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Postgraduate Medical Journal (October 1973) **49**, 741–742.

Triplets—one ectopic, two intrauterine

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Summary

A case of ovarian ectopic conception, complicating a simultaneous twin intra-uterine pregnancy is described, in which the operative diagnosis was confirmed by histological examination.

Such cases are extremely rare and comment is made upon this with references.

A 32-year-old para 4+0 was referred on 21 October 1970 for gynaecological opinion with a history of 37 days amenorrhoea and intermittent, severe right lower abdominal pain for the previous fortnight. Her last menstrual period was on 12 September 1970. She was not sure whether she was pregnant. Her appendix had been removed 13 years ago. On examination, her general condition was good. There was marked tenderness in the right iliac fossa and both vaginal fornices. A pregnosticon test done that day was negative. A presumptive diagnosis of ectopic pregnancy was made and blood was cross-matched. An examination under anaesthesia on 23 October 1970 revealed a soft uterus about the size of an 8–10 week pregnancy. On a spiration of the Pouch of Douglas about 20 mls of fresh unclotted blood was obtained. At laparotomy 60–70 mls of both fresh and old unclotted blood was found in the pelvis. The uterus was soft and enlarged to about 10 weeks gestation, which was bigger than the period of

amenorrhoea (6 weeks approx.). The right fallopian tube was enlarged, and oozing small blood clots from the fimbrial end mixed with small bits of tissue. The right ovary had a small area of old blood-clot adherent to it. A corpus luteum could not be identified. A right salpingectomy and resection of the haemorrhagic part of the right ovary was done. Histology from the ovarian tissue reported 'fragments of blood-clot, some fresh, some showing inflammatory infiltration and some of it undergoing organization and haemosiderin deposition, probably representing the contents of a ruptured corpus luteum, since some of the fragments are covered by a layer of cells resembling those lining a luteal cyst. In one section there are a few degenerate chorionic villi, confirming the diagnosis of ectopic pregnancy'. Histology report from the tubal specimen showed 'the lumen of the fallopian tube filled with blood. Scattered collections of decidual cells could be seen in many of the mucosal papillae, but no trophoblastic elements were seen in or around the fallopian tube'.

Following operation she made a good recovery. The pregnosticon test was repeated on 26 October 1970, 5 days after the first negative test, and was now positive. She was booked for hospital confinement and the uterus continued to enlarge. An Ultrasonic Scan done 4 weeks after the laparotomy reported an

intra-uterine pregnancy of 19 weeks gestation. All along the size of the uterus was bigger than the period of amenorrhoea suggested. The foetal movements were first felt in the second week of January 1971 at 18 weeks gestation (uterine size 22 weeks). She developed mild hypertension on 2 April 1971 and was admitted for rest. An X-ray of the abdomen then revealed a twin pregnancy. The following day she fell down and twisted her left knee and developed a painful haematoma. No fracture was detected. A diagnosis of torn, left semi-lunar cartilage was made and plaster of Paris was applied to be removed in labour. She made a good recovery and went into spontaneous labour on 18 April 1971, and had an uneventful delivery of twin male babies, weighing 2.32 kg and 2.5 kg. Her second baby was an assisted breech delivery with binovular placenta. Both babies were healthy, and survived.

Discussion

The case is interesting in that the patient originally had a triplet pregnancy of which one ovum was in an ectopic implantation. We have been able to trace only eight previously recorded cases in the literature with simultaneous intra-uterine and ectopic triplet gestations. The case is also unusual in this series of eight, in that here the ectopic pregnancy appears to have been in the ovary which in itself is a rare site. The findings at laparotomy and histology confirm this. The criteria for ovarian pregnancy (attributed to Spiegelberg, as quoted by Jeffcoate) apply to this

case; that is, (i) normal fallopian tube and fimbria, separate from the pregnancy sac, (ii) pregnancy sac in the position of the ovary, and (iii) histological confirmation of the ovarian tissue around the pregnancy.

Acknowledgment

I am grateful to Dr E. E. Rawlings for permission to publish this case under his care.

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Postgraduate Medical Journal (October 1973) **49**, 742–745.

Tic convulsif: The association of trigeminal neuralgia and hemifacial spasm

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Summary

Both trigeminal neuralgia and hemifacial spasm are sometimes caused by a posterior fossa mass lesion. When these two disorders co-exist, a rare association known as 'tic convulsif', a lesion involving the fifth and seventh cranial nerves in the cerebellopontine angle is extremely likely. Twenty-eight cases of tic convulsif have been mentioned in the literature and two more case are reported here. They are of interest

in that both cases many years elapsed between specialist opinion being first sought and the discovery of the underlying lesion.

Case 1

In 1960, a 39-year-old housewife developed clumsiness of the right hand and intermittent right facial twitching which had begun round the right eye, but soon spread to the right side of the mouth.