Internal migration of the ovum : with report of a case of repeated ectopic gestation possibly supporting the theory.

17

INTERNAL MIGRATION OF THE OVUM;

WITH REPORT OF A CASE OF REPEATED ECTOPIC GESTATION POSSIBLY SUPPORTING THE THEORY.[1]

"Innere Ueberwanderung des Eies" is an expression which it is difficult to render perfectly into English. It signifies, as you know, the supposed migration of the impregnated ovum from the tube in which impregnation occurred into the uterine cavity and thence into the opposite tube, in which it remains and develops, with the usual results of ectopic gestation. It may also be assumed that the ovum is impregnated in the uterus and then enters the opposite tube. This theory, which has been discussed *pro* and *con* by Wyder, Schäffer, and Pestalozza, has been recently considered at length by Veit, who points out the various sources of error in former observations. It is clear that this phenomenon is not capable of being studied experimentally or under physiological conditions, since it is essentially a pathological process, being considered as possible only when the distal end of the tube in which ectopic gestation occurs is positively occluded *before* impregnation takes place. The original observations of Bischoff on rabbits are hardly in point, since they apply to bicornate uteri, in which the conditions are essentially different from those in the human female. It is evident that this fact is extremely difficult of demonstration and will only be admitted in the face of positive anatomical proof. It is much to be regretted that, with the large number of specimens of ectopic gestation that have been described, little or no attention has been paid to this interesting possibility, it being assumed that the occlusion of the fimbriated end of the tube, when present, always takes place *after* impregnation, as lucidly described by Bland Sutton.

[1] Read at the annual meeting of the American Gynecological Society, May 17th, 1893.

The following case has been carefully studied with especial reference to this theory, which it would appear to sustain to some extent, although it is not claimed that the evidence is conclusive. An additional reason for placing it on record is its extreme rarity, no other exactly similar specimen having been described, so far as I can ascertain.

The following is a history of the case, as obtained partly from the patient herself, and partly from her physicians: Mrs. McK., age 41, a slight but wiry subject, has been married twenty-two years and has had two children, the youngest being 18. She had one early abortion between the two labors, which were normal. Six years after the birth of the second child (*i.e.*, twelve years ago) she missed two periods and had the ordinary symptoms of pregnancy. Soon after skipping the second period she began to have colicky pains and hemorrhage, and thought that she was about to abort. Dr. Beardsley and Dr. Minard, of Brooklyn, who then attended her, inform me that a bimanual examination made at that time revealed a tumor to the right of the uterus and closely adherent to it. They satisfied themselves that the organ was empty. The pains continued at irregular intervals for three months (the patient having frequent fainting spells), accompanied by a chocolate-colored discharge, and during this time she had an attack of pelvic peritonitis. Five months after their disappearance the menses returned. About this time Dr. Minard made a second examination and found the uterus slightly enlarged, with the same tumor, the size of an orange, adherent to its right border and the surrounding parts. She inferred that it was a fibroid. For ten years the tumor remained unchanged and occasioned comparatively little inconvenience.

During the following two years the periods recurred regularly, but were attended with severe colicky pains. Then (according to the patient's statement) she again missed several periods, during which time she had symptoms of pregnancy and another attack of peritonitis. She was examined by several physicians in Philadelphia, who were unable to arrive at a positive diagnosis. The menses reappeared and recurred regularly until September 1st, 1892, when she menstruated for the last time. Throughout this interval of ten years her health was excellent, with the exception of the dysmenorrhea. Soon after the last menstruation she began to have morning sickness and pain in

