



Ectopic Pregnancy

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I. ABSTRACTECTOPIC PREGNANCY

Leonard A. Lang

Historically

The first recorded case of abdominal pregnancy goes back to Aloucasis, an Arabian physician of the 11th century, who reported a case wherein he saw parts of a fetal body escape from the abdomen of a woman by the process of suppuration. Then, we have the interesting case of the lithopedion of the City of Sens, reported by Cordaeus, in the 16th century. Cornex, also in the 16th century, dilated an ulcer near the umbilicus and removed a semi-putrid fetus, which had been present five years. In 1500, Jacob Nufer, a Swiss swine spayer, opened up the abdomen of his own wife, after midwives and lithotomists had given her up in labor, and extracted a living baby. Some authorities quote this as one of the earliest Caesarean sections, but inasmuch as his wife had four normal deliveries after the operation, this contention loses weight. Primerose, in 1594, removed an extra-uterine child from the abdomen by abdominal incision, four years after another surgeon, Jacob Noierus, had removed a former extra-uterine fetus by enlarging a fistula in the abdominal wall of the same patient.

Since then, numerous cases have been reported.

The first case of tubal gestation recorded is that of Riolan, who in 1604, followed a typical case with death from hemorrhage. The patient was posted and he carefully described the specimen of a right tubal pregnancy.

The first recorded case of operation for extra-uterine pregnancy in America is that of Dr. John Bard, who delivered a suppurating full-term fetus from the abdomen, in December 1759.

In 1791, Dr. William Boynham, a country physician in Virginia, successfully operated upon an abdominal pregnancy and again upon a Negro slave in 1799.

Parry, in 1876, collected 500 cases of extra-uterine pregnancy, of all ages, among whom 366 died and 163 recovered (mortality, 67.7%).

Although abdominal section was first suggested for the treatment of tubal pregnancy by Harbert, in 1849, the honor of performing the first operation of this type goes to Lawson Tait, in 1883. He lost his first case, but lost only one of the next 40 cases. Before this time, electricity was advocated, with the idea of destroying the life of the fetus by a strong galvanic current, applied via the vagina.

The first American operation for ruptured ectopic pregnancy was by Charles Briddon, in 1883. Unfortunately, his patient died in two days from shock. From Tait's time on, we find frequent reports of the diagnosis and operative treatment of ruptured ectopic pregnancy.

Frequency

Extra-uterine pregnancy, or ectopic pregnancy, or ecchysis, may be defined as that condition which arises when a fecundated ovum lodges and imbeds in any situation outside the cavity of the uterus, and is not as rare as may seem on first thought.

Wynne reports a frequency of 1.3% in all gynecology cases on the Johns Hopkins service, over a period of about 10 years.

Schumann reports 1 in 303 pregnancies for the city of Philadelphia, in 1918.

Urner, at the Minneapolis General Hospital, sees between 12 and 17 cases a year, while the total number of normal deliveries (not including abortions, etc.) runs in the neighborhood of 1,700 per year.

At the University of Minnesota Hospitals, there are 8 to 10 cases a year.

Classification

In classifying ectopics, we common-

ly label them according to the site of lodgement of the ovum. Then we have:

- (1) Tubal pregnancies, may be ampullar, isthmic, fimbrial and interstitial, in about that order of frequency. Interstitial pregnancies (5%) are rather dangerous because of the duration of the pregnancy before symptoms occur and there are larger vessels to be ruptured when rupture finally occurs. (2) Ovarian, and (3) peritoneal, which is questioned by many observers. (4) An abdominal pregnancy may be (a) primary in which we have implantation early, directly on the peritoneum (?), or (b) secondary, from a ruptured tubal, ovarian, or interligamentous pregnancy. (5) An interligamentous pregnancy results from a tubal pregnancy rupturing through the inferior tubal wall, into the broad ligament.

