The pain was referred to the symphysis and a little above it. Thinking it might be owing to an overdistended bladder, I passed a catheter, but very little urine passed. The patient, though possessed of great fortitude, was now continually yelling, her face began to turn white, her pulse became weak and *infrequent*, and she was on the point of fainting. A quarter of a grain of morphia seemed to give no relief. Hot applications were applied before I came. They increased her suffering and were discontinued. I ordered ice and telephoned for assistance. Dr. Black was out, and Dr. Stewart was then called upon. Relating the history of the case to him on the way, he remarked that it was exactly the history of an extra-uterine pregnancy. The patient was now in less pain; the ice had relieved her, and a slight vaginal flow appeared. The os was found soft and dilating. The symptoms now pointed to an abortion. There were no symptoms pointing to internal hæmorrhage, and it was decided to wait. The pains became paroxysmal. Three hours after this I examined and found the vagina filled with a tense sac about the size of a goose egg, perhaps smaller. It was attached to something presenting at the os. I left it till next morning, in hopes that it would all come away. It did not, and I was under the necessity of rupturing it to get at the decidua in the cervix. The sac was found filled with blood clot and red liquid. The clot was arranged concentrically around the sac wall, to which it was fixed firmly. It was harder, darker and more resistant at its circumference, softer and getting more red looking towards the centre, where there was a cavity filled with liquid blood, or serum or amniotic fluid stained red. I saw no embryo. The decidual membrane presented nothing abnormal to the naked eye. There was no microscopical examination.

The woman made a fairly good recovery, but the pelvic pain which radiated down the thighs persisted. I was therefore uneasy lest the pregnancy might have been complicated with ectopic gestation. But under choloroform neither Dr. Stewart nor myself could discern anything abnormal, save the globular mass before referred to, and even that had considerably diminished in size.

The case is interesting as an illustration of the difficulties of diagnosis between recurring intra-uterine hæmorrhage and rupture or abortion of the sac in a gravid tube. The symptoms of ectopic gestation with rupture and abortion, which were absent in her case, were those of severe hæmorrhage and a tumor or marked thickening of the tube. But the latter may be hard to detect, especially if the ovum be fixed in or near the fimbriated extremity, or if the tube be so thin walled as to permit of an early rupture. Then if the sac rupture into the broad ligament, the amount of hæmorrhage may exceptionally be very small.

I can offer no explanation of peritonitis accompanying or following intra-uterine hæmorrhage. I think the hæmorrhage must have been the result of degenerative changes in the decidua. The placenta is not formed before the third month, and the condition therefore was not what is known as apoplexy of the placenta. The sac surrounding the clot must have been a distended portion of the amnion.