the placenta, the lack of serious haemorrhage and the rendering of a formidable procedure into a comparatively easy operation. Greenhill remarks on the absence of technical difficulties and the easy separation of the placenta and foetal sac in a case he operated on 5½ months after foetal death.

If, therefore, the foetus is dead, laparotomy should be postponed for at least three weeks. A warning should be added to the above statement. Sometimes the general condition deteriorates rapidly as seen in Case 1. Here laparotomy should not be delayed too long or the risk of operating on a debilitated patient may outweigh any advantage gained over technical difficulties.

In Case 1 the firmly attached pelvic portion of the sac was left in situ to avoid extra trauma and at discharge, after 21 days, the organizing tissue persisted as a symptomless pelvic swelling. Similar residual pelvic swellings are reported by other writers, slowly decreasing in size, but they may persist up to four months after discharge from hospital.

**SUMMARY**

Two cases of advanced abdominal pregnancy are described.

The diagnosis of the condition is discussed and the under-mentioned points are emphasized as of diagnostic value.

1. Persistent mal-presentation and failure of external version.
2. Palpation and inspection of the cervix uteri.
3. Passage of a uterine sound.
4. Comparative clearness of the foetal parts in straight X-rays.
5. Intrauterine injection of lipiodol.
6. Failure of pitocin to produce palpable contractions.

Treatment is briefly referred to and the importance of the correct time for laparotomy is pointed out.

Our thanks are due to Dr. J. L. Parker, Medical Superintendent of King Edward VIII Hospital, Durban, for permission to publish these cases, and to the late Dr. F. W. Simson for the pathological report.

**REFERENCES**


**PREGNANCY COMPLICATED BY FIBROMYOMA AND HYPERTENSION**

**A CASE REPORT AND A DISCUSSION**

E. A. STRASHEIM, M. Sc., M.B., Ch.B.

_Medical School. University of Pretoria, Pretoria_

Paul Titus¹ states that 'fibromyomata are so common a complication of pregnancy and they may have such variable and remote effects that they must be considered from the standpoint not alone of the pregnancy or labour or puerperium, but jointly in relation to all three in the advent of a child'. Such consideration will justifiably become more important when it occurs in a chronic hypertensive patient (i.e. a patient whose blood pressure is over 120/80 mm. Hg before the 20th week of pregnancy).

Mrs. M., primipara, 34 years old, had her last menstrual period on 16 December 1947. She was seen for the first time on 28 January 1948.

_Menstrual History._ Menarche at 14 years, 5/28-30 day type, increasing to 7/28-30 day type over the past 18 months.

_Previous History._ For the past 12-18 months she has been conscious of a lump in her lower abdomen. This has gradually become bigger. Bowels and micturition, normal. _Heart and lungs_, nothing abnormal detected. _Blood pressure_, 150/92 mm. Hg. _Optic fundi_, normal. _Urine_, clear. _Blood Hb_, 68%.

On _abdominal palpation_ an irregular mass was felt rising out of the pelvis to three fingers above the symphysis pubis. It was decidedly dextro-verted and of firm consistency.

Vaginal examination showed an enlarged and softened uterus with a firmer mass situated in its right upper posterior aspect. Pelvic measurements were all within normal limits. She had been trying to conceive since her marriage four years before and was very keen to have a baby.

She was therefore very carefully followed through pregnancy, the course of which can best be summarized in the table on p. 663.

No abnormal foetal position ever presented itself at any time and the foetal heart auscultation never gave rise to worry.

On 23 August 1948, when she was judged to be 36 weeks pregnant, a _lower-segment_ caesarean section was done and a healthy male infant extracted (weight, 6 lb. 4 oz.). A large intramural fibroid was shelled out from the posterior upper aspect of the uterus (size $5\frac{1}{2} \times 3\frac{1}{2} \times 2$ inches).

The _Post-operative Course of the Blood Pressure_. It remained at 124/72 mm. Hg for the first four days...
and then gradually rose again until after two weeks it was 148/84 mm. Hg, where it has remained. The retinal arterial spasm disappeared completely and the fundi were judged normal on discharge.

