Now we come to a time when every one is supposed to be able to make an early diagnosis. Formerly, we were prone to mistake cases of ectopic gestation, with tubal rupture, for pelvic hæmatocele, just as now we doubtless sometimes overlook the fact that we may have pelvic hæmatocele which depends for its origin on causes other than ruptured ectopic pregnancy. On looking over one of my old case books I find a case on record which appears worthy of mention in this connection.

Feb. 4th, 1884. Mrs. T. D.—Age thirty-seven years, and healthy up to the time of writing. Nine years ago she had one child, but since that time had menstruated regularly. On February 4th, 1884, she complained of indigestion with pain and weight in the pelvis. At her last menstruation she did not notice anything unusual, except that the discharge was rather scanty. Two days later, whilst still menstruating and going about her usual light household duties in her regular way, she was suddenly seized with acute agonizing pain in the pelvic region; she turned cold and pale, and exhibited the symptoms of extreme shock with loss of blood. She was put to bed, and relieved under opiates. Subsequent bimanual examination revealed a hard mass reaching nearly to the umbilicus and filling the pouch of Douglas. Febrile symptoms supervened, and a soft spot developed. I opened from below, draining out the fluid blood and scraping out the blood clots, which were easily broken down by the finger, and washed out with antiseptic fluid, and drained.

The treatment was tedious, but perfect recovery took place; and, about three months after operation, an examination revealed the uterus still somewhat enlarged, with a small hard substance remaining in Douglas' pouch. In April of this year I saw the woman, who has passed the menopause, is well and has not had any pelvic symptoms since 1884. I have condensed these extracts from my notes, and have not much comment to make on the case. If, however, it were to happen in my practice at the present time, the hæmorrhage having ceased, I would probably adopt a somewhat similar line of treatment, but would make the opening larger, in order that the clearing out of the pelvis might be more complete and the drainage more free.

Though neither the scope of this paper nor the time allowed for its presentation would permit of any lengthy digression into the realms of anatomy, physiology, or pathology, yet there are some points on which we may well spend a few moments.

The Fallopian tubes, as you know, are from four to four-and-a-half inches long, pass sinuously outwards from the upper angles of the uterus towards the sides of the pelvis, and are enclosed in the upper free margins of the broad ligaments. They may be dealt with for convenience of description in three parts: The isthmus, that narrow, straight portion