EXTRAUTERINE GESTATION AT TERM WITH HEALTHY BABY.

BY

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ALL cases of extrauterine gestation late in pregnancy are sufficiently rare and interesting to be worth recording in some detail, but the following case has several features that are probably unique.

E. M., a married woman, aged 25, first attended the ante-natal department of University College Hospital on July 3rd, 1923, being pregnant for the first time. Apart from scarlet fever and a vague history of "gastric trouble" she had always been very healthy. Her periods had been quite regular during her married life until February. On February 10th a period began which lasted four days, after which she saw nothing.

During the first three months of the pregnancy she suffered from morning sickness, and during the last few days of June she complained of attacks of colicky pain around the umbilicus, lasting for three or four minutes. Sometimes she vomited during these attacks, and at other times not at all. There was no vaginal bleeding then or, indeed, at any time during her pregnancy.

She was examined for the first time on July 5th. Her general condition was good, and her heart and lungs normal. The height of the fundus was noted as twenty-six weeks, although she was only twenty weeks and five days pregnant according to her dates. The presenting part was above the brim, but the presentation could not be determined. The foetal heart sounds were not heard, although foetal movements had been noticed by the patient. The pelvic measurements were normal, and the urine contained no sugar or albumin.

She next attended on August 16th, when the presentation was found to be a right sacro-anterior. On October 11th she again complained of attacks of pain of one month's duration, which were becoming more frequent. There was no vomiting, but she was compelled to lie down during the attacks. She was unable to pass water during the attacks, and also complained of frequency and pain on micturition. On examination the height of the fundus corresponded to thirty-five weeks' pregnancy; the presentation was still a breech, her temperature 98.6° F., blood pressure 136/96 mm. of mercury, and urine quite normal. On this date the foetal heart sounds were heard for the first time at the fundus uteri. Nothing abnormal was noted on abdominal examination, and she was given a palliative for her symptoms.

On October 18th the presentation was transverse, and on the 27th she was admitted as an in-patient. On the 29th she was examined under anaesthesia. The foetal parts were not excessively easy to define even under the anaesthetic. The foetus lay in the left cephalic dorso-posterior position. After attempting external version the head lay above the pelvic brim slightly to the right, but could not be pushed down into the pelvic cavity, although it did not appear to be unduly large. On internal examination no pelvic contraction could be discovered, the external os was closed, and the cervix not taken up. Two theories were invoked to explain the failure to complete the external version: (1) extension of the legs of the foetus; (2) a short umbilical cord caught round the neck or the body of the foetus. At the end of the manipulation the foetal head lay in the right iliac fossa, and the foetal heart rate had risen from 140 to 180 per minute.

On the next day the head again lay on the left side, and an x-ray examination was made. The film confirmed the presentation, and showed that the foetal legs were flexed and the bones normal in every way. The patient was discharged with instructions to come up immediately if labour began, and in any case to come into hospital two days before the expected date of delivery (November 17th). She was readmitted on November 15th with the foetus still lying transversely. Two lines of treatment were considered: (1) internal version during labour; (2) Caesarean section. The latter was finally decided on as the patient was anxious to have a living child, and the risk to herself was probably not greater than that of internal version and breech extraction. Her general condition was still that of a normal healthy pregnant woman.

On November 20th an operation was performed by Professor F. J. Browne, under general anaesthesia (chloroform followed by ether), administered by Dr. H. N. Webber. A right lower paramedian incision 8 in. long was made, and the abdomen opened. At once several abnormalities were noted. In the first place, the left round ligament lay almost in the mid-line at the pelvic brim (suggesting torsion of the uterus); secondly, the "uterus," which was pale yellowish in colour, had two dark venous sinuses low down on its anterior surface lying subperitoneally. An incision was made between them, and to our surprise liquor amnii began to

escape before the scalpel had sunk to any appreciable depth. In enlarging the incision a slight nick was made in the lower edge of the placenta, and from this free haemorrhage occurred. The foetus was then delivered, and the cord, which was wound once around the trunk, separated. Meanwhile the house-surgeon had endeavoured to turn the uterus out of the abdomen, but it was noticed that he only held placenta and membranes in his hand. On further examination the uterus was found lying above the pelvic brim, and pushed far over to the right side, while the placenta was attached to the left cornu of the uterus and the left broad ligament. There were no adhesions to the hollow viscera, so that removal of the placenta presented no great difficulty. The infundibulo-pelvic and broad ligaments and the cornu of the uterus were clamped, and the placenta and membranes, with the left tube and ovary and the greater part of the left broad ligament, removed. (The right tube and ovary appeared quite normal.) Owing to the softness and vascularity of the parts ordinary pedicle ligatures cut through and failed to control the haemorrhage, which was fairly free. This was controlled by digital pressure until interrupted mattress sutures of catgut could be inserted. These effectively controlled the bleeding, and all that then remained was to cover over the raw area with peritoneum, using that of the anterior and posterior layers of the broad ligament.

The patient left the theatre in fair condition, with a pulse rate of 130 per minute, and on returning to the ward she was given rectal salines, and, later, morphine 1/4 grain with atropine 1/120 grain. She quickly rallied from the haemorrhage, and was able to suckle her baby after the third day. The temperature was normal throughout the puerperium. On the tenth day the stitches were removed, and on the twenty-first the patient left hospital. No lochia were seen at any time.

The baby was a full-time female child, well formed, and weighing 6 lb. 6 oz. at birth. After dropping to 5 lb. 11 oz. on the fourth day it gained weight steadily, and left hospital weighing 6 lb. 10 oz. It was fed at the breast every three hours during the day.

The Specimen.

The specimen removed at operation was found to consist of a sac, placenta, ovary, tube, and part of the left round ligament. The sac wall contained three layers—amnion, chorion, and peritoneum. The placenta was divided into several separate areas with membrane between, and the insertion of the cord was velamentous about one inch from the lower margin of the placenta. The maternal surface was rough, where it had been detached from the uterus and the base of the left broad ligament, but a considerable part of it was smooth on both sides, due to the attachment of the placenta to the posterior layer of the broad ligament, which had been removed with it, and therefore remained *in situ*. The left tube and ovary lay below and in front of the sac, and the inner end of the tube was extremely stretched, so that it at first appeared to end three inches from the left cornu of the uterus. This, however, was only apparent, the isthmus being stretched over the sac wall and placenta so as to be indistinguishable from them. The left ovary contained a corpus luteum. It was concluded that this was a case of secondary ligamentary pregnancy, which had grown at the expense of the posterior layer of the broad ligament.

Comment.

Several features in this case are worthy of note as being unusual in cases of extrauterine gestation:

1. Neither the symptoms nor the signs during pregnancy were sufficiently pronounced to suggest the diagnosis of extrauterine gestation. In most recorded cases an extrauterine gestation lasting till term has produced a severe or fatal illness, whereas in this case the patient was comparatively well throughout the pregnancy.

2. The diagnosis was not made until the operation was in progress.

3. This case probably provides a unique reason for the failure of external version. It is, indeed, remarkable that the sac was not ruptured by the attempt.

4. Contrary to the usual findings in such cases the child was not deformed.

5. The unusually favourable site of the placenta no doubt accounts for the happy result to mother and child.

When last seen, on March 15th of this year, the mother and baby were both doing well, and the baby weighed 13 lb.

A similar case was reported by Dr. Fairbairn in the *Proceedings of the Royal Society of Medicine*, vol. xii, April, 1919, p. 183; and another by Mr. Jessop in the *Obstetric Transactions* for 1875.

I am much indebted to Professor Browne for his help and for his permission to publish this case.