disturbances and nightmares have been described (Irvine *et al.*, 1962; Smirk, 1963).

To my knowledge this is the only recorded case of hyperpyrexia developing during the administration of methyldopa.

I wish to express my thanks to Dr. P. Freedman for permission to report this case, and to Dr. J. A. Amos, of Redhill Pathology Department, and Dr. F. G. Clayton, of Merck Sharp and Dohme Ltd., for their advice.

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Cervical Pregnancy

Rare conditions, unless dangerous, concern the specialist only, but if knowledge of their existence promotes good treatment they should have a more general interest.

Cervical ectopic pregnancy follows a blastocyst implanting below the internal os of the cervix. Only 60 instances are reported in the literature, but probably cervical pregnancy is commoner than this, and its recognition would lead to better treatment.

CASE REPORT

A married woman aged 36 had bled heavily from the vagina twice in the two weeks before admission to hospital. She had had two full-term pregnancies. The first, five years previously, was normal but followed by a curettage for retained products; the second was two years later, when a lower-segment caesarean section was performed for pre-eclampsia. The last normal period started on November 10, 1961. After 45 days a little painless bleeding occurred, and a week later vaginal bleeding restarted, continuing until admission on January 8, 1962. Otherwise the patient had felt well, there being no abdominal pain or vomiting.

On admission she was not shocked, but was slightly anaemic. Heart and chest were normal, and the abdomen was soft, a non-tender, firm mass arising just above the pubis. Vaginal examination showed the cervix to be soft and bulky, with some products of conception at the open os. The uterus seemed small but firm, and the adnexae were normal. A provisional diagnosis of incomplete abortion was made and the patient was prepared for operation, an intravenous drip being set up. The haemoglobin was 8.18 g./100 ml. and compatible blood was cross-matched.

The patient was re-examined under general anaesthesia. A gestation sac was seen suspended in a sessile fashion from the anterior wall of the cervical canal, which was curetted, most of the chorionic tissue coming away easily. Ergometrine 0.5 mg. was given intravenously, causing uterine contraction but not affecting the cervix; consequently flavine gauze was packed firmly into the canal. The bleeding was controlled and the patient returned to the ward.

Four pints (2.27 l.) of blood were given, and 24 hours later the pack was removed, there being no further bleeding. Examination 10 days after the operation showed a normal multiparous bulky cervix.

COMMENT

The site of ovum implantation is dependent on the time of fertilization, rate of ripening, and rate of passage along the Fallopian tube. If fertilization is early or the rate of passage is slow, then a tubal ectopic pregnancy could occur. Rapid tubal passage, however, may allow the ovum to arrive low in the uterus (placenta praevia) or even in the cervix if the internal os is not tightly closed.

Unless that part of the uterus on which the ripening ovum rests is in a favourable state there may be no nidation, and consequently loss of the ovum. There is no decidua in the cervical canal; hence many ova that arrive there will be rejected. Those that implant have to erode their trophoblastic tissue into the cervical substance and no true placenta can be formed. With death of the embryo at eight to twelve weeks there will be more bleeding than from a normally sited abortion. The more mature the pregnancy, the deeper the trophoblastic erosion, and when eventual separation occurs the bleeding is even more profuse.

Cervical pregnancy occurs most often in multigravidae who have had operative dilatation of the internal os. There is a short period of amenorrhoea followed by painless bleeding, which is often profuse. Occasionally the heavy bleeding occurs after interference, either criminal or therapeutic. Trophoblastic disruption may occur through the cervix to allow intraperitoneal bleeding (Rubin, 1911).

Examination shows a soft bulky cervix, the external os being open, and products of conception often protrude through. The uterus itself feels small and may be firm, perched on top of the swollen cervix. Commonly, heavy bleeding starts with the examination.

Differentiating a cervical pregnancy from an intrauterine abortion may be helped as shown:

	Cervical Pregnancy	Intrauterine Abortion
Body of uterus	Small and firm	Big and soft
Cervix	Soft and ballooned out	Soft and patulous
Internal os	Closed	Open
External os	Open	May be closed
Products of conception	Confined to cervical canal	In uterus; may be overflowing into canal

Shelling out as much trophoblastic tissue as possible should be done under anaesthesia. Blood transfusion is always required, and firm packing of the cervix is usually needed. Should bleeding continue, a hysterectomy may be necessary.

Mortality as high as 50% has been reported, while recently Mayberger (1958) showed a 20% maternal death rate. Cervical pregnancy is a dangerous form of ectopic pregnancy and is one that requires early recognition and adequate treatment to prevent disaster.

I am indebted to Mr. Ian Jackson for permission to publish this case and for his helpful advice.

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The Polio Research Fund has given £11,319 for a new laboratory to be erected and fully operational within the next few weeks at the Poliomyelitis Centre, West Hendon Hospital. The laboratory will undertake research on British artificially powered limbs.