# FOUR CASES OF EXTRA UTERINE PREGNACY

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**1) Full Term Ectopic Pregnancy**

On 16.2.67 an African women from 140 miles away was admitted with severe abdominal pain. She appeared

to be at term There was some fluid in the abdomen and the foetus appeared to be lying in the abdomen transversely.

She was given a blood transfusion and 1ml of spinal nupercaine injected. After 5 minutes the respiration became laboured but she responded to ephedrine, adrenaline and oxygen. At operation the amniotic sac and placenta were adherent to the abdominal wall, omentum, spleen and uterus. The foetus was extracted but the haemorrhage was severe. A subtotal hysterectomy was preformed as most of the placenta remaining was adherent to the uterus. The placental site was covered with oxycel gauze and the abdomen closed, but the patient collapsed and died. The infant weighed 7 lbs. 8ozs. It is obvious that any attempts to remove the placenta should be avoided.

**2) Full Term Ectopic Pregnancy**

An African primipara was admitted 23.6.67. She appeared to be 32 weeks pregnant, but the head was palpable in the right upper quadrant and the feet in the left upper quadrant. The foetal heart was heard above the umbilicus. She developed a respiratory infection which did not respond to pencillin, but cleared after a course of Ledermycin. The foetal heart was heard on 24.7.67 and it seemed probable that she had an extra uterine pregnancy. She complained of general abdominal pain but no signs of haemorrhage. On 27.7.67 a laparotomy was performed under spinal nupercaine and a full term but macerated foetus was removed. It appeared that the foetus had died only two days before. The placenta was left in situ. A blood transfusion of 1 pint was given. She was given a course of pencillin and streptomycin. On 11.8.67 a mass was still palpable to the umbilicus, and her general condition was improving. She was discharged on 22.8.67.

**3) Ruptured Caesarian Scar:**

An African women of about 20 years was admitted to Kalene Mission Hospital in December 1965 with abdominal pain having had a previous Lower Segment Caesarian Section in 1964. The uterus was then about 14 weeks pregnant, but she complained of acute abdominal pain. The pain subsided until June 23, 1966 when she was re-admitted with an abdominal swelling the size of a full term pregnancy. A laparotomy was performed under spinal anaesthesia and full term foetus was found lying in the upper abdomen above the uterus which was the size of a 14-week pregnancy, but had ruptured and lay with the edges wide open. The foetus was dead and was removed leaving the placenta. The uterine edges were brought together with a layer of interrupted sutures, but could not be approximated accurately. There was a fairly heavy haemorrhage but the placenta was left untouched, care being taken not to dislodge the edges at all. The blood transfusion of 2 pints was given. A month later there was a residual hard mass around the umbilicus. By October no definite mass could be felt in the abdomen.

The patient was again seen 19th July 1967 with a uterus the size of 16—18 weeks pregnancy. By August it had reached the umbilicus.

On 9.10.67 she was about 26 weeks pregnant but on 7.11.67 began complaining of severe abdominal pain. A

further laparotomy was done under spinal nupercaine. There were many adhesions round the uterus. The uterine scar appeared to be firm but an abscess was present which had a purulent discharge. The infant was extracted through an incision in the upper part of the uterus and breathed spontaneously. It was very premature and died the same day. The placenta was removed and the uterine incision closed. A drain was inserted and the abdomen closed. The post operative period was uneventful and the patient was discharged 27.11.67. She has had to be admitted three times since with abdominal pain and vomitting, the last admission being March 1968. These attacks of pain appear to coincide with her periods.

**4) Full Term Ovarian Pregnancy:**

An African primipara aged about 38 years was admitted on 11.2.67 from a rural dispensary. She looked ill and complained of abdominal pain. A pelvic mass the size of an 18 week pregnancy was palpable in the abdomen On vaginal examination the cervix was soft and the mass appeared to be continuous with the cervix, but a large hard mass was filling the Pouch of Douglas, and extending up to the umbilicus. A diagnosis of bicornuate uterus was put forward.

On 20.6.67 on vaginal examination the foetal head was presenting but lying over to the right. The foetal heart was heard.

On 12.7.67 the pregnancy appeared to be full term, but the cervical os was not dilated and would not admit one finger.

On 13.7.67 a laparotomy was performed under spinal nupercaine. A large grey 'sac' filled the abdomen and an incision was made over as for a lower segment section. A full term foetus was removed and the cord cut. The infant breathed spontaneously. The sac now collapsed showing a small uterus posteriously the size of 10—12 week pregnancy. The sac was found to be the right ovary and loosely adherent to bowel. It was removed with the right tube, and on examination the placenta was found in it complete. The mother made an uninterrupted recovery. The baby was abnormal; the head being asymmetrical and the pinna of the right ear only residual. There was also a right club foot. Mother and baby were kept in hospital for two months, so that the baby could be well established and foot was put in plaster of Paris. They returned a few weeks after discharge to have the plaster changed and the baby was then thriving.

# LETTERS TO THE EDITOR

## The doctor Zambia needs

Your Editorial in the October 1968 number of the Journal entitled "The Doctor Zambia Needs" deserves to be widely read and applauded by all who have the future welfare of the Zambian patient at heart.