Etiology

Concerning the etiology of ectopic pregnancy, there is a great deal of conflicting opinion in the literature. Probably an ovarian pregnancy results simply from the fertilization of the ovum before its escape from the Graafian follicle (Leopold). The variable etiology of tubal pregnancy may be discussed under the following heads:

(As a foreword, we may recall that normally, fertilization probably occurs in the middle third of the tube, and anything that prevents or delays the proper time and place for this fertilization, or does not allow progress of the fertilized ovum into the cavity of the uterus, may contribute to the formation of a tubal pregnancy.)

1. Conditions which interfere mechanically with the downward passage of the ovum, as

- (a) Peritoneal adhesions, which may compress the lumen or interfere with the peristalsis of the tube.
- (b) Polypi, projecting into the lumen.
- (c) Tumors, such as myomata (Case I), ovarian or interligamentous cysts which distort the tube and narrow its lumen.

(d) Fetal convolutions of the tube, which persist into adult life (constriction or interference of peristalsis).

(e) Diverticula of the lumen of the tube.

(f) The presence of accessory ostia has been demonstrated as a cause in some instances (Williams).

(g) Puerperal atrophy of the tube (Dührssen).

(h) External migration (Case IX) of the ovum to tube of opposite side may cause sufficient growth by delay so that it cannot pass through the lumen.

(i) Abnormal amount of membrana granulosa (M. Kerr).

2. Conditions resulting from inflammatory conditions of the tubes (emphasized by Tait).

(a) History of gonorrhoea with salpingitis is often elicited (10% ectopic histories, probably) (Case VII - hydrosalpinx).

(b) History of postpartum or post-abortual infection is not uncommon.

(c) History of previous operation in the pelvis. (Cases II, V, VII). Litzenberg said that 15% of his series had a previous operation. (Giles reports 125 cases of conservative operations, followed by pregnancy in 26%, of which 24% were ectopic.)

(d) Relative sterility: "30% of women, ectopically pregnant, have one child sterility." (Schumann) (Cases I, II, V, VI, VIII).

3. Physical and developmental conditions favoring decidual formation on the tubes (Webster)--a sign of degeneration or reversion.

Pathology

The pathology of ectopic pregnancy

has been thoroughly worked out by Litzenberg. He finds in the first place the tube has no decidua and no real submucosa. Therefore, the muscular wall is invaded and there are large vessels which may be eroded. Universal hemorrhage is found overflowing the intervillous and muscle fiber spaces. Although there is no true decidua, we may find decidual reaction present in isolated and scattered "decidual islands." There is a chorion frondosum but no decidua basalis; there is a capsule of the chorion but no decidua capsularis. Because there is no protecting decidua, the erosion of the blood vessels occurs early—hemorrhage causes overflowing of the intervillous spaces and extends into the capsule of the ovum in all cases. This results in internal rupture and then bleeding into the lumen of the tube. (This is misnamed "tubal abortion" by many observers.) The changes in the uterus: The uterus increases in size, but not to the size of intrauterine pregnancy of the same period of gestation. True decidua is formed in the uterus. This decidua degenerates with death or rupture of the ovum and thus we get external vaginal bleeding or a decidual cast may be passed.

Symptomatology and Diagnosis

The following points are worth reviewing and emphasizing: A woman of the child-bearing age (60% between 26 and 33 years) comes to us, usually because of a delayed menstrual period, followed by vaginal bleeding, usually of a dribbling or spotting nature, and lower abdominal pain, unilateral. There may be a history of the passage of a decidual cast (Cases I, III, V). She may, or may not, show other presumptive signs of pregnancy, such as nausea and vomiting, prickling sensation in the breasts, etc. On questioning, we are likely to get a history of one-child sterility, old pelvic infection, or previous pelvic operation. The temperature may be normal, or low-grade (99.2 to 100°), or quite high (Case VIII), especially with a rupture. Leucocyte count, also, is usually elevated mildly, but may be 20,000 (Cases VIII & IX) with 90% neutrophils with free blood in the abdomen. There may be a history of shoulder-strap pain (Cases IV, VIII & IX) or pain along the costal margin, on either side, due to irritation of the

phrenic nerve terminals and reference to the shoulder-strap regions due to the fact that the phrenic is derived from the cervical plexus. Quite commonly, there is a history of a fainting attack (Cases III, VI, VIII) or dizziness, associated with the pain, and which is out of proportion to the possible blood loss. A history of pain on defecation (Cases I, VI, VII, VIII, IX) is not unusual and is quite suggestive.