<table>
<thead>
<tr>
<th>Period of Pregnancy</th>
<th>Blood Pressure (mm. Hg.)</th>
<th>Optic Fundi</th>
<th>Urine</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 weeks</td>
<td>150/90</td>
<td>Normal</td>
<td>Clear</td>
<td>Abdom, cramps and P.V. bleeding for three days.</td>
</tr>
<tr>
<td>12 weeks</td>
<td>150/90</td>
<td>Normal</td>
<td>Clear</td>
<td>Slight P.V. bleeding for one day.</td>
</tr>
<tr>
<td>18 weeks</td>
<td>156/90</td>
<td>Normal</td>
<td>Clear</td>
<td>Headache.</td>
</tr>
<tr>
<td>23 weeks</td>
<td>188/100</td>
<td>Normal</td>
<td>Clear</td>
<td>Headache.</td>
</tr>
<tr>
<td>26 weeks</td>
<td>190/110</td>
<td>Normal</td>
<td>Clear</td>
<td>Headache.</td>
</tr>
<tr>
<td>28 weeks</td>
<td>210/120</td>
<td>Normal</td>
<td>Clear</td>
<td>Headache.</td>
</tr>
<tr>
<td>30 weeks</td>
<td>220/120</td>
<td>Normal</td>
<td>Clear</td>
<td>Headache.</td>
</tr>
<tr>
<td>32 weeks</td>
<td>200/120</td>
<td>Slight arterial spasm</td>
<td>Clear</td>
<td>Increasing dyspnoea.</td>
</tr>
<tr>
<td>34 weeks</td>
<td>210/120</td>
<td>Slight arterial spasm</td>
<td>Clear</td>
<td>Dyspnoea and oedema.</td>
</tr>
<tr>
<td>36 weeks</td>
<td>216/120</td>
<td>Arterial spasm</td>
<td>Clear</td>
<td>Dyspnoea and oedema.</td>
</tr>
</tbody>
</table>

Treatment instituted on the first occasion of threatening abortion, when the patient was eight weeks pregnant, was massive stilbestrol therapy according to the method suggested by Abarnel and was continued to the 34th week.

**DISCUSSION**

It will be noted that there was a fairly rapid increase in blood pressure from the 18th week. In a series of 239 cases, Browne and Dodds found a rise of blood pressure to occur in 61% and they conclude that in hypertensive patients there is always a tendency for the blood pressure to rise further and that the prognosis for the foetus is poor if the initial pressure is 150/100 mm. Hg or over. Browne also states that it is usual for albumin to appear in the urine when the systolic reaches 160 mm. Hg. This he calls the "critical level", with the foetus tending to die shortly afterwards in utero. In spite of the very high blood pressure in this case, albuminuria never appeared. Various authorities emphasize that there is a drop during the second trimester in a certain proportion of cases. This is stated to be a good prognostic sign. The present case had only a slight temporary drop in the third trimester for 3-4 weeks after which there was again a rise (from the 34th week). Such a finding is particularly stressed by Chesley and Annitto as being ominous for the baby and they recommend termination of pregnancy as soon as possible.

Numerous investigators have proved in fairly large series of cases that hypertension per se should not be a contra-indication for pregnancy, provided a careful watch is kept and a few additional precautions such as bed-rest, sedatives and regular weight-control, are adhered to when necessary.

The associated presence of a large fibroid further complicated the decision about the subsequent treatment. Titus strongly recommends conservative management during pregnancy with caesarean section, myomectomy and/or hysterectomy at term. Eisaman showed in a series of 59 patients with fibroids and whose pregnancies went beyond seven months, that vaginal operations always resulted in a higher morbidity, with post-partum haemorrhage as a common complication.

Fibroids can also cause abortion or premature labour which is well illustrated by Pierson's series of 191 cases in which 24% ended prematurely with the tumours considered to be the cause in 16%. They can also result in pressure on the various pelvic organs, while a very common complication during pregnancy is necrobiosis or red degeneration of the tumour. In labour fibroids can give rise to complications by causing mechanical obstruction, abnormal foetal positions and, by interfering with uterine contractions, result in uterine inertia and interfere with placental separation. Pierson found uterine inertia in 34.6%, while in unselected cases its frequency was only 1%.

The optic fundal findings proved of additional help in this case and Hallum lays particular emphasis on the prognostic significance of the retinal findings during pregnancy and makes a plea for more regular routine ophthalmoscopic examinations of the retina in antenatal care.

Buckell in an analysis of 122 cases of fibroids with pregnancy, found that pregnancy was normal in only 40%, and he comes to the conclusion that the presence of fibroids is a serious complication and that caesarean section should be seriously considered in all elderly primipara and all other patients where there is an additional complication.

**REFERENCES**