the breasts, and in October the same colicky pains which she had had twelve years before returned, but without the former hemorrhage. The pains were always initiated by a movement of the bowels, and were so severe that she often fainted. She was confined to her bed at intervals until November 4th, when, as she was taking an enema, she was seized with a sudden "tearing" pain in the lower part of the abdomen, collapsed, and was thought to be dying. Dr. W. E. Beardsley, of Brooklyn, who saw her at this time, diagnosed probable rupture of an ectopic sac. She rallied, but was in such pain that she required large doses of morphine. Two days later she had a similar attack, less severe, from which she soon recovered, so that two days later she was able to take a journey from Brooklyn to my office. On account of her extreme tenderness I was not able to make a satisfactory examination. I found a circumscribed tumor, apparently as large as the fetal head at term, firmly adherent in Douglas' pouch and pushing the uterus forward and to the left. It was semi-solid in consistence and very sensitive. I did not venture to make a positive diagnosis, but could hardly believe that there had been a ruptured ectopic sac, on account of her good general condition (the uterus was small and the breasts presented no characteristic appearances of pregnancy), and advised the patient to enter the hospital for examination under ether. This examination was made on December 7th, my colleague, Dr. Cleveland, being present. Under anesthesia it was easy to make out bony nodules in the tumor, which was supposed to be a dermoid cyst with general adhesions. Abdominal section was performed three days later. On opening the abdomen the pelvic cavity was found to be shut off by the adherent omentum and intestines. On separating these, fluid blood and old clots welled up from Douglas' pouch. Behind the right broad ligament, and adherent to the side of the uterus, was a mass the size of an orange, which, when partly detached and lifted up, was seen to be an unruptured sac without a pedicle. As the hemorrhage was rather free, I at once inserted my hand to the bottom of the pelvis, in order to hastily enucleate the tumor. I encountered a fetus (between three and four months old) floating in the midst of the fluid and coagulated blood. On taking it out and holding it in my hand it made vigorous movements of the arms and legs for at least three or four minutes, which were observed by several spec-

tators. Its umbilical cord was traced to a second sac below, and adherent to, the first; this was quickly freed, brought up into the wound, and the usual pedicle was tied. During this manipulation the first sac ruptured, a bony nodule and a little caseous material escaping into the abdominal cavity. A large raw surface was left within the pelvis, from which free oozing