On examination, we find the abdomen to be tender and often rigid over one or the other lower quadrants. Bimanual examination may reveal blood coming from the vagina. (The blood is brownish, discolored and usually not abundant).

The cervix is discolored (often very pale blue in marked hemorrhage); softened some, but not as in normal pregnancy; very tender, in fact, exquisitely tender on motion. The uterus is found to be enlarged and softened, but not to the degree expected in normal pregnancy. A very tender mass is palpated in one or the other adnexal region; or we may palpate the boggy crepitant feel of a fairly recent hematocele (Case VI) in the culdesac, or to one side of the uterus.

If there has been considerable hemorrhage, we have all the evidences of hemorrhagic shock (Cases VIII & IX), fast pulse, low blood pressure, pale, cold, moist skin, air hunger, etc.). Also, examination of the abdomen may reveal a definite fluid wave. Cullen has described a bluish-green discoloration of the umbilical region, which many careful observers have never seen.

Laboratory aids are the Friedman test, which can be read in 24 hours, in an emergency; and x-ray of the abdomen, in cases of possible advanced extrauterine pregnancy. We cannot place too much reliance on the Friedman test because after serious disturbance of the implantation, the Friedman test is likely to be negative after a few days (Cases VI, VII).

The differential diagnosis, to be excluded, include mainly

- (1) Normal pregnancy, (Difficult in

Piscacek uterus),

- (2) Hemorrhage from a corpus luteal cyst, with or without a normal pregnancy,
- (3) Threatened or incomplete abortion,
- (4) Salpingitis,
- (5) Pelvic tumors,
- (6) Ureteral colic, and
- (7) Pregnancy in a rudimentary horn.

In most reported series in late years, the diagnosis has proven correct at operation in 70 to 75% of cases; but this apparent inaccuracy is not so great when we compare it with the possible emergency; which if left to itself, leads to a mortality of about 66% as Parry's series showed. The present mortality is between 2 and 3%.

Treatment

At operation, it is a good rule to do only what is necessary while in the abdomen; and depending on the condition of the patient, to do this as quickly as possible. It is better to remove the entire affected tube, coming-out the cornua, as ectopics have been known to recur, if this is not done. Make every attempt to isolate and leave the ovary on the affected side.

If the other tube does not show signs of old infection, it is better left in, even though it may be shown that the patient has about 10% chance of developing another ectopic, but about 50% chance of normal gestation (Schumann). Much difference of opinion exists on the disposition of intraperitoneal blood in cases of marked hemorrhage. Some scoop it all out and may or may not wash out the abdominal cavity with saline; others leave all the blood present. Some take out the defibrinated blood, mix it with saline and transfuse the patient. Some just take out the clots that obscure the field and leave the blood to be absorbed (Cases VIII, IX). The latter is our usual practice unless there is strong reason for

fearing infection. Where there is any considerable hemorrhage, it is well to start intravenous glucose, or blood transfusion (Case IX) when ready to enter the abdomen. With no evidence of infection, there is no need of drains.

Postoperative convalescence is usually uneventful, although a second transfusion may be necessary after operation.

Abdominal pregnancies, such as Case V, are probably secondary to tubal rupture, or ovarian pregnancy (which is very rare and demands very exacting criteria.) The criteria of Spiegelberg are as follows:

1. The tube must be intact grossly and microscopically.
2. The fetal sac must be in the position of the ovary.
3. The fetal sac must be connected to the uterus by the utero-ovarian ligament.
4. Ovarian tissue must be present in the sac in several places.

