ample, the recognition of pregnancy may be quite impossible in the first three months. The same thing may be true, at least in the second month, from other conditions of the uterus which retard the usual changes of density.

Among the morbid conditions which simulate utero-gestation, especially in the second month, are chronic metritis, subinvolution, fluid accumulation in the uterus (hæmatometra or hydrometra), a flexed and hyperæmic uterus, a soft submucous fibroid.

In general, pathological growths are distinguished from gestation by the absence, for the most part, of the signs of pregnancy and by the presence of the signs of disease; moreover, the rate of the growth in pregnancy is unlike that of any other pelvic tumor, and in neoplasms of other organs than the uterus, the latter may be differentiated from the tumor by the touch.

Chronic metritis and subinvolution are distinguished by greater density. Fluid accumulations present the characters of a tense cyst. A uterus containing a soft submucous fibroid may usually be easily differentiated from that of gestation by the history. The same is true of a flexed and hyperæmic uterus. The physical signs in the latter case are frequently misleading, especially the softening and thinning at the point of flexion, but there is a notable absence of the normal elasticity of the tissues. It may be remarked here that the gravid uterus of the early months is by some writers described as doughy. This, I think, is a mistake; resiliency or elasticity is a notable characteristic of the uterus of gestation, so long as the ovum is living.

It will be observed that the morbid conditions which may mislead are not so commonly to be expected in first pregnancies. The diagnosis is less difficult, therefore, in women pregnant for the first time, and in healthy primiparæ may be positively established in every case by the sixth or eighth week, frequently at a still earlier period.

Ectopic Pregnancy.—The possibility of diagnosis in ectopic pregnancy has been the subject of much acrimonious discussion. Great difference of opinion prevails.

It is now generally conceded that with very rare exceptions, all ectopic pregnancies are primarily tubal. The major part of them are seated in the free portion of the tube. Pregnancy in the free portion of the tube ruptures before the fourteenth week—in many cases during the second month. The signs on which we must rely, therefore, for the diagnosis of pregnancy before rupture, when the pregnancy is ectopic, include only those of the first three months. Usually only a portion of these are available, since the majority of cases rupture some weeks before the end of the third month. Furthermore, the uterine signs of normal gestation are not all present in ectopic, and those which are found in misplaced pregnancy are not so fully developed as in normal cases at the same stage. Moreover, the occurrence of extra-uterine pregnancy always implies the existence of more or less pelvic disease, and the pathological conditions which have brought about the ectopic fœtation in greater or less degree embarrass the diagnosis. Similiar complications are comparatively rare in normal gestation.

Tubo-uterine pregnancy, pregnancy in the intra-mural portion of the tube, is more difficult of recognition than that which takes place in the free part of the tube, and for these reasons: If the ovum lodges at the inner end of the oviduct, close to the cavity of the uterus, the enlargement of the uterus is nearly symmetrical, and before rupture differentiation from ordinary pregnancy is extremely difficult or impossible. If the fruit sac is located in the outer segment of the intra-mural portion of the tube, that is, just within the wall of the uterus, at the cornu, the case is difficult to distinguish from pregnancy in the rudimentary horn of a double uterus. Yet in the latter case the distinction is not important, since the treatment is much the same in both.

It must be granted that in extra-uterine fœtation certain additional signs are engrafted upon those of normal pregnancy, but they are usually more or less masked by the results of pelvic disease. Again, it must not be forgotten that in a large proportion of cases the opportunity for diagnosis never presents before rupture.

After rupture, particularly if much hemorrhage has taken place, failure to recognize the state of affairs is rarely excusable. With a patient, however, who has suffered habitually from dysmenorrhœal pains and in whom the