If the University of Zambia authorities are concerned that teaching in the Medical School in Lusaka should not follow too closely the traditional pattern they too deserve to be applauded. If the University authorities intend to emphasize social medicine (a term that surely needs more definition) at the expense of clinical medicine they must be firmly opposed. However, if by an emphasis on social medicine is meant the correction of those glaring gaps in the traditional curriculum such as psychiatry, sex education and the realisation of the patient in his human setting, no objection can be entertained. That a 'sociologist with a stethoscope' will be neither sociologist nor doctor should be self evident. Furthermore, the Zambian patient is usually too perceptive to be fobbed off by an alleged doctor who is not fully trained in the traditional clinical arts.

In regard to the clinical training to be given to the Lusaka medical students I agree with you that the graduates should be able to deal easily with the emergencies you mention but I would add that they should be expected to have a detailed knowledge of the clinical as well as the public health aspects of the endemic diseases we face—malaria, trypanosomiasis, tuberculosis, leprosy and schistosomiasis.

Also, it is to be hoped that the planners of the curriculum remedy those other glaring gaps in conventional undergraduate training—ophthalmology, oto-rhino-larynology and dermatology.

The best approach, I know of to the problem of integrating, within the undergraduate curriculum, the clinical disciplines in its widest sense, sociology, genetics, epidemiology, biostatistics, human biology and family practice is that of the Comprehensive Medicine Unit of the University of Cape Town (Gordon 1965, 1966). To quote from the former reference: "This method of instruction (the traditional method of clinical teaching) has stood the test of time and is sound—as far as it goes. However, it does not teach students about individual patients—about sick persons rather than sick kidneys; nor does it deal adequately with the management of individuals with reference to their personal, emotional and domestic problems as well as their physical troubles. Comprehensive Medicine aims at filling these gaps in the conventional teaching approach. IT SUPPLEMENTS BUT DOES NOT REPLACE THE USUAL METHODS OF CLINICAL INSTRUCTION." (my capitals).

It should be noted that the head of this unit was a clinician, a physician of sufficient eminence now to have become head of a unit of the Mayo Clinic.

This letter is published with the permission of the Permanent Secretary for Health.

**References**

Gordon, H. (1965) in Medical Education in South Africa, Natal University Press; Pietermaritzburg, pp. 128—132.

Gordon, H. (1966). Teaching 'General Practice'. South Africa medical journal. 40, 1941.

MARK N. LOWENTHAL,
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## Renal Cyst and Polycythaemia

Sir,

The patient with renal cyst and polycythaemia we described in the October 1968 issue of the Journal came to surgery on November 26th, 1968.

Through a right renal incision a huge extra-peritoneal cyst was excised in toto. This structure contained sero-sanguinous fluid. Histological examination by Dr. J. Fine, Kitwe Central Hospital, showed the cyst to be lined by fibrous tissue and unstriped muscle with some normal renal parenchyma in places.

S. A. Doctor
M. N. Lowenthal

## Notes and News

**Clinical Meetings: Zambia Medical Association, Congo Border Branch.**

Recent meetings under Z. M. A. auspices have been held at the Luanshya and Ndola General Hospitals.

The Luanshya programme on November 27th, 1968 consisted of:—

Mr. Howell: A recurrent tumour of clavicle which had a 4-year history and was shown to be a metastatic thyroid carcinoma although thyroid enlargement was absent.

Dr. Slater: A case which 2 years ago appeared to be a salmonella septicaemia subsequently recognized as a monocytic leukaemia.

Dr. Mason: A patient who following termination of pregnancy and sterilization became unreasonably jealous of her husband's business associates—the Othello syndrome.

Dr. Kaye: A case of pulseless disease in which it was thought that the underlying aotitis was quiescent.

Dr. Nicklin: A baby weighing 45lbs. at 8 months and whose elder sister was barely 30lbs. at 3 years—a case of congen: tal adiposity.

Mr. Howell: An adolescent African with clinical signs of plastic peritonitis with pleural and pericardial calcification—biopsy showed the diagnosis to be generalized oxalosis.

**At Ndola the programme: January 23rd, 1969:—**

Dr. Lowenthal: Tuberculoid leprosy in an Asian.

Mr. Kirk Main: 1. A bone grafting technique, 2. An aspect of I.V.P. technique.

Miss Lerer: Spontaneous vesico-vaginal fistula.

Dr. Lowenthal: A neurological problem: thickened nerves and peripheral wasting in the upper limbs and spastic paraplegia in a young man.

Mr. A. Gregor M.R.C.V.S.: Zoonoses in Zambia.

The next Copperbelt wide clinical meeting will be held at the Malcolm Watson Hospital, Mufulira, on March 28th, 1969.

M.N.L.

## BOOK REVIEW

**"INTEGRATING REHABILITATION IN AFRICA"**

**Proceedings of Second Symposium on Rehabilitation in Africa**

Editor and Conference Secretary: Prof. B. Oscar Barry O.B.E., F.R.C.S.E., D.T.M. & H.

National Fund for Research into Poliomyelitis and Other, Crippling Diseases, Vincent House, Vincent Square, London., S.W.1.

Publishers: The Garden City Press Ltd., Letchworth, Hertfordshire.

Price £2/2/-

This is a record of the papers read at the second symposium on rehabilitation in Africa sponsored by the National Fund for Research into Poliomyelitis and other Crippling Diseases.

All the Rehabilitate disciplines are presented and discussed with the majority of writers appealing for more technicians and equipment.

A difference of opinion is expressed regarding the priorities for treatment: The Surgeons working in Africa recommending one course of action and the visiting authorities strongly recommending another.

For anyone interested in Rehabilitation this well produced book should be read.

J. M. GOLD.
M.Ch. (Orth). F.R.C.S.

## INDEX TO ADVERTISERS