There are about 50 cases in the literature that satisfy these conditions.

The diagnosis depends first upon the history of an acute attack, corresponding to an ectopic rupture. If the ovum is not destroyed, development may continue and the fetus may grow to maturity. The fetal movements are more vigorous and demonstrable than a normal pregnancy. The patient usually complains of vague abdominal pains. The fetus often may be readily moved about on examination and there may be symptoms of peritoneal irritation, such as nausea, vomiting, constipation or diarrhea, intestinal hemorrhage and frequent urination. Often the uterus may be isolated on bimanual examination and fetal extremities may be felt per vaginam.

If the fetus dies, it may become macerated or infected, with symptoms of toxemia or sepsis intervening, and later subsiding as the fetus becomes converted into a lithopedion or adipocera.

If the fetus lives to maturity, false labor supervenes (active fetus, painful contractions of the uterus and vaginal bleeding) after which the fetus dies and the condition terminates in one of the ways mentioned above.

In the treatment of abdominal or advanced extra-uterine pregnancy, the management of the placenta becomes an important factor as well as the fact that a possible infant life is to be considered, as well as that of the mother. The incision is made usually to one side of the midline and overlying the gestation sac, which may be adherent to the anterior abdominal wall. The sac is incised, the child extracted and the cord tied, as in Caesarean section. The sac is inspected for bleeding vessels, and the location of the placenta is ascertained. If the vessels supplying the latter can be isolated, this is done and they are ligated and the placenta is removed, but if the location of the placenta is such that bleeding cannot be controlled, two methods present themselves:

1. Marsupialization, by stitching the edges of the sac to the abdominal wound and packing the cavity with gauze. In a few weeks, the placenta sloughs out and a sinus may remain which usually closes spontaneously, or

2. Leave the placenta in situ and close without drainage. (Beck reports 12 cases of which 4 died, or 33%; and marsupialization in 52 women, of whom 22 died, or 39%).

Usually, if the fetus has been dead for 4 to 6 weeks and no infection is present, it is possible to remove the placenta without uncontrollable bleeding. On that account, it is often advisable to delay operation for a month or 6 weeks, in cases where the fetus is known to be dead.

Where the fetus is known to be alive, there is little added risk in waiting until the 38th week of gestation, when a fully developed child may be expected. From the standpoint of the mother alone, the 6th or 7th month is the best time for operation, with very little risk up to the 38th week.

When evident infection is present, with a dead fetus, many recommend the vaginal route for operation, if the fetus is accessible.

II. CASE REPORTS

I. Myomata at cornu.

Case is white female 34 years of age, admitted to University of Minnesota Hospitals 1-6-35 and expired 1-9-35 (3 days).

Married 9 years. Gravidia I, Para 0.
(First pregnancy)

10-26-34 - Last menstrual period, normal, no spotting or vaginal bleeding of any type up to 3 weeks before admission. No nausea or vomiting.

12-15-34 - Severe crampy pain in both lower abdominal quadrants, also in chest, aggravated by breathing. Pain severe, lasted 24 hours. Given medication. Was in fair health and comfortable.

12-30-34 - Attack of abdominal pain as before. Physician diagnosed pregnancy. Frequent attacks up to time of admission - mild, $\frac{1}{2}$ to 1 hour. No further chest pain.

1-6-35 - Severe pain in lower abdomen since 8:30 A.M. Apparently went into shock. 10 P.M. - Admitted. Pain generalized, more marked on left. Pulse 140. Blood pressure 128/60. Abdomen - distended with dullness in both flanks. Pelvic - uterus moderately enlarged and softened. Cervix - firm, painful on motion. Culdesac - tender and boggy. Laboratory: Blood - Hemoglobin 58%, leucocytes 18,650, neutrophils 94%. Diagnosis: Ruptured ectopic pregnancy. Operation: Left tubal myoma at cornu excised with tube. Abdomen had large amount of blood.

