unchecked until death occurs, or until surgical interference arrests it; while in the latter case conditions favorable to coagulation obtain, and hæmorrhage is less likely to prove fatal. In the former case the blood is so diffused as to give very uncertain physicial signs of its presence; in the latter case the blood is clotted, circumscribed, and can be recognized as a distinctly defined tumor; in the former the ovum always dies, in the latter it generally dies at the time of rupture.

Success in treatment will depend upon correct diagnosis before rupture takes place, and I believe most cases can be made out pretty certainly before that accident happens, if sufficient care be exercised in the investigation. Physicians see comparatively few of these cases, and the subjective symptoms not being very characteristic, it is not surprising that so many go on to a fatal end without a serious effort to solve the difficulty. Irregular menstruation and pelvic pain are the most common subjective symptoms, but these pertain to women so commonly that one is led to prescribe without a physical examination being thought necessary, and in the meantime, while we are waiting for our drugs to set matters aright, our patient is approaching a catastrophe that has no parallel in life. He who would be right in these cases must be willing to bring all care and thoughtfulness to bear on them, and must not be satisfied with a few superficial questions and a haphazard prescription. The subjective symptoms are usually well enough marked to direct attention to the possible affection, and should lead to a thorough physical examination when the true condition may become known. Pain is not confined to the place of fœtal development, but may be felt most severely about the rectum or along the nerves of the thigh. In one of my cases the first complaint was a severe pain extending from the kidney to the iliac fossa, and it gave me the idea that it was due to the passage of a renal calculus. When the growth of the fœtal mass has become sufficient to cause pain, there is usually a good deal of tenderness there on pressure, and this may interfere somewhat with the examination, but even with considerable tenderness, an enlargement may generally be felt by palpation in the region of the distending tube externally. There can be felt, per vaginam, an enlargement at one side of the uterus, and a bulging downwards of Douglas' *cul de sac*, the whole enlargement conveying a sensation of bogginess, not having the hardness of a fibroid, nor the softness of an abscess or a cyst. The uterus is somewhat enlarged, pushed to the opposite side, and the cervix is often crowded upwards behind the pubic bones.

As growth goes on, these physical changes become more marked, symptoms due to pressure are more distressing, pains become paroxysmal, blood may flow from the uterus, the whole or portions of the decidua may be discharged. Rupture usually occurs between the tenth and fourteenth week in the more common form of extra-uterine fœtation, and the symptoms then are truly appalling.

The patient is suddenly siezed with violent pain in the abdomen, she becomes pale and cold, an indescribable look of anxiety and distress marks her countenance, her pulse fails, and she is evidently in the very jaws of death before her terrified friends can summon aid. If she survive the shock and the hæmorrhage, she slowly rallies after some hours, and the subsequent progress of the case will depend on circumstances. If the fœtus die it may become absorbed, or may be converted in a lithopedium, or the bones may undergo a change by saponification into adipocere. Fatal peritonitis may supervene, or an abscess may form and discharge externally. If the fœtus live, it may go on to full term, or a repetition of the collapse may occur from a fresh rupture, and another hæmorrhage.

It is stated by writers that patients usually think themselves pregnant, but not one of those under my care could be convinced that she was so, and I feel doubtful if a patient's statements in this respect are of much value from a diagnostic point of view. Having, by direct means, reached the conclusion that ectopic gestation exists, the diagnosis may be more thoroughly established by indirect means. It is often easier to decide what a thing is not than to tell what it is, and by a process of exclusion, we may eliminate all, or nearly all, of the conditions that resemble this, and so fortify our position, and facilitate the subsequent management of the case. Ovarian, parovarian and fibroid tumors