

## ABDOMINAL PREGNANCY

Name:—a Brahmin, was admitted to the Hospital on the 25th of April, 1948.  
 History of fever: pain all over the body.  
 Patient pregnant, examined by Lady Doctor.  
 Height of foetus: 20 weeks.  
 Foetal heart: not heard.  
 Diagnosis: Anaemia and Pyelitis.  
 Treated for same.  
 Discharged on 15th of June 1948.  
 Attending out-patient.

22nd of February 1949.

Patient admitted with history of bleeding.

Full term pregnancy.

Patient could not give date of last M.P. but said this was the same pregnancy and she was now 14 months pregnant.

Examination:

P.A., R.S.A., Breech

Mass felt in L.I.F.

F.H. not heard.

P.V. Os closed, no bleeding.

Patient prepared for caesarian section.

Spinal A. M.1/6 A.1/100 given 1/2 hr. before.

Penicillin 50,000 units 3 hrly. ordered.

Incision: Mid-line.

Dead foetus, full term, post-mature, in coils of intestine.

Mass left side uterus attached to ovary, consisting of placenta and blood clot, same removed easily.

Patient made a uneventful recovery, sutures removed 10th day.

Discharged on 14th day.

## CONCLUSION

Ectopic pregnancy must have occurred resulting in tubal abortion. The pregnancy then became implanted in the peritoneal cavity and the placenta attached to the intestines. The foetus continued to grow until full time but death had occurred before operation. There was no maceration of the foetus.

It is interesting to note that the patient gave no history of any acute abdominal pain due to the ectopic pregnancy. The tubal abortion had taken place without causing any arresting symptoms. She was not conscious of any irregularity apart from the fact that she was 14 months pregnant. There had been some bleeding vaginally which gave rise to the suspicion of a placenta praevia.

What they were saying in the bazaar;

Two hours after the operation, a Doctor from the town came to the Hospital and asked one of our Doctors if it was true what they were saying in the bazaar, that Dr. C. had removed a cobra from a woman's abdomen...

### LUNG ABSCESS WITH PYO—PNEUMOTHORAX TREATED WITH PENICILLIN AND ARTIFICIAL PNEUMOTHORAX

A refugee Hindu unmarried girl named Santi Devi, 16 years old, was admitted in the Medical Ward, Kali Kamli Hospital, Kurukshetra on 20th December, 1948 at 10 p.m. with following complaints:—

1 Temperature ranging between 101°F to 105°F

[for the last 10 days]

2 Coughing.

[for the last 8 days]

- |   |                                        |                       |
|---|----------------------------------------|-----------------------|
| 3 | Loose Motions.                         | [for the last 3 days] |
| 4 | Sticky and foul smelling perspiration. | [for the last 6 days] |
| 5 | Offensive Sputum and breath.           | [for the last 5 days] |
| 6 | Dyspnoea.                              | [for the last 7 days] |

*Family History.* Her father was working in a sugar factory in Lahore. Communal disturbances broke out in Pakistan during September, 1946. At that time he got a severe attack of haemoptysis and he died as a case of tuberculosis in June, 1947. On 4th December, 1947 she got a severe attack of cough, cold and developed pain on the right side of her chest. She taking it to be an attack of pneumonia, took few tablets of M and B. 693. In the meantime she developed a severe dry cough with persistent high temperature, and pain also increased. On 7th December, 47, she consulted various doctors and was treated for few days as a case of Typhoid and Pneumonia without relief.

On 12th December, 1947, she developed high fever and severe cough with blood stained sputum. On 15th December, she was examined by another doctor who diagnosed her as a case of pneumonia only and kept her on sulfa drugs for 4 days. Her condition grew worse.

On 20th December, 47, she came to Major Khandhari, Medical Officer in charge of Kali Kamli Hospital, Medical Ward, Kurukshetra and he diagnosed her as a case of Pulmonary Tuberculosis.

*She was isolated on examination.*

- 1 Body was wet with perspiration.
- 2 Breathing was shallow and rapid.
- 3 Temperature 104°F; Pulse 140 p.m. with low tension.
- 4 X-ray right side of her chest showed diminished movement, inter costal spaces were full, and apex beat visible about  $\frac{1}{2}$ " interior to the nipple line in the 5th space.
- 5 Spleen slightly palpable.
- 6 No Sugar or albumin in the urine.
- 7 Stool; No ova or Cyst seen.
- 8 Blood Smear:—Showed marked Polymorphonuclear leucocytosis.
- 9 Sputum tested:—Showed abundance of pus cells, Streptococci, Staphylococci and Pneumococci. No A.F.B. were detected.

On 20th December, 1947, an exploratory needle was put in to collect material for detailed examinations but it was unsuccessful.

On 30th December 47, she vomited 1 pint of pus at 11 p.m.

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|----------------|-----------------|---------------------|
| 1 Face Pallor  | 2 Temp. 99.4° F | Pulse 60 to 64 P.M. |
| 3 Palpitation. | 4 Dyspnoea.     |                     |
| 5 Insomnia     | 6 Sweating.     |                     |
| 7 Fainting.    |                 |                     |

*Injections:* 1 I.M. Coramin 2 c.c. stat and 6 hourly given.  
 2 I.N. Cal. Gluconate 10% c.c. and Redoxen 5 c.c. alternately.  
 3 I.M. Penicillin 40,000 units stat and 20,000 units 3 hourly.  
 4 2 Lakh units Penicillin dissolved in 10 c.c. of double distilled water intrapleurally; single injection was given by the civil surgeon Col. Bhatia i/c of the Kali Kamli Hospital, Kurukshetra on 1st January, 1948.

*Diet.* Milk, Eggflip, Barley and Albumin water were given.

Her general condition was little improved, but she was transferred from Kali Kamli Hospital, Kurukshetra to the Sanatorium, Bhowali on 15th January, 1948, under the treatment of Doctor S.N. Singh, Medical Officer i/c Police Ward, Sanatorium, Bhowali.

**Treatment.** The general treatment consisted in improvement in the ventilation of the special block, general cleanliness around the patient, Tincture Benzoin Co. inhalations by means of a Nelson's inhaler were given 4 hourly, and other treatments as follows:—

**Artificial Pneumothorax.**

| Date     | Initial Pressure | Air Withdrawn | Final Pressure | Dose Unit Penicillin |
|----------|------------------|---------------|----------------|----------------------|
| 20.1.48. | 14 16            | 300 c.c.      | 4 6            | 200,000.             |
| 5.1.48.  | 10 12            | 300 c.c.      | 2 5            | 200,000.             |
| 30.1.48. | 8 10             | 200 c.c.      | 0 2            | 200,000.             |
| 5.2.48.  | 4 6              | 150 c.c.      | 0 2            | 200,000.             |
| 15.2.48. | 2 5              | 150 c.c.      | 4 2            | 200,000.             |

Under the above treatment the signs and symptoms began to disappear very rapidly. Temperature came down to 98.8°F. within 3 days, cough decreased, gradually and disappeared in 6 days. The general condition much improved after 4 days. Toxic diarrhoea, and perspiration stopped and appetite increased. All the complaints which she had at the time of admission disappeared within 10 days and patient was fit enough to be moved. Gradually pus and air have been absorbed and the lung has partly expanded. She had been taking nourishing diet and lived out as much as she could in the fresh air from January, 1948 to the 30th October 1948. Her whole condition gradually improved and she left the Bhowali Sanatorium free from symptoms on 1st, December, 1948.

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