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 article1 and editorial comment2 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

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Full-Term Abdominal Pregnancy

To the Editor: Dr. Old's recent report on successful outcome in a case of abdominal pregnancy (7ABFP 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

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