hemorrhage or suppuration of ruptured sac and peritonitis;

Or into broad ligament extra-peritoneal gestation; when it may develop in broad ligament to full term and be removed at viable period as a living child;

Or may die and be absorbed as extra-peritoneal hæmatocele;

Or may die, and the suppurating sac discharged at or near the umbilicus, or through the umbilicus, or through the bladder, vagina or intestinal tract;

Or may remain quiescent as a lithopædian;

Or may become abdominal intra-peritoneal by secondary rupture.

III. *Tubo-uterine or Interstitial*—Is contained in that part of the tube embraced by the uterine tissue, and so far as known is uniformly fatal by intra-peritoneal rupture before the 5th month.

Of these, by far the most common form is the tubal. All agree that the majority of cases are primarily tubal.

Causes—Are stricture of the tube due to lessening of its calibre by old inflammation or by contraction of lymph thrown out by pelvic peritonitis and flexions of the tubes.

Tait gives us "desquamative salpingitis" as a cause; here, catarrh of the mucous membrane leads to loss of cilia, and allows of the implantation of the impregnated ovum on the surface of the denuded tube.

Lusk gives as a cause "dilatations with hernial pouches due to protrusions of mucous membranes through the separate bundles of muscle fibres of the tube."

The Diagnosis.—Cases proved by abdominal section or post-mortem show that diagnoses have been made before rupture, but it is rarely done, and in any case can only be presumptive, because the same symptoms are present in cases of "retroflexed gravid uterus," in "ovarian cyst," "uterine fibroid," "hematosalpinx," or pregnancy in the rudimentary horn of a bicornate uterus. All these conditions, at different times, have been diagnosed as extra-uterine pregnancy.

Want of diagnostic skill may by some be assigned as the cause of mistaken diagnosis. Such cannot be charged against Dr. Mann of Buffalo. Yet Dr. Mann diagnosed a case as one of extra-uterine pregnancy, and, as he supposed, killed the embryo by electricity. That same case, a short time afterwards, fell into the hands of Dr. Wylie of New York, who operated and found a large purulent sac containing a pint or more of fluid, but nowhere any trace of an extra-uterine pregnancy ever having been present.

Dr. Mundé diagnosed a case as one of extra-uterine pregnancy, and operated, only to find a normal pregnancy in the rudimentary horn of a bicornate uterus. This mistake in diagnosis would surely not be attributed to want of diagnostic skill on Dr. Mundé's part.

From the nature of things, most cases rarely come under observation before the period of rupture, because there are seldom symptoms, or, if any, not alarming enough to lead the patient to seek medical aid.

The symptoms of the period prior to rupture are indefinite and indistinct, as best given by Dr. Joseph Price, and are:

I. As partial or complete cessation of menstruation for one or more periods, generally accompanied by other rational symptoms of pregnancy, though occasionally all these are wanting.

II. Pain which is peculiar, being generally severe, paroxysmal and long continued; a *sickening* pelvic pain which is neither cramp-like nor colicky, though it is often described by these terms; these pains, probably caused by distension of the tube, are apt to subside for a time, only to recur again.

III. The appearance of uterine hemorrhage which is again peculiar, in that it is usually irregular both as to time and quantity, generally lighter in color than the normal discharge, and contains shreds of tissue which are portions of decidua vera.

Physical examination further shows the uterus slightly enlarged, cervix soft and patulous, and to either side and slightly behind is found a painful mass.

Histories are not to be relied upon in making a diagnosis in extra-uterine pregnancy before rupture. It is only after repeated examination and watching the enlargement of the tumor that we can even make a presumptive diagnosis. There is one point, however, in the history of most cases that should be of some assistance—that is, there has been a long period of sterility either with no former pregnancy or following one or more confinements. Parry says: "Women who have become pregnant with the child outside the uterine cavity frequently show a previous inaptitude for conception. If the woman has borne children, a period of sterility frequently precedes the extra-uterine pregnancy." This was the case with my patient; she had already borne children, and then did not become pregnant for nearly ten years; during which time she suffered with continuous pelvic trouble.

Now, a *diagnosis of extra-uterine pregnancy* having been made, how are we to treat the case for the best interests of the patient? If diagnosis be correct, and the tumor left undisturbed, it will continue developing until about 12th week, when rupture takes place, which in the majority of cases means death to the mother, unless relieved by operation. Of 149 cases of intra-peritoneal rupture reported by Parry, 145 proved fatal.

Reading the mass of literature on this sub-