probable. Sometimes rupture of the tube may occur so early as to lead to a fatal result before any suspicion of pregnancy is entertained by either the patient or the physician. Such a case occurred in the practice of the late Dr. Shaver, of Blenheim. The patient had menstruated in a normal way a month before her death. Dr. Shaver was called in the night, a distance of four miles, to see this woman, and found her in great pain about the pelvis and lower part of the abdomen. The attack had come on very suddenly while she was in bed; she was pale and clammy, and her pulse weak and frequent. A hypodermic dose of morphine relieved the pain and the doctor left her feeling more comfortable. He was called again soon after he reached home, and recognizing the gravity of the case took Dr. Langford with him. The patient was dead when they arrived. The autopsy showed a small ruptured sac in the upper part of the tube near the uterus, and a very large quantity of blood free in the abdominal cavity. Dr. Shaver sent the specimen to me and I submitted it to Dr. A. B. MacCallum, of Toronto, who reported that examination showed what seemed to be placental tissue in the ruptured sac. In such a case it is almost certain that the most careful physical examination would prove negative, and no treatment other than opening the abdomen and securing the vessels would avail. The question of vital importance in ectopic gestation is early diagnosis, and I shall point out what has sufficed to aid me so much in this. In every case I have seen, pain has been the initial symptom, and in every case examination has revealed the following: Pain came on suddenly. In one case it seemed in the kidney and along the ureter and was like the pain of renal colic. In every case there was more or less shock, and fear of impending death. In two cases this fear was so marked as to amount to absolute terror. A menstrual period had been missed in each case, then the flow had returned at one or more irregular intervals, and had been accompanied by unusual pain of an intermittent kind. In three of the cases decidual membrane had been passed. Physical examination showed (1) The cervix softened like that of a pregnant woman, and the vagina and cervix of a bluish color. (2) Cervix not in the median line but pushed to one side. (3) A tumor in the region of the broad ligament, and, if the pregnancy be advanced two months or more, occupying Douglas' sac. (4) A history of former uterine or tubal disease is usual. (5) Irregular flow of blood from genital tract and discharge of decidual membrane. Of the five cases one died from rupture and hæmorrhage before anything could be done. One came under my care two years after the pregnancy, but she gave such a vivid account of her sickness at that time that I expressed to her my belief that it had been an ectopic pregnancy, and that the fetus had died at that time. Next day, while sitting on the chamber vessel, quite a mass of macerated fetal bones was passed, but she was unable to tell whether they came from the rectum or from the vagina. I herewith present some of the material which, as you will see, resembles cranal bones which have undergone change into adipocere. This woman recovered. One case, the first I had recognized, was operated on by Dr. Donald McLean, of Detroit, whom I called in for that purpose. Although the operation was very quickly and skilfully done, the woman died from shock fourteen hours after. The fourth case I correctly diagnosed when she was six weeks pregnant, but operation was refused and other advice sought. Seven weeks later the sac ruptured into the peritoneal cavity, and I was asked to see the woman and to operate. A very large quantity of blood was free in the abdominal cavity, but the bleeding had been arrested, apparently on account of the weak heart and the resulting low blood pressure. There were extensive adhesions, but these were easily separated and the patient got well. I