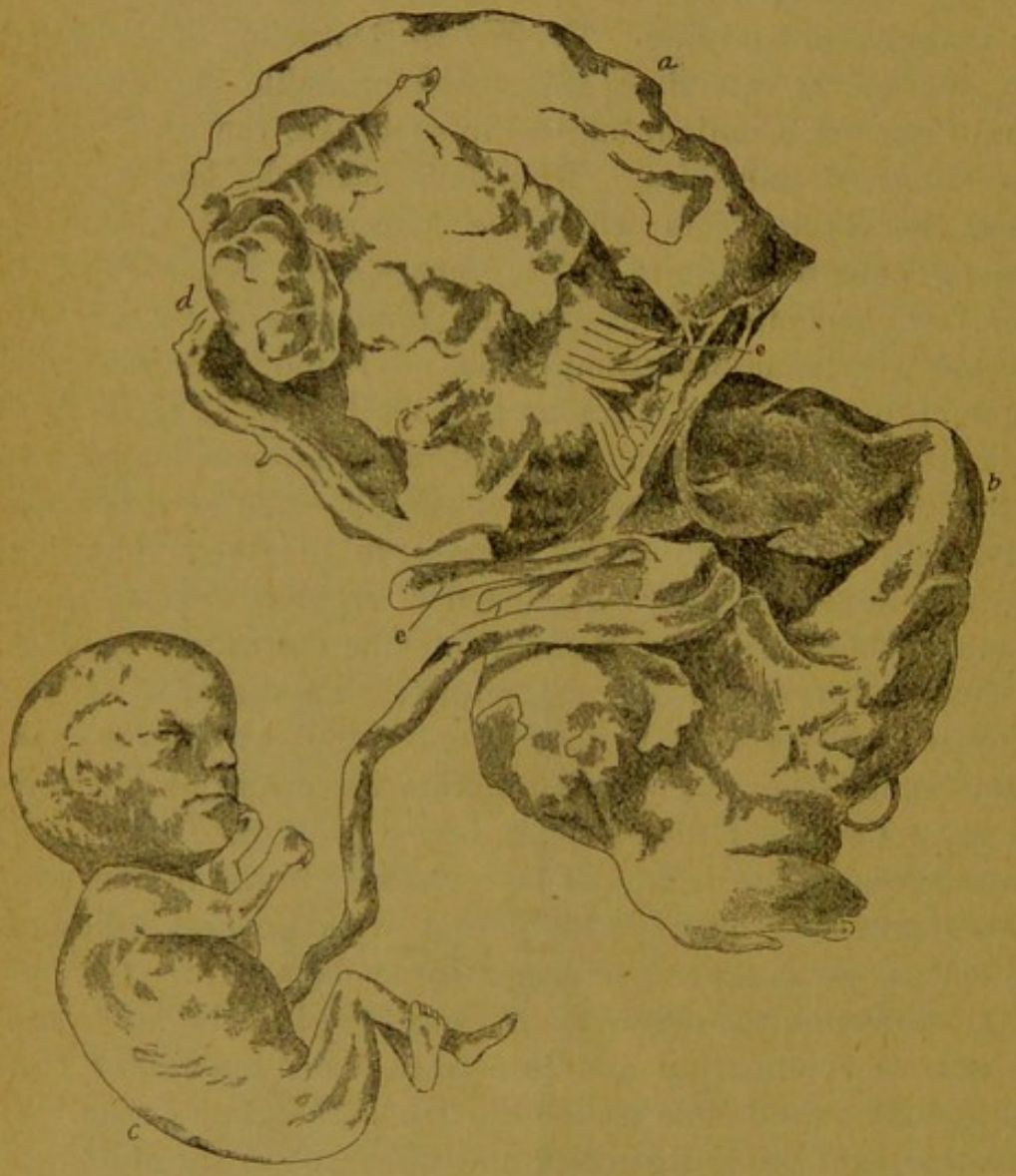


FIG. 1[1].—Showing relative positions of the two sacs and fetus before removal. Seen from behind. *a*, old sac, containing mummified fetus; *b*, recent ruptured sac; *c*, four months' fetus with cord leading to recent sac; *d*, cranial bones of mummified fetus; *e,e*, ribs and long bones.

occurred. The posterior fold of the right broad ligament was seen to be intact, showing that neither sac was intraligamentous. The left ovary and tube were rather firmly adherent, but were easily removed. The pelvic cavity was thoroughly

[1] I am indebted to Dr. John Aspell for these beautiful and accurate drawings.

irrigated and was packed with iodoform gauze, a drainage tube was inserted, and the wound was closed in the usual manner. The patient rallied well from the operation, but subsequently developed pneumonia, from which she nearly succumbed. (She passed pseudo-decidual membrane *for the first* time on the second day.) The abdominal wound absolutely refused to heal until after the patient had been placed on specific treatment, when it slowly granulated. During the fourth week a large induration developed at the site of the ruptured sac, and a pelvic abscess was feared; but under persistent treatment with hot water and ichthyol (a drug which I have found especially valuable in cases of pelvic induration following celiotomy) the in-

FIG. 2.

FIG. 3.

FIG. 2.—Showing the relation of the Fallopian tube to the two sacs. *a*, old sac; *b*, recent sac; *c*, atrophied ovary; *d*, divided proximal end of tube; *e*, fimbriated extremity of tube.

FIG. 3.—Left tube and ovary. *a*, ovary; *b*, divided proximal end of tube; *c*, fimbriated extremity of tube.

flammation entirely subsided, and the patient was discharged "cured" just six weeks after the operation. I examined her at my office two months later, and found the uterus small and movable, no tenderness in the surrounding tissues, and only a slight induration around the right stump. The abdominal cicatrix was firm. She was in good health, with the exception of such nervous disturbances as are commonly observed after removal of the adnexa.

Judging the specimen to be sufficiently valuable to merit careful study, I sent it to Dr. J. Whitridge Williams, of the Johns Hopkins Hospital, whose report is appended. My warm-

est thanks are due to our talented Fellow for the interest which he has taken in the case. In order to preserve the specimen for your inspection, no microscopical examination has yet been made.

"*Report on Case of Double Tubal Pregnancy.*—The specimens consist of the left tube and ovary, a large, irregular mass derived from the appendages of the right side, and a well-developed fetus of from three to four months. They are all preserved in weak alcohol.

