If the infection occurs at an early stage of foetal life, pronounced changes occur in the eyes and microphthalmos may result.

A presumptive diagnosis of congenital toxoplasmosis can be made if the characteristic findings of cerebral calcifications, chorioretinitis and hydrocephalus are found. The diagnosis is confirmed, if the serological findings are sufficiently positive.

Case report

On the 21st January 1966, a girl aged 11 years was referred to the ophthalmic out-patients department for defective vision.

The patient had a history of squint when very young. Vision R.E. unaided 6/18. Vision L.E. unaided 6/60. Examination of the fundi after pupillary dilatation by homatropine showed no abnormal changes in the right eye.

The left fundus showed a square shaped cicatrical chorioretinal focus, situated on the temporal part of the posterior pole about 4 disc diameters from the optic papilla and measuring 4 × 4 D.D. The surface of the focus was covered by small clumps of pigment, surrounding a central atrophic area. Some sinuous choroidal vessels were visible at the bottom of the focus. The retinal vessels were normal. The temporal half of the optic disc showed a marked pallor.

Vision in the right eye could be improved to 6/9 with glasses. The vision of the left eye could not be improved.

Radiological examination of the cranium did not reveal any calcifications.

Physical examination did not show any abnormal changes. Two tests for cytoplasm modifying antibodies (the Sabin and Feldman test) carried out a fifteen days' interval were positive at 1/16 which suggested a past infection or a chronic infection of long duration.

Our thanks are due to Dr. Alastair Dudgeon of the Hospital for Sick Children, London, for carrying out the C.M.A. tests for us.
risk of life than that of any other pregnant woman."

Material and Findings

In this survey, a study was made of all the para 7 or over delivered at St. Luke’s Hospital, Malta, during the two-year period 1963-1964. A comparison was also made between the results obtained in all para 5 patients and those who were para 10 or over during the same period. The figure for the para 7 or over was 638 out of a total of 4052 admissions, constituting 15.7 per cent. This high figure indicates the class of patients admitted, mostly from the lower social strata. A large proportion of these patients converge to the one hospital from the villages. Though they all had their delivery in hospital, antenatal attendances had often been erratic.

TABLE I
Distribution according to parity of 638 grande multipara

<table>
<thead>
<tr>
<th>Parity</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>22.6</td>
</tr>
<tr>
<td>8</td>
<td>20.5</td>
</tr>
<tr>
<td>9</td>
<td>15.4</td>
</tr>
<tr>
<td>10 or over</td>
<td>41.5</td>
</tr>
</tbody>
</table>

The highest parity recorded in this group was 22. The patient was aged 43 and had a normal pregnancy and delivery.

TABLE II
Distribution according to age

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>—</td>
<td>4.3</td>
</tr>
<tr>
<td>30 - 34</td>
<td>20.7</td>
</tr>
<tr>
<td>39 - 39</td>
<td>47.8</td>
</tr>
<tr>
<td>40 - 44</td>
<td>26.0</td>
</tr>
<tr>
<td>45 or over</td>
<td>1.2</td>
</tr>
</tbody>
</table>

The youngest patient was 24 years old and was para 7. There were three patients aged 46, the oldest in the series.

Toxaemia. Under this heading are included all patients whose blood pressure was found to be above 140/90 on more than one occasion during the pregnancy. There were 142 cases, forming 22.9 per cent. This is a high rate and is possibly related to the frequent occurrence of gross obesity in the series, which together with glycosuria forms almost a picture of endemic disease in this class of patient in Malta. Another factor for the high figure has been the difficulty in following up and adequately treating hypertensive patients who refuse in-patient treatment.

There were 13 cases of abruptio placentae i.e. 2.03 per cent, and 10 cases of placenta praevia i.e. 1.56 per cent. There were 6 cases of retained placenta or 0.95 per cent.

Operative intervention. Caesarean section was carried out in 43 cases or 6.7 per cent. of the series. Hysterectomy was performed in 5 cases, three times for the three cases of rupture of the uterus in the series and twice for intractable bleeding during Caesarean section on friable uteri. The three cases of uterine rupture occurred in women who were para 7, 8 and 9 respectively.

There was one maternal death or 0.15 per cent. This was para 11, aged 38, who had a Caesarean section for fulminating toxaemia and died five days later from pulmonary oedema and heart failure. (Table III).

Prematurity — here taken as being 5 lbs. 8 ozs. or less at birth — accounted for 5.8 per cent. or 37 cases. There were 11 sets of twins or 1.8 per cent. The rate for still-births was 5.0 per cent. or 32 cases — an understandably high figure when considering the incidence of toxaemia.

