she was constantly sick at the stomach, could not retain anything. I sent her to the hospital, and on making an examination found the cervix softened, an ovoid tumor lying to the left of the uterus, apparently continuous with it, and in size about two inches wide and three inches long. It was extremely tender to the touch; slightly movable. Further examination disclosed to the right what I believed to be the body of the uterus. I was puzzled as to the condition; I thought there was a congenital lateral displacement of the uterus to the left, and to the right a fibroid growth. It seemed to me that if my conclusion was correct, the severe and almost constant pain could be accounted for by the firm attachment of the organ in an unnatural position, preventing its gradual ascent from the pelvis. Again it struck me that it might be a case of ectopic gestation. The great amount of pain, threatening rupture, together with the history of flow in February, of a shreddy character, gave strong probability of ectopic gestation.

Still another solution presented itself. There was a possibility that it might prove to be a bicornate uterus. I determined to give the patient chloroform to facilitate examination. I accordingly asked Drs. Clinton and Yeomans in consultation and explained the nature of the case. Chloroform was administered, and we proceeded to make a careful examination. I stated I was in doubt as to tubal pregnancy or bicornate uterus.

Both Dr. Clinton and Dr. Yeomans made an examination and found the condition as stated. I determined, therefore, to find out if possible whether the body to the right was the uterine body; and with this object in view, cautiously introduced the sound, directing it to the right, and it passed in without resistance to a distance of three and one-half inches. By external pressure from above, and gentle movement of the sound, it was clear, from the very perceptible movement, that the sound was in the uterine cavity; that much at least was clear. There appeared to be no means of determining between tubal pregnancy and bicornate uterus, except by exploratory incision. The patient's condition was fast becoming desperate from the constant pain, incessant vomiting, and loss of sleep. She was terribly emaciated, and was evidently fast going down. It was decided to make an exploratory incision, our conclusions leaning towards tubal pregnancy. Preparations were accordingly made, and on the following day, assisted by Drs. Clinton and Yeomans, I opened the abdomen and the condition was at once disclosed. The tumor proved to be the impregnated left horn of the uterus; the tube and ovary were normal. On the right side was the other horn with tube and ovary. Ovary on the right was smaller and tube shorter than that on the left. I at once closed the abdomen with three tiers of catgut sutures. The skin was approximated with fine silk sutures, and the usual dressing applied. Patient returned to bed very weak, but soon rallied. Vomiting and nausea increased; pain also continued more severe than before. Hypodermic of morphia and