Where the fertilized ovum is arrested and undergoes development in that portion of the tube which passes through the uterine wall, we have what is termed interstitial or tubo-uterine gestation. This differs from the more common and true tubal variety in that, instead of thinning of the sac, there is thickening of that portion which extends into and involves the wall of the uterus itself; and thus we have an explanation of the fact that, in the true tubal variety, we have rupture taking place usually between the eighth and twelfth weeks, whilst in the interstitial variety it may be delayed much longer.

The sac of the tubo-uterine gestation may rupture in two days, either it may burst into the uterus and so terminate along natural channels, or it may rupture into the peritoneal cavity when, if left alone, it is apt to prove rapidly fatal. We are reminded that in these cases the sac does not rupture into the mesometrium. (Sutton.)

When rupture takes place the placenta may remain within a cornu of the uterus, and the fœtus in the tube; or, if the placenta is not expelled at the time of rupture, it may remain in the tube whilst the fœtus is developed in the peritoneal cavity; or, both fœtus and placenta being expelled, the latter becomes attached to any contiguous part or organ, and continues to grow and develop, producing its train of untoward complications. The ovum in these cases finds its favorite resting place in the pouch of Douglas, and it is under these circumstances that we find the uterus enlarged and pushed upwards and forwards. Though uterine enlargement takes place, there is nothing within it, but there is usually a sanguinious shreddy discharge.

In a classification of 77 cases, A. Martin gives 48 as of the ampullar variety, and 8 isthmal, the remaining 21 cases were divided up between interstitial, intraligamentary, tubo-ovarian, ovarian, and undetermined. Howard Kelly states that in his experience rupture within the folds of the broad ligament, with intraligamentary subperitoneo-pelvic development, is rare. Such cases are difficult to differentiate from those of pseudo-ligamentary tumors. In the former cases, however, the ovary remains on the surface of the tumor, though it is flattened and drawn up.

The clinical history of the fertilized ovum is somewhat difficult to describe, as cases vary with position and with individual peculiarity. The early symptoms resemble those of ordinary pregnancy, but as time goes on the tumor that is developed is found on one side of the uterus, it is painful, sensitive to the touch, and has a peculiar, semi-elastic feeling that is somewhat characteristic. It can be readily felt and distinguished from the enlarged uterus beside and towards its inner side. As well as the pain of a dull character, there are sharp attacks of severe pain, and often a sanguinolent shreddy discharge. Where rupture takes