array of the more frequent tubal form in almost every museum; since 1877 I have dissected and mounted no less than four, for the museum of the Royal College of Surgeons alone. The records of our Society's 'Transactions' teem with cases of tubal gestation. Yet notwithstanding the publicity thus given to extra-uterine fœtation, only six specimens of the tubo-uterine form can be found in the metropolis. In Parry's standard work, 31 cases of this variety are included in a table of 500 cases of extra-uterine pregnancy; but in that table 230 cases are set down as "doubtful." This ambiguous series, however, must have been mostly made up of cases that were chiefly doubtful as to their originally tubal or "abdominal" character; cases of hopeless matting together of pelvic structures so common in all such disorders when of long standing; but interstitial fœtation is less likely to be overlooked and classified among these 230 doubtful cases.

In fact it seldom reaches the stage at which it becomes "doubtful" to a dissector. Interstitial pregnancy generally ends in a "fœtal cataclysm," as Dr. Barnes would say, at the second or third month, as in Mr. Roberts' case; hence there is no time for pelvic peritonitis, burying the ovaries in adhesions and contorting the tubes in every possible direction.

This tendency to early rupture of the cyst involves, of necessity, great difficulties in diagnosis, which is practically impossible during the first few weeks.* In these days of abdominal surgery a rescue of a case like that of Mr. Roberts, by a very experienced operator may yet be recorded; but the very circumstances under which this accident must occur will seldom bring the patient within timely reach of a surgeon who can manage complicated cases of ovarian and uterine tumours. A purely tubal cyst, even at this early stage, certainly bleeds less rapidly, moreover diagnosis is not so difficult; on the other hand the soft swelling on the right of the uterus in Mr. Roberts' case could hardly have been detected on palpation, although abdominal section would have revealed its true character. Then, amputation of the uterus above the cervix would have been the sole practicable course.

The tendency to early rupture is clearly due to the thinness of the cyst towards its upper or peritoneal aspect. The lower portion of its walls tend rather to grow thicker, and, supposing that the upper part does not rupture, pregnancy may continue till term. Rokitansky has described such a case, quoted in several works by contemporary writers. I can well understand how the fœtus might be born into the uterine cavity, after expulsion from the sac, and then directly, or after an interval, delivered from the uterus "into this breathing world" in the usual manner. Dr. Mundé describes a case* where he fully believes that such a phenomenon occurred; the patient recovered, so that the precise condition of the parts could never be ascertained.

The cases of suspected hernial embryo-bearing pouches of the uterus, well known to Fellows of the Society, may, in many instances, have been really tubo-uterine cysts, and there is every reason to believe that the former uterine orifice of the tube, in the part of the cyst that projects into the uterine cavity, might become dilated, from various causes, so as to admit a sound or even the fore-finger. This orifice might dilate, in the delivery of the fœtus into the uterus, as the os externum dilates in natural labor, but it is more probable that it would be rapidly rent asunder. In the discussion on Dr. Barnes' paper on the so-called "Missed Labour," Mr. Spencer Wells and Dr. Gervis suggested the possibility of some missed labor cases being instances of tubo-uterine pregnancy.† But the cases quoted in support of this theory were theoretical, in so far as they all recovered, as did Dr. Mundé's patient; besides, the tubo-uterine nature of the pregnancy was based on the fact that the sound had been previously passed into an (apparently) empty uterus, without producing abortion; but this accident does not always follow the introduction of a sound into a normally gravid uterus. On the other hand, Dr. Roper's cases, mentioned by him in the same discussion, appear to have been verified by dissection; that obstetrician believes in hernial pouching of the gravid uterus through rupture of a part of its inner

* Dr. Gibbes, of South Carolina, distinguished a tumour in a case of tubo-uterine pregnancy, which he took for a fibro-myoma, and De la Faille correctly diagnosed a case from the intense pain caused by pressure on the uterus.—(See Parry, 'Extra-Uterine Pregnancy.')

* 'American Journ. Obstet.,' 1879, p. 330. The same remark applies to Dr. Lenox Hodge's case, just published in Parry's work.

† 'Trans. Osbt. Soc. vol. xxiii., p. 100.