"*Right side.*—It is very difficult to make out exactly the relations existing in the specimen from this side. At its posterior part is seen the right ovary, which measures 3, 1.5, and 0.7 cen-

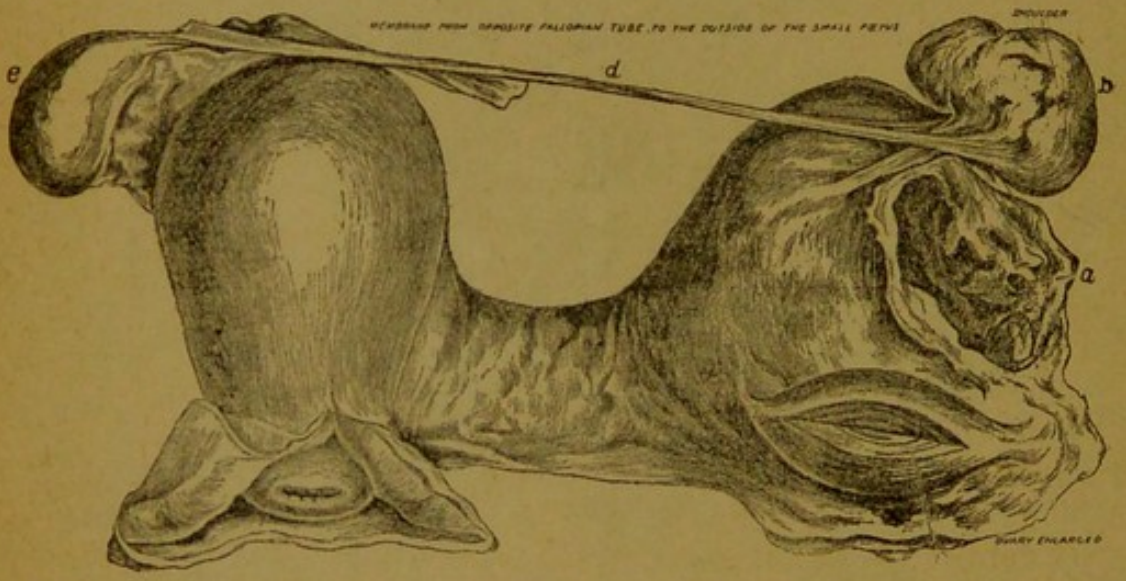


FIG. 4.—Haydon's specimen. *a*, ruptured sac; *b*, old sac containing fetal bones; *c*, ovary, with corpus luteum; *d*, adhesion extending from opposite tube (*e*) to old sac.

timetres in its various diameters. On its surface there are numerous thin adhesions and a number of cicatrices; on section one sees a number of small corpora fibrosa, but absolutely no trace of a fresh corpus luteum. Roughly speaking, the rest of the specimen may be divided into two portions, an internal and external, according to their relation to the uterus. The internal portion is ovoid in shape and measures 7, 4.5, and 3.5 centimetres in its various diameters. Its exterior is of a dull-white color and is covered by more or less thick, organized adhesions. Its surface is somewhat irregular, and beneath it may be seen structures which resemble the hands and feet of a small skeleton, and appear hard and bone-like to the touch. Some of

the larger projections are very hard and apparently correspond to larger bones. Extending almost the entire length of the anterior surface of this ovoid mass is an opening, through which it is seen that the interior of the mass is almost entirely filled with fetal bones of every description, between which is a reddish, soft, very friable material. In the centre of the mass is quite a large cavity, lined by a thin, reddish membrane. All the bones appear to lie outside of the cavity, between it and the wall of the sac. We are unable to state to what this cavity corresponds.

"The walls of the sac which contains the fetus are thin—from one to two millimetres. We would not designate this part of the specimen as a lithopedion, for it presents no signs of calcification of the fetus, the only calcareous portions of the specimen being the fetal bones, which are somewhat softer than usual.

"The external portion of the specimen is likewise more or less ovoid in shape, and measures 6, 5, and 4 centimetres in its various diameters, and sits like a cap upon the lateral end of the mass just described. Its exterior is very irregular and for the most part of a reddish color, and presents many adhesions. At its lateral end may be seen the patent fimbriated extremity of the tube, which can be traced for a short distance. Its extremity is two centimetres in diameter at its widest part. What appears on the exterior to be the tube can be traced over the surface of the ovoid mass containing fetal bones, for a distance of six centimetres from the fimbriated extremity; but its lumen can only be followed for a short distance. The walls of this part of the tube appear to spread over and to be continuous with the surface of the ovoid mass containing the fetal bones. It is thus seen that the two portions of the specimen were originally intimately connected, and that they were separated by a rupture which occurred at the lower part of the specimen, just at the lateral end of the first portion. Through this point of rupture it is seen that the second portion of the specimen is occupied by a cavity, about three centimetres in diameter, lined by a smooth, thin membrane, which corresponds to the amniotic cavity; to one portion of which a portion of umbilical cord, six centimetres long, is attached. On section it is seen that the reddish part is composed of placental tissue. It is evident that it was in this portion of the tube that the fetus which was removed at the operation was developed.

