted at obstetrics and gynecology department of CuMCH, those were found as ectopic pregnancies after emergency Laparotomy and who gave consent to participate in the study. ***Exclusion Criteria:*** Patients who were clinically suspicious, but

laparotomy findings ruled out ectopic pregnancy and who did not give consent to participate in the study. ***Statistical Analysis:*** Collected data was entered into Microsoft Excel and analyzed using SPSS version 23.0. Descriptive statistics were used to summarize the data and a p-value of <0.05 was considered statistically significant. The results were presented using tables, figures, and narrative descriptions. ***Ethical Consideration:*** Ethical permission for the study was taken from the IERB of Cumilla Medical College, Cumilla. Written informed consent was taken from all participants.

Results

Table-I describes that out of a total of 5,872 patients, there were 4,952 deliveries, among which 105 cases were identified as ectopic pregnancies. This represents an ectopic pregnancy rate of 2.1% in the study population. Table-II shows that majority 46 (43.8%) patients belonged to age group 21-25 years. The mean age of the study population was 26.8 ± 5.6 years. Pie chart shows that most patients were multiparous, accounting for 64 (61.0%) cases. Primiparous women constituted 28 (26.7%) cases, while 13 (12.4%) patients were nulliparous.

Table-I: Patient statistics and incidence of ectopic pregnancy

Patient statistics	Number
Total patients (n)	5,872
Total deliveries (n)	4,952
Ectopic pregnancy (n)	105
Incidence of ectopic pregnancy (%)	2.1*

*Incidence calculated as number of ectopic pregnancies per total deliveries

Table-II: Age distribution of the study patients (n=105)

Age (years)	Number (n)	Percentage (%)
≤20	9	8.6
21-25	46	43.8
26-30	22	21.0
31-35	15	14.3
>35	13	12.4
Mean ±SD	**26.8±5.6 years**	

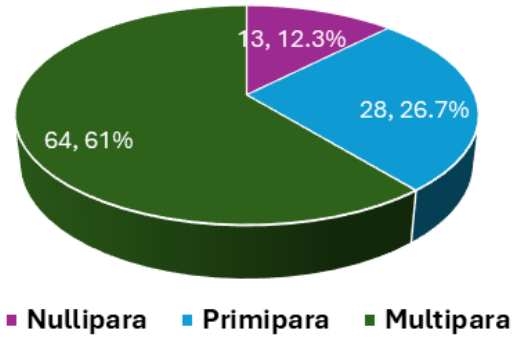

Figure-1: Distribution of parity among patients with ectopic pregnancy (n = 105)

In this study, majority of the patients 103 (98.1%) presented with amenorrhea followed by abdominal pain 94 (89.5%) and per-vaginal bleeding 71 (67.6%). Shock was present in 13 (12.4%) patients (Table-III). Table-IV illustrated the risk factors found in patients with ectopic pregnancy in this study. Amongst the various risk factors, previous abortion was common (44.8%) followed by pelvic inflammatory disease (26.7%), Prior abdominopelvic surgery (25.7%), infertility (20.0%) and previous ectopic pregnancy (18.1%). Table-VI shows that most ectopic pregnancies occurred in the ampullary region (63; 60.0%), followed by the isthmic region (31; 29.5%). Right-sided ectopic pregnancies were more common (60%) than left-sided (40%).

Table-III: Clinical presentation of the patients with ectopic pregnancy (n=105)

Presenting features	Number (n)	Percentage (%)
Symptoms		
Amenorrhea	103	98.1
Abdominal pain	94	89.5
Per vaginal bleeding	71	67.6
Syncopal attack	3	2.9
Signs		
Abdominal tenderness	57	54.3
Pelvic tenderness	36	34.3
Shock	13	12.4
Adnexal mass	4	3.8

Table-IV: Risk factors found in patients with ectopic pregnancy (n=105)

Risk factors	Number (n)	Percentage (%)
Previous abortion	47	44.8
Pelvic inflammatory disease	28	26.7
Prior abdominopelvic surgery	27	25.7
Infertility	21	20.0
Previous ectopic pregnancy	19	18.1
Intrauterine devices (IUDs)	11	10.5
H/O genital tuberculosis	6	5.7
Tubal ligation	1	1.0
Others	12	11.4

