COMMENT

The absence of a history of trauma suggests that this was a case of a rupture occurring spontaneously in a pathologically enlarged spleen. Although the presence of blood in the peritoneal cavity suggests that at least one of the ruptures had occurred prior to operation it is not possible to be certain about the "spontaneous" origin of all the ruptures, as even comparatively mild trauma, which is necessarily inflicted on the viscus during operative manipulation, may be sufficient to cause the rupture of a spleen which is grossly enlarged.

The enlargement of the spleen in this case exceeded that usually seen in cases of lymphatic leukaemia, but the cells in the peripheral blood were undoubtedly lymphocytes, and as they were of the small variety no difficulty was experienced in differentiating them from the cells of the myeloid series.

The absence of infarcts also points to lymphatic leukaemia as being the causative factor in the splenomegaly. The incidence of splenic infarction is much less frequent in lymphatic leukaemia. Lubarsch (1927) records infarcts in only 12.5% of lymphatic cases as against 50% of myeloid cases. There was no evidence of malaria or of kala-azar. It was concluded that lymphatic leukaemia was solely responsible for the splenic enlargement.

My thanks are due to Mr. R. Anthonis, surgeon, General Hospital, Colombo, for the case notes, and to Mr. K. M. M. Michael, of the Department of Pathology, University of Ceylon, for the photograph.

G. H. COORAY, M.D., M.R.C.S., D.T.M.&H.,
Reader in Pathology, University of Ceylon.

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Torsion of Fallopian Tube during Pregnancy

Torsion of the Fallopian tube is in itself a rare condition; only about 120 cases having been recorded in the past 50 years. Records of this condition occurring during pregnancy are even less common. For this reason, and because of its general interest, the following case is reported.

CASE REPORT

A primipara aged 27 was admitted to hospital on April 26, 1951, complaining of abdominal pain. This pain, which was constant and dull in character, was situated in the right iliac fossa and radiated across the abdomen and round to the back. It had been present for approximately 60 hours, originally awakening her in the night. During the previous six hours it had become more severe. Vomiting occurred on two occasions on the first day of her illness. Her bowels had been constipated and she had nocturia and painful micturition for two days. No previous history was obtained of a similar pain or of any previous illness. Her last menstrual period started on September 12, and she therefore appeared to be 32 weeks pregnant. Her pregnancy up till then had been uneventful. She had been attending an antenatal clinic regularly.

On examination her tongue was furred. She was tender above the right inguinal ligament, although not markedly so. There was no tenderness in either loin. The size of the uterus appeared to be much in advance of her dates. Rectal examination, although causing discomfort, was negative. On vaginal examination a soft mass was felt in the right iliac fossa outside the uterus.

On admission the temperature was 99.4° F. (37.4° C.) and the pulse 80. In four hours her temperature had risen to

100.4° F. (38° C.) and her pulse to 100. A catheter specimen of urine revealed an acid reaction with a trace of protein. The deposit contained a few pus cells and a very occasional red cell. A provisional diagnosis of acute appendicitis was made and operation was decided upon.

The abdomen was opened through a right pararectal incision. A large mass was palpated in the right iliac fossa, and the right Fallopian tube was gangrenous in its whole extent. Its removal was impeded by the size of the uterus, and its congestion caused bleeding difficult to control. A gauze pack was inserted into the right iliac fossa.

The surgical post-operative course was uneventful and the gauze was removed on the second day. Morphine was given to prevent the onset of labour, but on the fourth night after operation labour began. The patient was transferred to a maternity unit four days after operation. At this time labour was well advanced and the membranes had ruptured. The cervix was dilated to two fingerbreadths and the head was in mid-cavity. A Danby belt was applied to give support to the abdominal wound. Labour progressed slowly, and four hours later the cervix became fully dilated. An episiotomy was performed because of delay in the second stage due to a rigid perineum, and a live male infant weighing 8 lb. 2 oz. (4.2 kg.) was delivered.

The puerperium was uneventful, and both the abdominal wound and the episiotomy healed well. When seen one month later both patient and baby were well.

Pathology.—The right Fallopian tube measured about 3 by 2 in. (7.5 by 5 cm.) and was very congested. A single twist had occurred at the proximal end of the isthmus. Sections showed complete infarction.

COMMENT

Only two cases of torsion of a normal tube in pregnancy have previously been reported in the English literature (McKerrow, 1934; Caldwell, 1949). Twisting of a hydrosalpinx or a haematosalpinx during pregnancy occurs more often. Green-Armytage (1929) and Sheldon (1936) reported cases of torsion of both the Fallopian tube and the ovary during pregnancy; but in our case the ovary was not involved. All cases reported were operated upon as acute appendicitis, and thus laparotomy is necessary for diagnosis. Pyelitis and twisted ovarian cyst are other conditions that have to be considered in the diagnosis.

It was noticed that the site of pain was low in the right iliac fossa. The pain of appendicitis in pregnancy is usually higher up in the abdomen owing to the displacement of the appendix by the enlarging uterus. Because of this an incision was made over the site of maximal tenderness.

It is obvious that the patient was mistaken in her dates. One must assume from the weight of her child that the pregnancy was considerably more advanced than had been thought. In the two cases previously referred to the condition occurred at about the sixth month and pregnancy then went on to term. Our patient was stimulated into labour. The good ultimate result in both patient and child is noteworthy.

We wish to thank Mr. S. B. Chambers, senior surgeon, Royal South Hants Hospital, for his permission to publish this case; Mr. R. W. Knowlton, obstetrician; and Dr. H. H. Gleave, pathologist, for his report on the specimen.

N. P. ELLISON, M.B., B.Ch., B.A.O.,
Late House-Surgeon, Royal South Hants Hospital.

J. S. W. CHAMBERS, M.B., B.Ch.,
Obstetric House-Surgeon, Southampton Borough General Hospital.

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