which, in degree of development, as indicated by the clinical history and the size of the cyst, lies midway between the two specimens in Guy's Hospital.

*London Hospital.*—The two examples in the museum of that institution are immortalised in the late Dr. Ramsbotham's 'Principles and Practice of Obstetric Medicine and Surgery.' Unfortunately, neither specimens show the relations of the tubes, uterus and cyst intelligible. In E*h* 24 "the bones of a fœtus, probably near full time, are seen lodged in a sac behind the uterus; they are as clean as if macerated." "A portion of one of the long bones," says Dr. Ramsbotham, "protruded from the cyst into the cavity of the colon." The further account of the dissection, in that author's work, not quoted in the catalogue, leaves little doubt that the cyst which "occupied the right side of the uterine walls" is truly tubo-uterine. Had the cyst been in the free part of the tube, no matting together of the parts, by adhesions could have forced it into the uterine walls, but it is unfortunate that the relations of the right Fallopian tube cannot be seen. The specimen might, however, be an example of a hernial pouch in the uterus, such as Dr. Roper has described; to this question I shall presently return.

E*h* 105 is "a shrivelled fœtus of about four months which has escaped through a laceration in the uterine wall, in a case of parietal gestation." The cyst and uterus are included in the specimen. Dr. Ramsbotham most truly observes that the preparation does not display the peculiarities of the case well "having been taken from the body hurriedly and at great disadvantage." By the courtesy of Dr. F. C. Turner I have been enabled to examine this specimen very closely. The lower part of the cervix with the os externum has been cut away, the uterus has been laid open from the fundus to close above the cervix. The cyst has been completely severed from the uterus and sewn on to it by threads passed through their serous lining only. It has no aperture excepting the rent through which the fœtus escaped, but, on close scrutiny, the edges of the lower part of this aperture are found to be uterine tissue, cut artificially in dissection. Moreover, the tube and the ovarian ligament proceed from the outer aspect of the cyst, precisely as from a uterus; the ligament of the ovary never springs from a true tubal cyst in this manner. The whole aspect of the cyst, from outside, is like the uterus from which it has been severed, and its walls are of pure uterine tissue. Dr. Ramsbotham's description of the dissection leaves little doubt of the true nature of the specimen; the cyst was "formed within the walls of the uterus," and "one tube was attached to the cyst." The same author figures Breschet's case which bears all the appearance of being tubo-uterine.

The museum of *University College* possesses one specimen (35-43) labelled "A case of extra-uterine fœtation in the substance of the uterus,* close to the end of the Fallopian tube. Rupture of the ovum at seventh week, hæmorrhage and death in twenty-four hours." The manuscript catalogue describes the specimen as having been taken from the body of a young woman, and the rupture of the cyst was clearly caused by violent exercise. This specimen is well prepared, the cyst is not half an inch in diameter, being smaller than in the specimen $2517^{65}$ at Guy's Hospital. There can be no doubt that the cyst is here a dilatation of the part of the tube that passes through the uterine walls, a bristle has been introduced through the tube into the uterus, and it traverses the cyst, concealed by the chorion which lines the inner aspect of that abnormal cavity. The uterus possesses a decidua.

Thus, including the preparation from Mr. Roberts' case there appear to be six examples of so-called interstitial fœtation mounted as pathological specimens in London museums. It is most significant that, in all the four where the condition of the affected parts has been intelligibly displayed, the tubal origin of the "interstitial cyst" is self evident.

These notes are intended to be strictly pathological, still they suggest certain obstetrical considerations. "Interstitial" or tubo-uterine pregnancy is a rare accident, as our London museums prove, for practitioners are never backward in presenting to such collections specimens of extra-uterine gestation, and the numerical richness of a series is facilitated by the fact that sudden death is so frequent an ending of this abnormality of gestation that a necropsy is generally allowed, or even enforced by a coroner. Hence we see a goodly

* Dr. Barnes would be thoroughly justified in the use of his term "ectopic gestation" in such a case as this, where the older term reads as an absurdity see 'Trans. Obst Soc.,' vol. xxiii., p. 94), but space prevents me from entering into questions of synonyms.