OPEN ACCESS

Table-V: Site and side of ectopic pregnancy of the study patients (n=105)

Distribution	Number (n)	Percentage (%)
Site		
Ampullary	63	60.0
Isthmic	31	29.5
Tubal abortion	9	8.6
Ovarian	2	1.9
Side		
Right	63	60.0
Left	42	40.0

Discussion

Ectopic pregnancy is a life-threatening gynaecological emergency in early pregnancy. Globally its incidence has been on the rise over the past decades, varies from 0.25-2.0% of all pregnancies[22]. In this study the incidence of ectopic pregnancy was 2.1%. Nath et al.[23] revealed the incidence of ectopic pregnancy was 2.9/1000 deliveries. Other studies reported 0.56-1.95% incidence in developing countries and 2.5-4.9 % in developed world[24,25]. Ganitha and Anuradha[17] observed the incidence of ectopic pregnancy is 1 in 167 pregnancies (0.6%) or 6.3 per 1000 deliveries which is not comparable to our study.

Present study showed that majority 46 (43.8%) patients belonged to age group 21-25 years. The mean age was 26.8±5.6 years. In many studies, the peak incidence was seen after 25 years which is similar to this study[8,16,19,23]. Younger age group has high prevalence because they are more sexually active, predisposed to PID, STI and their sequelae. Study in Iran however reported an increasing incidence of ectopic pregnancy with advancing maternal age. It is suggested that the higher risk is due to chromosomal abnormalities in the trophoblastic tissue[26]. This difference observed in our country could be due to early age of marriage. Additionally, maximum occurrence of ectopic pregnancy (61.0%) was seen in multipara. Yadav et al.[16] reported multiparous women were found to be more prone to have ectopic pregnancy (65.75%). Conversely, Ranji et al.[19] observed that the majority of their patients were primigravida. Nath et al.[23] reported that most of the patients were nulliparous (34.28 %) which are not comparable to this study.

In this study, the majority of patients (103; 98.1%) presented with amenorrhea followed by abdominal pain (94; 89.5%) and per-vaginal bleeding (71;67.6%). Around 12.4% of the patients were presented in a state of shock. Yadav et al.[16] reported the most common presenting clinical symptoms were amenorrhea (93.15%), abdominal pain (87.67%) and vaginal bleeding (64.38%). Ranji et al.[19] study also corroborates our study. Nath et al.[23] reported most of the patients presenting with the classic triad of amenorrhea (96.57%), abdominal pain (88.57%) and vaginal bleeding (56.0%). Patel et al.[27] reported abdominal pain was the most common presenting symptoms (92.30%) followed by amenorrhoea in 84.61% cases.

In the current study, history revealed that 74.1% of cases had at least one high-risk factor. Amongst the risk factors, previous abortion was the commonest 47 (44.8%) followed by pelvic inflammatory disease 28 (26.7%). 19 out of the 105 patients had previous ectopic pregnancy hence the recurrence rate was 18.1%. Ganitha and Anuradha[17] study, 26 patients had single identifiable risk factors on history and examination while 12 patients had two risk factors, 2 patients had multiple risk factors, and 10 patients had no recognizable risk factor. The most common risk factor was pelvic inflammatory disease (40%), followed by a history of previous abortion (20%) and previous abdominopelvic surgery including tubal ligation, LSCS, and appendicectomy (14%). While all forms of contraception lower the overall risk of pregnancy, the chance of ectopic pregnancy is higher if contraception fails, especially in women using an IUD or who have had tubal sterilization[28].

In our study, 10% of patients were using copper IUCD. Other identified risk factors included a history of infertility due to tubal blockage or other causes, infertility treatments, endometriosis, and a previous ectopic pregnancy[28]. Nath et al.[23] study also found same high-risk factors as this study. Patel et al.[27] reported that the majority of patients (42.3%) had a history of infertility, which was identified as a significant risk factor for ectopic pregnancy. Use of family planning methods, such as prior tubal sterilization, accounted for 30.76% of cases. Additionally, a history of infertility treatment, including ovulation induction, was present in 15.38% of patients, which is also recognized as a risk factor. Similar to our study, there were no cases of maternal mortality reported.