1-8-35 - Chest shows definite evidence of consolidation in right middle lobe.

1-9-35 - Expired.

Autopsy Findings

1. Pneumonic consolidation of both lobes on left and all 3 on right to some degree.

2. Decidual cast in uterus (3 x 4 cm.).

3. Myoma at left cornu (2 cm.) of uterus. (Another had been removed with pregnant tube. There were apparently 2 myomata constricting lumen of tube).

II. _____

Case is white female, 30 years of age, admitted to University of Minnesota Hospitals 9-7-33.

Married 7 years. No pregnancies.

History: Appendectomy, diagnostic curettage and biopsy of cervix one year previously. Biopsy diagnosed as carcinoma. Sent in for irradiation one year later.

Catamenia: Had been regular up to 7-18-33 which was last normal menstrual period.

8-1-33 - Anomalous menstrual period accompanied by severe left lower quadrant pain, lasting 2 days, accompanied by vomiting. Continuous pain (dull) in left lower quadrant since. No bleeding since.

9-7-33 - Admitted. Temperature 99.2. Pelvic - corpus anterior, normal size. Cervix - down and back and to right, not tender, no growth. Adnexae - somewhat tender, mass (6 cm. in diameter) in left lower quadrant, probably cystic ovary.

9-8-33 - Operation reports: Curettings - atrophic endometrium. Cervix - infected polyp. Left tube - villi and decidua. Note: type that would revert to tubal mole?

III. _____

Case is white female, 38 years of age, admitted to the University of Minnesota Hospitals 11-24-34.

Gravida XI, Para IX. Last pregnancy normal; delivery at term 4-4-33. No operation or sepsis.

9-15-34 - Last menstrual period. Began bleeding one week later, continuous but slight flow up to admission.

10-20-34 - Passed something resembling tissue (cast ?) from vagina.

11-1-34 - Sudden central abdominal pain. Fell unconscious to floor on getting out of bed. Taken to other Hospital. Remained under observation for 2 weeks. Jaundice developed at this time. Mild abdominal pain and soreness up to admission. No shoulder-strap pain.

11-24-34 - Admitted. Temperature 99.6. Abdomen - mass palpable to 2 fingers below umbilicus. Pelvic - vagina, cyanotic, bloody discharge; cervix - soft, tender on motion, cyanotic; copus - size of 1½ to 2 months pregnancy, soft, pain on movement; adnexae - mass on left, 7 or 8 Cm. in diameter, very tender. Laboratory: Blood - Hemoglobin 71%, leucocytes 5,800, erythrocytes 3,610,000, neutrophils 80%.

11-26-34 - Recurrence of acute abdominal pain. Operation: Ruptured ectopic, left (chorionic sac and villi present). Considerable organizing adhesions and some fresh blood. Note: Jaundice and decidual cast.

IV. _____

Case is white female, 23 years of age, admitted to University of Minnesota Hospitals 9-18-33.

3 children. Married 3 years. Last pregnancy 8 months previous to admission.

8- -33 - Last menstrual period. Three days later, continued to flow for 3 weeks. No bleeding for 2 weeks before admission. Moderate, crampy, abdominal pain since onset of delayed menstrual period. Nauseated. No vomiting.

9-18-33 - Admitted. Temperature 99.8. Marked increase of pain. Faintness. Shoulder-strap pain on right, increased by pressure over right upper quadrant. Rebound tenderness in right lower quadrant. Pelvic - soft, tender mass in right adnexal region; cervix tender on motion; corpus anterior, normal in size, painful. Laboratory: Blood - Hemoglobin 82%, leucocytes 13,000, neutrophils 83%. Operation: right ectopic pregnancy, considerable blood in right lateral gutter. Note: Shoulder-strap pain on same side as blood in gutter.

