most stress on No. 3. The absence of cil. epith. from the tube due to a desquamative salpingitis.

Frequency.—In arriving at a probable conclusion as to the frequency of ectopic pregnancy, it must be remembered, as the late Matthews Duncan said: "There are many cases in which the disease is never suspected, and the foetus dies, and is, so to speak, entombed." Or, there may be hemorrhage into the tube, which, in part with the ovum, finds its way into the abdomen, while the embryo is quickly absorbed. So, too, in tubal abortion in the first week, the developing ovum occupying a place near the pavillion, may be expelled into the abdominal cavity by the contraction of the oviduct. It is quite probable the expulsion may occur without any serious symptoms, and the patient recover. Taking all these into consideration, Farvin states that there is probably one case of ectopic pregnancy in five hundred of normal pregnancies.

Varieties.—There have been many classifications, with sub-classes, but that of Lawson Tait seems the simplest.

I. Ovarian—(Possible, but not yet proven.)

II. Tubal—(a) In the free part of the tube, which ruptures either.

1. Into the abdomen, constituting intra-abdominal gestation.

2. Into the broad ligament, constituting extra peritoneal gestation.

This broad ligament or extra-peritoneal gestation may have various terminations.

1. May develop in the broad ligament to full term.

2. May die, and be absorbed as extra peritoneal haematocele.

3. May die, and a suppurating ovum may be discharged.

4. May remain quiescent, as lithopoedion.

5. May become abdominal or intra-peritoneal by secondary rupture.

III. Tubo-Uterine, or interstitial.

I. Ovarian.—Some writers, most prominent among whom is Tait, practically deny that we have such a variety; yet no criticism has succeeded in destroying the claims of Leopold, Patenko and Martin, which we must accept as primary ovarian.

II. Tubal Pregnancy.—This is by far the most frequent variety, some contending that it is the only one. In the first week after fecundation, the tube begins to thicken, due chiefly to vascularization without hypertrophy of the muscular fibres, in this respect differing from that of the uterine muscle in normal pregnancy. As pregnancy advances, the wall of the tube becomes thinner, and stretches, until in some cases its appearance is a thin, transparent membrane, composed only of an attenuated stratum of muscle covered with peritoneum.

The development of the foetal membranes derived from the ovum, with the exception of the placenta, is the same as in intra-uterine pregnancy. If the ovum continues to grow, the point at which the placenta is attached is of the greatest importance to the mother, as upon this depends largely her chance of life in case of rupture. If the placenta is implanted on the superior wall of the tube, the mother is in constant peril, as rupture here may be followed by violent hemorrhage, the detached placenta having no counter pressure to control its bleeding, as is the case when it is attached to the floor of the tube. If the placenta is implanted on the floor of the tube, the danger attending rupture is much less to the mother. Here the placenta is pushed down against the pelvic floor, insinuating itself between the layers of the broad ligament.

Occasionally the ovum is lightly attached in the ampullar extremity of the tube, and is extruded into the abdominal cavity, without rupture of the tubal walls.

Tubo-Uterine, or Interstitial Gestation.—The history of the embryonic development in this type of ectopic gestation differs from the tubal proper, on account of its different environment. Here the muscular fibres of the uterus undergo the same change as in normal pregnancy. Rupture is almost inevitable, but does