Advanced extra-uterine pregnancy associated with eclampsia

A report of 2 cases

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Summary

Two patients with advanced extra-uterine pregnancies developed fulminating pre-eclampsia, providing firm evidence that the uterus is not essential to the process of pre-eclampsia.

There were no pathological reflexes and no localising neurological signs. Standard procedures for the management of eclampsia as described elsewhere were instituted. Because the patient's cervix was not suited to induction, caesarean section was performed. After delivery of a 3.1 kg live male infant by a transverse incision into the thick-walled amniotic sac the placenta was found to be situated in the pouch of Douglas and associated with the right tube. The uterus lay anteriorly and was slightly larger than in the non-pregnant state. The placenta and amniotic sac were removed safely. The puerperium was uneventful. The patient's blood pressure had fallen to 120/85 mmHg by the 7th postoperative day and she had no evidence of proteinuria.

Case 2

The patient, aged 29, booked for antenatal care at the 26th week of gestation. Her previous pregnancy in 1973 had not been complicated by hypertension, nor did she give a history of hypertension or renal disease. She had delivered twins at term without any complications. She had failed to conceive since 1973 and had a new consort. On examination her blood pressure was 170/120 mmHg, pulse rate 78/min. Abdominal examination revealed the height of the fundus to be appropriate to 26 weeks' gestation; fetal parts were difficult to feel but the fetal heart was heard.

The patient was admitted for investigation and observation of the elevated blood pressure. A chest radiograph and an ECG were normal. The only abnormality found on biochemical renal function tests was an elevated urate level of 0.39 μmol/L. Examination of the urine showed considerable proteinuria. Ultrasound examination of the abdomen revealed an empty uterus with the placenta lying above and behind it. The fetus lay above the placenta; the fetal heartbeat was audible and the biparietal diameter was 68 cm (27 weeks). A diagnosis of extra-uterine pregnancy was made and it was decided to manage the patient conservatively.

Over the next few days, her blood pressure recordings fluctuated between 100 and 120 mmHg diastolic despite the use of methyldopa (500 mg 6-hourly) and dihydralazine (60 mg 8-hourly), and the serum urate level rose to 0.45 μmol/L. It was therefore decided to terminate the pregnancy. At laparotomy, findings were similar to those established by ultrasonography. The placenta was lying in the pouch of Douglas and extended over the back of the uterus. The fetus and membranes were removed easily, but the 600 g fetus died within a few hours of birth. The puerperium was uneventful except for mild pyrexia which settled on antibiotic therapy. By the 10th postoperative day the patient's blood pressure had fallen to 120/85 mmHg without antihypertensive drugs and she had only mild proteinuria.

Discussion

Sophian explained the high incidence of pre-eclampsia in primiparas, twin pregnancies and patients with concealed accidental haemorrhage on the basis of uterine overdistension and increased resistance to stretching of the uterus. This apparently leads to a reflex inhibition of renal cortical blood flow, resulting in both renal dysfunction and reduced placental blood flow. More recently, Brosens et al. have implicated the uterus as a cause of pre-eclampsia. In a series of excellent studies, they showed that placental bed biopsies in women with pre-
 eclampsia show no evidence of intravascular cytrophoblastic invasion of the spiral arteries. During the course of normal pregnancy, the intradecidual portion of the spiral arteries is invaded by cytrophoblastic tissue in a retrograde fashion, resulting in these arteries becoming dilated and funnel-shaped. Even this is contentious, as Sheppard and Bonnar have found that these lesions are not specific to pre-eclampsia. The 2 cases reported here add to the tally of 30 instances of the coexistence of pre-eclampsia with abdominal pregnancies in the Western literature and provide firm evidence against the uterus being essential to the process of pre-eclampsia. In these cases the hypertension and proteinuria abated within a short period, which suggests that the patients did have pre-eclampsia. The first patient was a primigravida and the second, although parous, had a new consort. The clinical picture of pre-eclampsia which these patients developed was indistinguishable from that occurring in an intra-uterine pregnancy.

Although the aetiology of pre-eclampsia remains an obstetric enigma, the modern concept of a vaso-active agent being implicated in the initiation of the process holds more hope than the uterus as a cause of this disorder.

REFERENCES

Ultrasonographic and computed tomographic appearance of focal tuberculosis of the liver

A case report

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Summary

A 50-year-old woman presented with a focal liver mass which mimicked the clinical and imaging (ultrasonographic and computed tomographic) characteristics of a pyogenic or amoebic abscess. Ultrasonographically-guided liver biopsy demonstrated features of a focal tuberculous abscess of the liver.


Tuberculous involvement of the liver as part of generalised miliary tuberculosis is well known. However, localised tuberculosis of the liver as a clinical entity producing large nodules or abscesses has been considered exceedingly rare, even in areas where tuberculosis is relatively common. Only 90 cases of focal tuberculosis of the liver had been reported up to 1975-1976. More recent reports mention the use of isotopes and ultrasonography in the investigation of patients, but do not describe any ultrasonographic features of focal tuberculosis. To our knowledge, the computed tomographic (CT) findings of focal tuberculous abscess of the liver have not yet been reported.

Case report

A 50-year-old black woman presented with right upper quadrant and left lumbar pain of 2 months' duration. She also complained of fatigue and weight loss. Clinical examination revealed an 8 x 8 cm tender mass in the left upper quadrant. Liver function test results were normal. The erythrocyte sedimentation rate was 130 mm/1st h (Westergren). The chest radiograph was normal. An ultrasonographic examination of the abdomen (Fig. 1) showed a 5 x 6 cm ill-defined echolucent mass in the left lobe of the liver, not enhanced by contrast medium (Fig. 2b). Tru-Cut biopsy of the lesion was performed under ultrasonographic guidance. Microscopic examination of the specimen obtained revealed multiple ill-defined granulomas with central necrosis. The surrounding tissue contained a large number of mononuclear cells admixed with scattered neutrophils. These findings were considered consistent with the diagnosis of tuberculosis. The patient was put on antituberculosis therapy consisting of isoniazid, rifampicin and ethambutol. A dramatic response in her

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