V.

Case is white female, 41 years of age, admitted to University of Minnesota Hospitals 2-20-34.

Married many years. No history of pelvic inflammatory disease or previous pregnancy.

1912 - Appendectomy.

3-21-33 - Last menstrual period.

6 weeks later - Severe lower abdominal pain and 1 week later, vaginal bleeding which continued intermittently for one month. Passed a fibrous cast (?) early in May.

5- -33 - Cured outside Hospital with diagnosis of probable incomplete abortion. Minimal curettings obtained. Nausea and vomiting at intervals thereafter. No further bleeding. Abdomen continued to increase in size after diagnostic curettage and physician thought he had missed an intra-uterine pregnancy. No movement felt and no heart sounds heard (unusual).

12-18-33 - Crampy, lower abdominal pain. Thought to be in labor (false labor). Vaginal bleeding. Nurse remained with patient 3 days while in supposed labor. Irregular uterine contractions continued until 1-2-34.

1-2- to 2-10-34 - No symptoms.

2-10-34 - Fever and chills.

2-13-34 - Severe lower abdominal pain. Nausea and vomiting. Temperature, pain, vomiting up to admission. Treated in home hospital with fluids, etc.

2-20-34 - Admitted. Temperature 101. Abdomen - very tender, full and rigid, fetus palpable with difficulty. Cervix - high, no separate corpus palpable. Laboratory: Blood - Hemoglobin 77%, erythrocytes 3,450,000, (2-20-34) leucocytes 20,150, neutrophils 82%. (2-21-34) Leucocytes 27,800, neutrophils 91%. Flat Plate X-ray: Fetus high above pelvis, evidently dead. Considerable gas about fetus. (2-24-34) Lipiodol into uterine cavity. Uterus displaced anteriorly and separated from fetal mass.

2-24-34 - Operation: Fetal sac entered by midline incision. Escape of gas. Fetus removed. Drains left in sac and high accessory abscess cavity.

3-23-34 - Discharged with draining wound.

Follow-up shows patient in good condition (wound healed).

Note: Typical abdominal pregnancy.

VI.

Case is white female, 26 years of age, admitted to University of Minnesota Hospitals 2-19-34.

One child, 5 years ago, instrumental delivery. No known sepsis.

12-4-33 - Last menstrual period, normal.

1- -34 - Menstrated for 2 weeks.

1-17-34 - Sudden lower abdominal pain and vaginal hemorrhage (1 day). Residual soreness with pain increasing and fainting spell one week later. Also vomiting. Vaginal bleeding intermittent, increasing. Rallied. Pain continued with slight bleeding. Defecation pain noticed.

2-5-34 - Freidman test negative.

2-19-34 - Admitted. Temperature normal to 99.2. Pelvic - corpus somewhat enlarged; cervix - moderately tender; mass tender, crepitant, and behind uterus. Laboratory: Blood - Hemoglobin 80%, erythrocytes 3,610,000, leucocytes 7,200, neutrophiles 62%.

2-20-34 - Freidman test negative.

2-21-34 - Operation: Left ectopic pregnancy. Numerous old organized blood clots.

Note: Positive defecation pain.
Crepitant mass behind uterus.
Negative Freidman test.

VII.

Case is white female, 28 years of age, admitted to University of Minnesota Hospitals 5-29-34.

One other pregnancy (ectopic). Previous operations: Appendectomy, 1928; left ectopic, 1930.

4-10-34 - Last menstrual period. (Had been regular for 4 years).

5-7 to 5-14-34 - Nauseated.

5-14-34 - Small amount of bleeding with pain.

5-17-34 - Sudden severe right lower quadrant pain. Bleeding recurred. Vomiting, anorexia, to admission. Rectum tender on defecation; diarrhea first 3 days.

5-28-34 - Severe right lower quadrant pain radiating down to anterior right lower extremity.

5-29-34 - Admitted. Temperature 99.4 to 99.8. Pelvic - cervix - soft, tender on motion; corpus - retroverted 3°, somewhat softened, questionably enlarged; tender adherent mass on right. Laboratory: Blood - hemoglobin 85%, leucocytes 5,850, neutrophiles 82%.

6-2-34 - Freidman test negative.

6-5-34 - Operation: Right tubal pregnancy.

Note: Previous ectopic pregnancy.
Negative Freidman test.

VIII.

Case is a white female, 29 years of age, admitted to University of Minnesota Hospitals 7-23-34.

One pregnancy, 10 years ago.

5-7-34 - Last menstrual period.

6-5-34 - Bearing down pain in pelvis. Vomiting. Pain persisted.

7-2-34 - Sharp right lower quadrant pain (

) No

7-16-34 - Sharp right lower quadrant pain (bleeding.

)

7-22-34 - Severe pain in lower abdomen, relieved by hypodermic. Shoulder-strap pain and chest pain. Bleeding from vagina with this attack.

7-25-34 - Two attacks of sharp lower abdominal pain. Fainted.

Defecation pain since early June.

7-23-34 - Admitted. Physical examination: Blood Pressure 68/40, pulse 130, temperature 102-103. Rigid abdomen, dullness in both flanks. Cervix - soft, very painful on motion. Corpus - size of 2 months pregnancy, anterior; painful on movement. Culdesac - bulging with crepitant mass suggesting blood clots. Laboratory: Blood - Hemoglobin 56%, leucocytes 28,800, neutrophiles 94%. Operation: Left tubal pregnancy. Considerable blood in abdomen (about 1500 cc.). Blood left in abdomen and following hemoglobin studies show a steady rise without transfusion.

Hemoglobin studies

7-23-34 -56%
 7-23-34 -40% (16 hr.)
 7-24-34 -26%
 7-25-34 -26% No transfusion.
 7-28-34 -37%
 7-29-34 -42%
 7-30-34 -45%
 8- 1-34 -51%
 8- 5-34 -55%

IX. _____

Case is white female, 28 years of age, admitted to University of Minnesota Hospitals 12-15-32. Gravida V, Para II. Last pregnancy, one year before. No history of sepsis.

10-22-32 - Last menstrual period.

Went over November menstrual period 4 days and began bleeding on 11-16-32, and continued up to admission.

12-15-32 - 1 P.M. - Severe pain in lower abdomen. Two hypodermics of morphine given for relief. Right shoulder-strap pain, marked. Uncomfortable feeling of fullness in rectum on moving bowels. Admitted. In extreme shock with blood pressure 70/0 and pulse 130, temperature 97°. Abdomen - full and tender; bulging of flanks with shifting dullness. Corpus - anterior, tender, small. Cervix - soft, very tender. Adnexae - exquisitely tender mass on right; another small mass on left, less tender. Laboratory: Blood - Hemoglobin 67% (after 2 transfusions); leucocytes 33,350, neutrophils 83%. Given intravenous glucose while getting donor and preparing for operation. 600 cc. transfusion begun during operation; 450 cc. several hours later. Operation: Estimate of 2000 cc. of blood in cavity. Right tube removed. Left corpus luteum ruptured.

12-25-32 - Discharged on 10th day in good condition.

Note: Operative preparation.

III. Timely Criticism

Everyone should carefully read the following letter from the State Board of Health Laboratories. This institution gives us invaluable services and we must cooperate at least to the extent of giving them properly labeled specimens. Fill out your request slips accurately and completely.

"For some time we have been receiving a number of Wassermann specimens from the University Hospital which have not been accompanied by data cards, the only identification being the labels on the tubes. These labels have been of variable types, sometimes only wrapping paper with no data but the name of the patient and often these names are blurred. We received eight such specimens today, four from Hospital patients and four from the Dispensary. We are uncertain of one of the names and no initials are given. For your information, we are listing the names of the patients found on the labels pasted on these specimens of blood: (Names Listed).