Limitations

The study population was selected from one selected hospital in Cumilla city, sample size was small and due to unavailability of laparoscopic instruments with expertness, open surgery was performed.

Conclusion

Ectopic pregnancy remains a major life-threatening emergency, causing significant morbidity and mortality. It also poses a serious challenge to women's reproductive health and should therefore be recognized as an important public health issue in our country. Emphasis should be placed on

prevention and early detection to allow for timely and effective management. Identifying underlying risk factors, careful follow-up, and access to diagnostic tools such as pregnancy testing, serum β-HCG measurement, and ultrasonography are essential for timely intervention. These measures can help reduce morbidity and mortality and improve future reproductive outcomes.

Recommendations

Future studies should be conducted in multiple centers with a larger sample size to improve the generalizability of findings. Upgrading diagnostic and surgical facilities, including the availability of laparoscopic instruments, along with training of skilled personnel, is strongly recommended to promote minimally invasive management of ectopic pregnancy.

Conflict of interest

The authors declared that they have no conflicts of interest.

References

1. Horne AW, Skubisz MM, Tong S. Molecular diagnostics and therapeutics for ectopic pregnancy. Mol Hum Reprod. 2015; 21 (2): 126-35. doi: 10.1093/molehr/gau084.
2. Sara HG, Uzelac PS. Early pregnancy risks. In: DeCherney AH, Nathan L, Goodwin MT, Laufer N, editors. Current Diagnosis and Treatment: Obstetrics and Gynecology. 10th edition, Columbus (OH): McGraw-Hill; 2007: pp 259-72.
3. Abdul FI. Ectopic pregnancy in Ilorin: a review of 278 cases. Niger J Med. 2000; 9 (3): 92-6.
4. Hoopmann M, Wilhelm L, Possover M, Nawroth F. Heterotopic triplet pregnancy with bilateral tubal and intrauterine pregnancy after IVF. Reprod Biomed Online. 2003; 6 (3): 345-8. doi: 10.1016/s1472-6483(10)61855-x.
5. Mukul LV, Teal SB. Current management of ectopic pregnancy. Obstet Gynecol Clin North Am. 2007; 34 (3): 403x-19x. doi: 10.1016/j.ogc.2007.07.001.
6. Jurkovic D. Ectopic pregnancy. In: Edmonds K, editor. Dewhurst's Textbook of Obstetrics and Gynaecology for Postgraduates. 7th edition, Oxford: Blackwell Science, 2007: pp 106-16.
7. Anderson FW, Hogan JG, Ansbacher R. Sudden death: ectopic pregnancy mortality. Obstet Gynecol. 2004; 103 (6): 1218-23. doi: 10.1097/01.AOG.0000127595.54974.0c.
8. Barnhart KT, Katz I, Hummel A, Gracia CR. Presumed diagnosis of ectopic pregnancy. Obstet Gynecol. 2002; 100 (3): 505-10. doi: 10.1016/s0029-7844(02)02142-7.
9. Practice Committee of the American Society for Reproductive Medicine. Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertil Steril. 2020; 113 (3): 533-5. doi: 10.1016/j.fertnstert.2019.11.025.
10. Yeasmin MS, Uddin MJ, Hasan E. A clinical study of ectopic pregnancies in a tertiary care hospital of Chittagong, Bangladesh. Chatt Maa Shi Hosp Med Coll J. 2014; 13 (3): 1-4. doi: 10.3329/cmoshmcj.v13i3.20993.
11. Moawad NS, Mahajan ST, Moniz MH, Taylor SE, Hurd WW. Current diagnosis and treatment of interstitial pregnancy. Am J Obstet Gynecol. 2010; 202 (1): 15-29. doi: 10.1016/j.ajog.2009.07.054.
12. Goyaux N, Leke R, Keita N, Thonneau P. Ectopic pregnancy in African developing countries. Acta Obstet Gynecol Scand. 2003; 82 (4): 305-12. doi: 10.1034/j.1600-0412.2003.00175.x.
13. Erickson BT. Ectopic pregnancy. In: Bader T, editor. Obstetrics and Gynaecology secrets. 3rd ed. Maryland Heights: Mosby; 2007: pp 109-13.
14. Gharoro EP, Igbafe AA. Ectopic pregnancy revisited in Benin City, Nigeria: analysis of 152 cases. Acta Obstet Gynecol Scand. 2002; 81 (12): 1139-43. doi: 10.1034/j.1600-0412.2002.811207.x.
15. Marion LL, Meeks GR. Ectopic pregnancy: History, incidence, epidemiology, and risk factors. Clin Obstet Gynecol. 2012; 55 (2): 376-86. doi: 10.1097/GRF.0b013e3182516d7b.
16. Yadav A, Prakash A, Sharma C, Pegu B, Saha MK. Trends of ectopic pregnancies in Andaman and Nicobar Islands. Int J Reprod Contracept Obstet Gynecol. 2016; 6 (1): 15-9. doi: 10.18203/2320-1770.ijrcog20164499.
17. Ganitha G, Anuradha G. A study of incidence, risk factors, clinical profile and management of 50 cases of ectopic pregnancy in a tertiary care teaching hospital. Int J Reprod Contracept Obstet Gynecol. 2017; 6 (4): 1336-41. doi: 10.18203/2320-1770.ijrcog20171388.
18. Dutta DC. Haemorrhage in Early Pregnancy. In: Konar H, editor. Textbook of Obstetrics, 7th edition, New Central Book Agency PVT Ltd., London, 2011: pp 177-82.
19. Ranji GG, Usha Rani G, Varshini S. Ectopic Pregnancy: Risk Factors, Clinical Presentation and Management. J Obstet Gynaecol India. 2018; 68 (6): 487-92. doi: 10.1007/s13224-017-1075-3.
20. Dalsgaard Jensen T, Penninga L. Non-operative treatment of ruptured ectopic pregnancy. BMJ Case Rep. 2016; 2016: bcr2016215311. doi: 10.1136/bcr-2016-215311.
21. Hajenius PJ, Mol F, Mol BW, Bossuyt PM, Ankum WM, van der Veen F. Interventions for tubal ectopic pregnancy. Cochrane Database Syst Rev. 2007; 2007 (1): CD000324. doi: 10.1002/14651858.CD000324.pub2.

