such as infection, myocarditis, electrolyte disturbances, or the use of drugs such as digoxin, propanolol, reserpine, or ajmaline.[3,5,6] However, the etiology of CHB in our patients of thyrotoxicosis is unclear as none of the above-mentioned conditions was present nor was there any evidence of other known precipitators of AV conduction disturbance. Further, the quick resolution of conduction abnormality within days bore no relation to the achievement of euthyroid state, which does not usually occur until at least 6-8 weeks of continuous antithyroid drug therapy.[7] Whether AV conduction disturbances can be included as primary disturbances in the spectrum of thyrocardiac disease remains elusive at present.

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Simultaneous bilateral tubal pregnancy after ovulation induction with clomiphene citrate

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Simultaneous bilateral ectopic pregnancy is a rare and difficult to diagnose preoperative condition. The frequency of bilateral ectopic pregnancy has been estimated at 1 in 200,000 uterine pregnancies and from 1/725 to 1/1,580 ectopic pregnancies.[1] We report a case of simultaneous bilateral tubal pregnancy; one ruptured and the other unruptured, following ovulation induction in a 25-year-old Indian woman.

The patient was a gravida-1 para-0, at 9 weeks gestation admitted with acute abdominal pain of 2 hours duration. This pregnancy resulted from ovulation induction with 100 mg of clomiphene citrate followed by intrauterine insemination (IUI). A transvaginal ultrasonogram 3 weeks after IUI showed a small intrauterine gestational sac without fetal pole. Her first pregnancy was a right-sided tubal pregnancy, which was also a result of ovulation induction with clomiphene citrate. She was treated with laparoscopic methotrexate (MTX) injection. This was 3 years ago. Clinical examination on admission revealed pallor and lower abdominal tenderness with stable vital signs. Vaginal examination showed tenderness on both fornices and cervical excitation. Transvaginal sonography revealed a small intrauterine gestational sac without fetal pole, a complex mass in the right adnexa and free fluid in the pouch of Douglas. Diagnostic laparoscopy followed by laparotomy and dilatation and curettage (D&C) was performed immediately. We have found 100 cc of fresh blood and some clots in the peritoneal cavity. Right tube showed a large hematosalpinx, friable and adherent to the ovary. Left tube showed a 2 cm unruptured ampullary ectopic. Right salpingectomy and left linear salpingostomy were carried out. Moderate amount of curetting was obtained on D&C. Histopathological examination identified chorionic villi in each tube, thus, confirming the presence of a bilateral tubal pregnancy and secretory endometrium with decidual changes in the endometrial curetting. The postoperative course was unremarkable and the patient was discharged on day 5 after the operation.

Bilateral tubal pregnancies and other unusual forms of ectopic gestations are seen more often today, as part of the rising incidence of ectopic

pregnancy in general and due to the increasing use of assisted conception techniques.[2] They are clinically not different from the more common unilateral presentations and, during an operation one side may easily be overlooked due to difference in size of tubal distension. Awareness, clinical vigilance and meticulous inspection of both adnexa at laparoscopy or laparotomy are therefore required so as not to miss the diagnosis.[2] Mock et al[3] has described the successful management of spontaneous bilateral tubal pregnancy by ultrasound-guided in situ injection of MTX 1 mg/kg into each fallopian tube, although systemic injection of 1 mg/m^2, the recommended dose for unilateral ectopic pregnancy usually fails. Laparoscopy remains the cornerstone of diagnosis and treatment in the majority of women with tubal pregnancy. Conservative surgery, laparoscopic bilateral tubal salpingostomy without suturing the tubal incisions are recommended by many authors as it provide better long-term results in terms of tubal patency and adhesion prevention.[4]

Our case was initially misdiagnosed as intrauterine pregnancy, and a diagnosis of ruptured right tubal pregnancy was made only after she was admitted with acute abdominal pain. Careful inspection at surgery revealed a smaller unruptured left tubal pregnancy as reported by De Graaf et al.[2] We report this case to demonstrate the need for careful ultrasonographic assessment of both fallopian tubes in high-risk cases before surgery and the importance of thorough evaluation of the whole pelvis during surgery for bilateral ectopic pregnancy.

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Voluntary seatbelt usage. *Did we reach there yet?*

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Some of these guys drive like maniacs trying to out do one another, so make sure that you have your seatbelt on at all times, is the advice given to all foreign visitors in the Kingdom of Saudi Arabia (KSA).[1] Not surprisingly, KSA loses over 21 billion Saudi Riyals annually due to sharp increase in road traffic accidents.[2] Road traffic accidents are a major cause of morbidity and mortality among young Saudis and plenty of studies in the Kingdom stand witness to this unfortunate truth.[3,4]

Seatbelts were first introduced in 1920 in the United States of America (USA), to keep the occupants in the cars from bumpy rides. By 1970, it was realized that seatbelt restraints protected the driver and the occupants from the severity of injuries. Legislation was then passed for mandatory use. The presence of cars' seatbelt does not mean that the occupants will use it. Seatbelt usage exceeds over 90% in some European countries and in USA up to 86%.[5] The western countries have reached this compliance due to legislation, health education and fines for non users. The objective of this study was to carry out an unobtrusive observation on seatbelt use at 6 different centers in Dhahran and Al-Khobar, KSA and to assess the compliance of seatbelt usage by people who are in the drivers seat at various locations. Six hundred drivers were unobtrusively observed by the investigators. The locations were: entry and exit gate of Saudi Aramco, King Fahd University of Petroleum and Minerals (KFUPM), Dhahran, first traffic light on entry into Al-Khobar, the end of Dammam-Al-Khobar highway, Al-Khobar Corniche, entry and exit gate of King Fahd Hospital of the University (KFHU) and entry of Al-Rashed Mall in Al-Khobar. The study was made 3 times weekly, each time, the driver of the third car at the location is the one observed, until the required number was achieved. The percentage of seatbelt users differed at different locations. The voluntary usage of seatbelts ranged from 17-100% with a mean of 56.8%. At Saudi Aramco, the seatbelt usage was 100% while 98% in KFUPM. At these 2 locations the prevalence was highest due to regular checks and penalties levied by the organizations. At other locations the mean usage was 35.75% (range 17-49%) with no checkpoints nor penalties if caught in these 2 locations. **Table 1** gives the voluntary usage of seatbelts and their