initiated, secondary intra-uterine pregnancy. This classification seems to be largely theoretical, as I am unable to find any positive demonstration of its ever having taken place. The only rupture that is known to have taken place is into the abdomen. Because of the thicker wall and the greater vascularity of the sac, intra-peritoneal rupture is usually more rapidly fatal in this variety than in the ordinary tubal pregnancy. Taylor says: "Hitherto this has always proved fatal in a very few hours." This form of pregnancy is apt to be confounded with pregnancy of the rudimentary horn. The diagnosis is said to be exceedingly difficult, if not impossible, previous to opening the abdominal cavity.

Symptoms.—When speaking of early rupture of tubal pregnancy, I anticipated some of the remarks on this part of the subject by pointing out the difficulties that lie in the road to making a diagnosis, owing to the absence of many, if not of all, the classical symptoms generally enumerated. In early rupture—the most fatal form if we take frequency into consideration when comparing it with interstitial pregnancy—there will likely be no pelvic or abdominal signs of definite importance. Very rarely is there any evidence to be obtained from the condition of the breasts. Often the earliest and only symptom is sudden abdominal pain, confined for the most part to one or other iliac region, and associated with symptoms of shock and hemorrhage.

While many cases are of this sudden and wholly unexpected type, a large proportion of ectopic gestations have well-defined symptoms, if carefully and diligently sought for. There are three links in the chain of symptoms which should receive the most earnest consideration, and which I think if properly followed up will aid in no small degree in arriving at an early diagnosis. They are:

1. The pre-pregnant history.
2. The menstrual history.
3. Uterine hemorrhage and the nature of it.

1. *The pre-pregnant history.*—In a large proportion of cases there is a history of several years having elapsed since the last pregnancy, or the patient has been married a number of years without conception. In a moderate proportion of such cases there accompanies this history one of pelvic disturbances, it may be simply of dysmenorrhea in some form; or it may be of a more serious or constant type, pointing to tubal or ovarian inflammatory disease. But whether one or both of these be present, a point that may often be elicited is that for a short time at least there has been a lull in these symptoms, the patient expressing herself as feeling better for some time past than she has perhaps for years before. This point is well to remember, for it will aid materially in making a differential diagnosis, in that there is a history of