tion of the broad-based family physician as an appropriate consultant, and patients will benefit as these physician collaborations become more formalized and frequent.

As the reference article[1] and editorial comment[2] conclude, the consultation-referral issue remains unresolved. The resolution seems at least twofold: education and practice based. Must we wait longer?

Loren H. Amundson, MD
Sioux Falls, SD

References

1. Williams PF, Peet G. Differences in values of clinical information: referring physicians versus consulting specialists. J Am Board Fam Pract 1994; 7:292-302.
2. Geyman JP. Communication problems and needs in the consultation and referral process. J Am Board Fam Pract 1994; 7:357-8.
3. Fry J. Hospital referrals: must they go up? Changing patterns over 20 years. Lancet 1971; 2:148.
4. Stephens GG. Consultant, referral, or collaboration? Continuing Educ Fam Physician 1978; 9:17-8.
5. Dolezal JM, Amundson LH, Sinning NJ, et al. Pricare and ambulatory referral. Continuing Educ Fam Physician 1980; 12:84-94.
6. Amundson LH. The family physician as consultant. Continuing Educ Fam Phys 1986; 21:111.
7. Vogt HB, Amundson LH. Family physician consultation/referral patterns. J Am Board Fam Pract 1988; 1:106-11.
8. Amundson LH, Vogt HB. The consultant family physician. J Am Board Fam Pract 1989; 2:34-6.

Full-Term Abdominal Pregnancy

To the Editor: Dr. Old's[1] recent report on successful outcome in a case of abdominal pregnancy (*JABFP* 1994; 7:342-3) brought to mind a previously unreported case that might be of interest to readers even though the details have been lost. In 1958 or 1959 a Native American (Lakota) woman presented at the Pine Ridge Indian Hospital in South Dakota at term in apparent labor. Fetal movement and heart tones were easily detected. The examining physician was easily able to palpate a fetal foot through the anterior vaginal wall in the area between the pubic symphysis and the cervix. Reasoning that this could only occur with uterine rupture or an abdominal pregnancy, and finding the patient's vital signs and appearance quite normal, he arranged for immediate ambulance transfer to the care of an obstetrician 120 miles away in Rapid City, SD. The consultant subsequently reported that the diagnosis of abdominal pregnancy was correct, that surgery was successful with (if memory serves correctly) 7 units of blood transfused, and that mother and baby both survived in good condition. If there is a lesson to be learned from this case, it is that careful clinical examination can sometimes lead to a correct and timely diagnosis in this rare condition.

Robert D. Gillette, MD
Youngstown, Ohio

References

1. Old JL. Full-term abdominal pregnancy: mother and infant survival. J Am Board Fam Pract 1994; 7:342-3.