"We would greatly appreciate it if you would call the attention of the responsible persons to this matter. Besides the fact that we receive no data cards on many of the University Hospital specimens, it is also true that when data cards are received they are practically never properly filled out. As you know this information is necessary for our records.

"We would appreciate your cooperation.

Very truly,

(Signed) O. McDaniel,
 Director."

NEW POLICIES

The Columbia Broadcasting System has recently issued a policy statement which is of interest to the medical profession. They say in part "The Columbia Broadcasting System has given particular consideration to recent trends in two general types of commercial program: those which are designed for children, and those involving unpleasant discussions of bodily functions, bodily symptoms, or other matters which similarly infringe on good taste. In addition, as a result of expressed public interest, careful study has been given to the amount of time that should be used by sponsors for their advertising messages."

In regard to children's programs, they state that the following will not be permitted in broadcasts for children:

The exalting, as modern heroes, of gangsters, criminals and racketeers will not be allowed.

Disrespect for either parental or other proper authority must not be glorified or encouraged.

Cruelty, greed, and selfishness must not be presented as worthy motivations.

Programs that arouse harmful nervous reactions in the child must not be presented.

Conceit, smugness, or an unwarranted sense of superiority over others less fortunate may not be presented as laudable.

Recklessness and abandon must not be falsely identified with a healthy spirit of adventure.

Unfair exploitation of others for personal gain must not be made praiseworthy.

Dishonesty and deceit are not to be made appealing or attractive to the child.

To be of assistance in reaching this goal, Columbia is engaging the services

of an eminent child-psychologist who will have the benefit of an advisory board of qualified members, with the special purpose of pointing the way toward programs designed to meet the approval of parents, children and educators alike. Columbia hopes thus to be equipped to appreciate and apply the parent's practical point of view no less than to reflect studied scientific judgment. The name of this consulting authority, and the membership of this committee, will be announced soon; and the new policy becomes completely effective July 30.

The new advertising policy will specifically exclude from the network all advertising of laxatives, as such, and any laxative properties in any other product. Deodorants, depilatories and other similar articles will also be excluded. Only one contract exists in the laxative series which does not expire until March, 1936. It probably means that all internal remedies will be banned from the air.

Commercial announcements ought to be cut from 6 minutes on a full hour program to 2 minutes 10 seconds on a quarter-hour program. In the daytime, there will be an attempt to limit the commercial programs and the commercial announcements. The new basic advertising policies are as follows:

1. No false or unwarranted claims for any product or service.
2. No infringements of another advertiser's rights through plagiarism or unfair imitation of either program idea or copy.
3. No disparagement of competitors or competitive goods.
4. No lottery or "drawing contest". No contest of any kind in which the public is unfairly treated.
5. No programs or announcements that are slanderous, obscene, or profane, either in theme or in treatment.

6. No ambiguous statements that may be misleading to the listening audience.

7. Not more than two price mentions on a 15-minute program.

Not more than three price mentions on a half-hour program.

Not more than five price mentions on a full-hour program.

8. No advertising matter, or announcements, or programs which may, in the opinion of the System, be injurious or prejudicial to the interests of the public, the Columbia Broadcasting System, or honest advertising and reputable business in general.

9. No appeals for funds

10. No testimonials which cannot be authenticated.

It is understood that the National Broadcasting Company is adopting a similar program. These changes will affect chain programs and company owned stations only. All other programs put on by locally owned stations will not be affected.

V. ANNOUNCEMENTS

1. HOSPITAL PICNIC

Today - 3:00 to 10:00 P.M.

2. NO MEETING NEXT WEEK

On account of Memorial Day.

Regular meeting the following week.

VI. MOVIES

Title: Outdoing the Daredevils.

Released by: Fox Motion Picture Corporation.