Malpresentations. There were 16 cases involving a transverse presentation or prolapsed cord or both, an incidence of 2.5 per cent. 12 of these required a Caesarean section, 1 had a hysterectomy for rupture of the uterus and three had a normal delivery. The rate of breech delivery was 6.2 per cent. i.e. 40 cases. There were 2 cases of face presentation, one of which, a persistent mento-posterior, necessitated a Caesarean section.

A comparison is made below between the obstetrical behaviour of the para 5 group and that of the patients who were para 10 or over. There was no appreciable difference in the incidence of placenta praevia and premature births. Toxaemia
TABLE III
Showing incidence of obstetrical complications in women who were para 7 or over according to various authors.

<table>
<thead>
<tr>
<th></th>
<th>Toxicemia</th>
<th>Abruptio placenta</th>
<th>Placenta previa</th>
<th>Retained placenta</th>
<th>Prematurity</th>
<th>Still-births</th>
<th>Maternal mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miller (1954)</td>
<td>4.1</td>
<td>3.1</td>
<td>1.0</td>
<td>1.6</td>
<td>8.8</td>
<td>1.9</td>
<td>0.17</td>
</tr>
<tr>
<td>563 cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schram (1954)</td>
<td>11.1</td>
<td>2.39</td>
<td>1.6</td>
<td>2.9</td>
<td>5.9</td>
<td>3.1</td>
<td>0.4</td>
</tr>
<tr>
<td>502 cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scharfman et al. (1962)</td>
<td>9.6</td>
<td>0.74</td>
<td>1.5</td>
<td>0.99</td>
<td>9.6</td>
<td>1.0</td>
<td>0.2</td>
</tr>
<tr>
<td>403 cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present series</td>
<td>22.2</td>
<td>2.03</td>
<td>1.56</td>
<td>0.95</td>
<td>5.8</td>
<td>5.0</td>
<td>0.15</td>
</tr>
<tr>
<td>638 cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

was more frequent in the higher parity group. Abruptio placentae and Caesarean section were approximately four times as common, while malpresentation and still-birth rates were twice as high.

Discussion

The grande multipara is or should be at no greater risk to her life than the one who has borne less children. The improved results are directly related to improved ante-natal care with early recognition and treatment of abnormalities, better nutrition and hygiene, the introduction of blood replacement therapy and antibiotics and the increased safety and more frequent use of Caesarean section. The result is that the atmosphere is now rightly one of optimism.

The findings of the present series are in consonance with the above statement.

This is not to claim that the grande multipara is the equal physically of the woman of lower parity. The title "grande" is often synonymous with "elderly" and thus any medical disease that might be present, such as hypertension and diabetes, is bound to be more advanced. Repeated pregnancies take their toll in the form of obesity, lordosis, varicose veins and the fatigue associated with caring for a large family. Moreover, she is often in economic straits and her nutrition is correspondingly poor.

The delivery of the grande multipara should on no account be undertaken in the home. The most favourable domiciliary conditions can never provide sufficient safeguard against the complications that are more likely to arise in this particular type of patient. The increased incidence of malpresentations and abruptio placentae and the possibility of uterine rupture

TABLE IV
Showing incidence of complications according to parity.

<table>
<thead>
<tr>
<th></th>
<th>Toxicemia</th>
<th>Abruptio placenta</th>
<th>Placenta previa</th>
<th>Retained placenta</th>
<th>Prematurity</th>
<th>Still-births</th>
<th>Uter. rupture</th>
<th>Cesarean sect.</th>
<th>Maternal mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Para 5</td>
<td>16.9</td>
<td>0.39</td>
<td>0.39</td>
<td>0.39</td>
<td>5.79</td>
<td>2.7</td>
<td>3.47</td>
<td>0</td>
<td>1.54</td>
</tr>
<tr>
<td>259 cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Para 10 or over</td>
<td>23.4</td>
<td>1.5</td>
<td>0.37</td>
<td>1.1</td>
<td>6.04</td>
<td>5.66</td>
<td>6.8</td>
<td>0</td>
<td>6.41</td>
</tr>
<tr>
<td>265 cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 case.</td>
</tr>
</tbody>
</table>

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make it imperative for all facilities for operative intervention and blood transfusion to be near at hand. Only in this way can the maternal risk be held in check.

Summary

A series of 638 grande multiparae is studied. The findings, and those of other authors, show a higher rate than average for certain obstetrical abnormalities such as toxaemia, abruptio placentae, still-birth and malpresentations. The maternal mortality is not appreciably affected.

References


PUBLICATIONS LIST

The following is an incomplete list of scientific publications since 1961 by graduates of our medical and dental schools; we would be glad to add to it in our next issue:


