J. O. R. STEWART: PORTAL GAS EMBOLISM

X-ray picture of liver region in Case 1, showing portal gas shadows (arrowed) extending to the periphery of the right lobe.

G. J. FRAENKEL AND J. CHASSAR MOIR:
CASE OF "LIGHTNING BURNS"

Photograph taken more than an hour after the flash of lightning, showing a fern-like pattern on patient's chest.

J. BRADSHAW: CASE OF ADVANCED ABDOMINAL
PREGNANCY

Lateral radiograph showing absence of any uterine shadow, and the foetal parts overlapping the mother's vertebral column.

Case of Advanced Abdominal Pregnancy

[WITH SPECIAL PLATE]

This case history concerns an abdominal pregnancy which resulted in the delivery of a living child. There had been severe abdominal pain early in pregnancy which makes it probable that the case was one of secondary rather than primary abdominal implantation of the ovum.

CASE REPORT

A married Indonesian woman aged 38 was admitted to hospital on February 10, 1961, complaining of slight but persistent generalized abdominal pain which had been present for 24 hours. The bowel habit and micturition were normal and there was no vomiting. There had been one normal delivery 20 years previously; there was no history of miscarriage. The menses had been normal and regular until the last period on January 15, 1961.

Examination showed a distended abdomen, the pattern suggesting that the small intestine was chiefly affected. There was no rigidity or guarding, nor was any abdominal mass felt. On pelvic examination a fullness and tenderness could be detected in the right fornix, but the uterus and adnexa were thought to be normal. A straight abdominal x-ray film, obtained with the patient in the erect position, was reported as normal. An examination of the stools showed copious ascaris ova. The haemoglobin level was 48%. As the temperature remained normal and there were no further pelvic symptoms, the patient was treated for ascariasis and anaemia, and was discharged in good condition on February 14.

Four months later, on June 26, she was admitted with spasmodic abdominal pains starting in the right hypochondrium and radiating across the upper abdomen. There had been no further menstrual bleeding since January 15 and the patient believed that she was pregnant. The abdomen was now found to be very rigid but not tender. There was a fullness between the pubes and the umbilicus. On pelvic examination a mass inseparable from the uterus was felt; it was the size of an 18-weeks pregnancy. The cervix could not be reached with the fingers, but a speculum examination showed that it was displaced to an unusually high position on the right side of the pelvis.

A further x-ray film showed the presence of a foetus lying transversely at a very high level in the abdomen. The foetal head, which was somewhat unusual in shape, lay under the left costal margin and the breech under the right. The position of the legs was remarkable, for they were extended and reached well down into the right iliac fossa (see Fig., Special Plate). Because of this new evidence the patient was palpated. In spite of foreknowledge, the foetal parts were still difficult to identify. The only certainty was that the foetal trunk lay transversely across the epigastrium. On the evidence available it seemed that the abnormal position might be caused by a large uterine fibroid.

During the next few days the patient's symptoms again disappeared, and on July 5 the foetal heart was clearly heard in the epigastrium. The patient was accordingly discharged and was subsequently seen weekly at the antenatal clinic. Attempts made to correct the lie of the foetus were all unsuccessful, and there was now a growing suspicion that this was a case of advanced abdominal pregnancy. The patient was accordingly readmitted to hospital on August 7.

A lateral film of the abdomen showed that the foetal head in particular and the breech to a lesser extent overlapped the bodies of the lumbar vertebrae. As this is a sign strongly suggestive of abdominal pregnancy, it was decided to perform a laparotomy: the patient was 30 weeks pregnant by dates.

On August 14 the abdomen was opened through a long midline incision. The peritoneum was found to be thick and friable. The peritoneal cavity contained much clear fluid, and lying free, without any recognizable amniotic membrane, was a well-developed foetus. As the child was

lifted out the umbilical cord ruptured without any obvious force having been applied. The baby, a female weighing 3½ lb. (1,590 g.), cried within seven minutes and thereafter gave no cause for concern. The placenta was identified by tracing the cord to its source. It was inserted between the bladder and the uterus, the bladder being displaced somewhat to the left and the uterus, which was enlarged, to the right. The anatomy was, however, so distorted that these structures were difficult to identify, but, being fused, they together formed a cup-shaped depression containing the placenta. As there was no sign of placental separation the cord was cut short and the placenta left *in situ*. The abdomen was closed without drainage. The total blood loss during the operation was not in excess of ½ pint (285 ml.).

Convalescence was uneventful. Prophylactic penicillin and streptomycin were administered for one week, and a catheter was left in the bladder for three days, as it was thought that any undue distension might promote placental separation. Lactation never became satisfactorily established. This was an interesting finding, for it is known that milk secretion is inhibited by the presence of biologically active placental tissue.

The child was well formed, although the head shape was unusual—probably because there had been no protection from the uterine wall by an amniotic sac. At nine months the child was re-examined and was found to be progressing normally; there was no suggestion that it was in any way mentally defective.

An intravenous pyelogram performed on August 26 showed a considerable dilatation of the right ureter and renal pelvis. Although such dilatation commonly occurs in normal pregnancy, it was unusually severe in degree and was still present after three months. This continued hydro-nephrosis may also have been caused by the persistence of the placental tumour. However, a further pyelogram obtained on May 28, 1962, showed a return to normal appearances, and by this time the abdominal mass had also considerably decreased in size.

COMMENT

The comparative rarity of advanced abdominal pregnancy, even in the tropics where ectopic gestation is unusually common, made the diagnosis difficult. In retrospect, the correct interpretation of the symptoms might have been made sooner had sufficient consideration been given to the history, the unusual clinical features, and, in particular, the x-ray findings. As regards the latter, the foetus was unusually high and was fixed in the transverse position; there was no evidence of a uterine wall around the foetus; the foetal legs were in a position that was hardly compatible with a normal intrauterine pregnancy. Most significant of all, the lateral film showed overlapping of the foetal parts in relation to the line of the mother's lumbar vertebrae—a sign which is now accepted as almost diagnostic of extrauterine pregnancy.

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A standing exhibition of architectural and domestic fittings for the disabled is to be opened in the Building Centre at Birmingham on May 29 by the Lord Mayor. The Central Council for the Disabled (until recently the Central Council for the Care of Cripples) has leased a section of the Centre, the intention being to vary the display every six months. On show will be part of a house—with the emphasis on the bathroom—designed and fitted for a disabled occupant. Details such as unobstructed walking surfaces, low-level controls for doors, windows, gas and electricity, rails, handgrips, and remote control for the front door will be available for test by visitors, who will be invited to tour by wheelchair.