not occur so early as in the tubal variety, on account of the greater thickness of the walls surrounding the gestation sac. Rupture occurs most frequently into the abdominal cavity, and in such cases the hemorrhage is profuse.

Diagnosis.—The history carefully reviewed often directs attention strongly toward ectopic gestation. To summarize briefly, it may be said that the diagnosis depends upon the following cardinal points :—

1. A history of probable pregnancy.
2. Paroxysmal pains, usually located at one or other side of the pelvis.
3. Irregular metrostaxis.
4. The expulsion of bits of decidua.
5. Considerable enlargement of the uterus and softening of the cervix, with discoloration of the vagina.
6. Tumor, lateral or posterior to the uterus, and indirectly connected with it. Uterus moderately, or not at all, enlarged.
7. Changes in the breast.
8. Anaemia.

Treatment.—I. Before rupture one of two courses are open to us ; either foeticide or abdominal section and removal of the gestation cyst. The foeticide means which have been adopted are :—

(a) Evacuation of the liquor amnii.

(b) Injection of solution of atropine, strychnine or morphine into the sac.

(c) Electricity.

This treatment, which may have been valuable in its day, has deservedly fallen into disrepute. The proper course to pursue is the removal of the affected tube.

II. At the Time of Rupture.—Immediate examination should be made to discover, if possible, whether the rupture has occurred into the broad ligament, or is intra-peritoneal. If into the broad ligament, a lateral tumor mass closely connected with the uterus will be detected. This mass, if circumscribed and fluctuating—shows the cul-de-sac to be free from fluid. In such a case the method of treatment is an expectant one, the possibility being that the hemorrhage will soon cease, if it has not already done so, and that the patient will recover, leaving a haematocile to be dealt with after, if necessary.

If examination reveals free fluid in the cul-de-sac, and there are no signs of improvement in the patient's condition, the natural inference is that the rupture is intra-peritoneal, and an immediate operation is indicated, as every moment detracts from the chances of recovery.

During the last four months I have met with and treated two cases of extra-uterine gestation, which will serve to illustrate the foregoing.

Case I.—Mrs. X—— ; aged 25 ; married three years ; no children ; no miscarriages ; menstruation regular and without pains until the beginning of the present trouble. Strong, healthy, active woman. Last menstruation on Nov. 15th, 1896. After this quite well until afternoon of Dec. 23rd, when she was seized with cramps in lower part of the abdomen. Went to bed for two days, and then appeared to be quite well again. On January 1st, 1897, had more violent pains in lower abdomen, but rest again seemed to give relief to the symptoms. On January 12th the cramps returned, coming and going for about twenty-four hours. There was no discharge from the vagina during any of the attacks. On vaginal examination, the cervix was found thrown forward against the anterior vaginal wall ; the body of the uterus was retroverted, enlarged and unusually hard, suggesting the probability of a small fibroid. There was no tenderness on examination, and no bulging of the upper part of the vagina, except that due to the misplaced womb. I had her removed to the Winnipeg General Hospital, and on January 18th operated. As soon as the peritoneum was opened dark blood-stained fluid exuded through the wound, and was followed by clots which had been floating loose in the abdomen. An examination of the pelvis showed a large collection of clots behind the uterus and broad ligaments. When these were removed, an unusual hooded arrangement of the right broad ligament was observed, as if Nature had attempted to wall in the exuded