near the uterus, the lumen of which will hardly admit a bristle; the ampulla, that larger, curved portion with a lumen large enough readily to admit an ordinary uterine sound; and the free funnel-shaped end of the tube, with fimbriæ converging towards its opening, one fimbria being attached to the ovary, acting as a guide for the ovum after it has been cast off from the Graafian follicle.

Section across a tube reveals the peritoneal layer, with a connective tissue and elastic fibre layer lying between it and the muscular layer. Then the mucous membrane lined with its ciliated columnar epithelium. No glands exist in the mucous membrane, though Bland Sutton asserted that the rugous mucous membrane had a glandular albuminous secretion, which served to cover the ovum in its passage along the tube. We remember that there is a direct communication through the vagina, uterus and tubes to the peritoneal cavity, which accounts for some of the pathological changes that may take place in this locality.

Ovarian pregnancy seems hardly possible, and yet we can understand how, with the fimbriated extremity of the tube in close proximity to the ovary, and, perhaps, even adherent in such a way as to cover completely, or partly, one or more Graafian follicles, on rupture, impregnation of the ovum *in situ* might result.

Opinions have varied as to the possibility of primary abdominal pregnancy. The view has been taken that the peritoneum would prove inimical to the life of the spermatozoa, but we cannot ignore well authenticated and indisputable facts. We have cases recorded where impregnation has taken place through artificial abnormal orifices in the uterus. Where one tube being occluded, pregnancy took place by migration of the spermatozoa through the sound to the diseased side. H. C. Coe and J. W. Williams have described one case where the left tube was the seat of two successive extra uterine pregnancies, one taking place twelve years before the other. Howard Kelly mentions a case in which, after he had removed a diseased tube on one side and a diseased ovary on the other, pregnancy occurred within a short time and the patient was delivered at term. At a later date an extra uterine pregnancy took place, and he was obliged to remove the remaining tube. We must, then, admit not only the power of migration of the spermatozoa, but the possibility of the external migration of the fertilized ovum.

Practically, however, ectopic gestation usually means primarily tubal pregnancy, which we will refer to under three heads:—

First. The tubal variety in which impregnation takes place in that portion of the tube lying between the uterus and the fimbriated extremity.

Second. The tubo-ovarian variety, where impregnation takes place in the outer end of the tube, or between it and the ovary.