

CORRESPONDENCE

Oral conception. Impregnation via the proximal gastrointestinal tract in a patient with an aplastic distal vagina

Dear Sir,

The report by Dr Verkuyl on oral conception [*Br J Obstet Gynaecol* (1988) **95**, 933-934] was most interesting. His patient had become pregnant, despite the absence of a vagina, through semen migrating across the abdomen space following puncture of the stomach wall with a knife, shortly after she had engaged in oral intercourse.

A similar episode was reported previously in the *American Medical Weekly* for 17 November 1874 by L. G. Capers and was noted by the *Lancet* (1875). This reported a bullet fired in the American Civil War, which on 12 May 1863 was said to have carried away the left testis of a soldier. This same bullet went on to penetrate the left side of a young woman nursing the injured nearby, and 278 days later she went into labour and gave birth to an 8-lb male infant. The hymen was intact and she was adamant that she was virginal. The infant was later operated upon and a malformed bullet was removed from a swelling in his scrotum. The soldier and mother were later reunited more formally, married and eventually produced three children by more routine methods.

Whilst it is known that 'capacitation' of semen is facilitated by many body fluids, including peritoneal fluid, it would appear that the calcium ion influx, which promotes acrosome reactivity, is not inhibited by acceleration or the very low pH of gastric hydrochloric acid.

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References

- Lancet* (1875) A voracious chronicle. *Lancet* **i**, 35.
Verkuyl D. A. A. (1988) Oral conception. Impregnation via the proximal gastrointestinal tract in a patient with an aplastic distal vagina. Case report. *Br J Obstet Gynaecol* **95**, 933-934.

Fetal supraventricular tachycardia: detection by routine auscultation and successful in-utero management

Dear Sir,

I read with interest the case report by Macphail & Walkinshaw [*Br J Obstet Gynaecol* (1988) **95**, 1073-1076] on the use of flecainide to treat fetal supraventricular tachycardia.

Readers may be interested in a further case of in-utero treatment of a fetal supraventricular tachycardia. A 24-year-old woman in her second pregnancy was found to have a fetal tachycardia of 240 bt/min on routine auscultation by her general practitioner; this was shown to be a supraventricular tachycardia by M-mode echocardiography. Despite digitalization for 10 days (maternal serum level of 2 µg), the arrhythmia persisted. Real-time scanning showed a small pericardial effusion together with a minor degree of ascites.

Verapamil was given orally, 80 mg three times daily, increasing to 120 mg three times daily after 5 days, to give a maternal serum level of 80 ng/ml. At this stage the fetal tachycardia settled to 120 bt/min. A repeat scan 6 days later showed no evidence of ascites or pericardial effusion. There was no recurrence of the fetal tachycardia. Labour was induced by amniotomy at 38 weeks. A male infant weighing 3350 g was born vaginally in good condition. The baby was digitalized for 10 days and has had no arrhythmias subsequently.

The use of verapamil would appear to have been a success for treating the fetal supraventricular tachycardia and mild degree of heart failure in this patient. It should, however, be avoided in the presence of advanced hydrops as, being a negative inotropic agent, fetal outcome could be further compromised (Wladimiroff & Stewart 1985). Whilst the lowest dosage should be used to restore sinus rhythm, maternal serum levels usually need to be in the upper part of the therapeutic range (50-100 ng/ml) as fetal levels are 25-50% of maternal levels.

Routine antenatal auscultation remains a use-