22. Shah P, Shah S, Kutty RV, Modi D. Changing epidemiology of maternal mortality in rural India: time to reset strategies for MDG-5. Trop Med Int Health. 2014; 19 (5): 568-75. doi: 10.1111/tmi.12282.
23. Nath J, Mishra A, Verma V, Gupta S. A 5-year study on ectopic pregnancy in North India. Sch Int J Obstet Gynec. 2021; 4 (3): 49-54. doi: 10.36348/sijog.2021.v04i03.001.
24. Tahmina S, Daniel M, Solomon P. Clinical Analysis of Ectopic Pregnancies in a Tertiary Care Centre in Southern India: A Six-Year Retrospective Study. J Clin Diagn Res. 2016; 10 (10): QC13-QC16. doi: 10.7860/JCDR/2016/21925.8718.
25. Singh S, Mahendra G, Vijayalakshmi S, Pukale RS. Clinical study of ectopic pregnancy in a rural setup: a two-year survey. J Med Res. 2018; 4: 37-9. doi: 10.31254/JMR.2018.4109.
26. Moini A, Hosseini R, Jahangiri N, Shiva M, Akhoond MR. Risk factors for ectopic pregnancy: A case-control study. J Res Med Sci. 2014; 19 (9): 844-9.
27. Patel UM, Gandhi MR, Jani PS, Kakani CR, Thakor N. Clinical profile and management of ectopic pregnancy in patients at GMERS Medical College and Hospital, Dharpur-Patan, North Gujarat, India. Int J Res Med Sci. 2017; 3 (4): 841-5.
28. Singh P, Pritam A, Khan M. Prospective observational assessment of ectopic pregnancy: incidence, risk factors, clinical characteristics, diagnosis, management and outcome. Int J Pharm Clin Res. 2021; 13 (6): 327-34.

Citation of this article
Jannat F, Begum NJ, Akter MS, Arzoo S, Islam MA, Afrose N, Nadia UH. Incidence, Risk Factors and Clinical Profile of Ectopic Pregnancy in a Tertiary Care Hospital in Bangladesh. Eastern Med Coll J. 2026; 11 (1): 36-41.
doi: https://doi.org/10.3329/emcj.v11i1.89998