"From the appearance of the specimen it is not necessary to suppose that the first pregnancy ever did rupture into the peritoneal cavity; for the tissues of the lateral part of the tube are seen to be continued directly over the portion of the specimen which contains the first pregnancy, and are only lacking at the uterine end, from which they could have been torn away readily at the time of operation. As no trace of the uterine end of the tube can be found, it is improbable that the spermatozoa penetrated the right tube from the uterus in the formation of the second pregnancy.

"The fetus measures 9 centimetres from breech to vertex and 12 centimetres from vertex to feet, and appears to be from three to four months old.

"*Left side.*—The left tube is 5 centimetres long and 0.3 and 0.7 centimetre at its thinnest and thickest parts. The fimbriated extremity is thickened, but not occluded, and is permeable for a fine sound. On its surface are a number of thin adhesions.

"The left ovary measures 2.5, 2.5, and 1.3 centimetres in its various diameters. On its surface are numerous thin adhesions.

"On section a large corpus luteum is found on the superior border of the ovary, and measures 1.5 by 1 centimetre in diameter; just beneath it an older corpus luteum is found. The ovary also contains a number of corpora fibrosa."

Before discussing the evidence afforded by the specimen in support of the theory of internal migration of the ovum, a brief comparison of the clinical history of the case with the anatomical condition found at the operating table will be of interest. This history is unusually clear and circumstantial. There is no doubt that the older sac was an unruptured extra-uterine pregnancy of twelve years' standing. The symptoms noted at that time were quite characteristic of that condition, without either the phenomena or local condition suggestive of internal hemorrhage. Moreover, the persistence of a distinct, circumscribed tumor for many years, together with its appearance before and after removal, prove that the sac remained intact, the fetus living to the age of three months or more, dying and becoming mummified. The attacks of peritonitis are easily explained, as well as the resulting colicky pains, especially at the time of menstruation. The second period of amenorrhea, occurring two years after the first, with a recurrence of many of the same symptoms

(especially those of pregnancy), it is difficult to explain. It seems incredible to believe, as one gentleman suggested, that there was actually a *third* ectopic gestation on the same side; but if two, why not three? The second may have been a tubal abortion without profuse hemorrhage. I prefer, however, not to hazard an explanation.

The symptoms referable to the recent rupture were quite characteristic, or would have been in a patient who had not had the same symptoms on previous occasions. One might well have been sceptical regarding the presence of this condition in a woman who, four days after a pint of blood had escaped into her pelvic cavity, could make a journey of several miles without apparent inconvenience. It is fair to infer (since the recent sac was not itself adherent, except to the older one) that the slight general effect of the rupture was due to the fact that the entire pelvic cavity was so enclosed by dense, old intestinal adhesions that the hemorrhage was necessarily limited in extent and the shock transient. An interesting question might be raised with regard to the probable development of a fetus that showed so much vitality under such unfavorable circumstances, since the hemorrhage had ceased and its placental attachment was intact.

I might dwell upon other interesting features in this remarkable case, but do not wish to exhaust your patience. I hesitate to apply to it the term "unique," but I have been able to find only a single case which at all resembles it. Repeated extra-uterine pregnancy after removal of one tube is, of course, not so very rare, and Bland Sutton has described an undoubted case of twin tubal conception, but repeated pregnancy in the same tube must be exceedingly infrequent. Taylor's[1] case of supposed repeated pregnancy in the same tube, each time with rupture, is open to considerable doubt, since there was no positive anatomical evidence of the first pregnancy, though the history pointed to it. If it actually occurred, it is probable that the first was a tubal abortion.

Haydon's[2] specimen (Fig. 4), obtained post mortem and described by Braxton Hicks, resembles mine, as will be evident from a study of the description and drawing. The patient was supposed to have aborted four or five years before, though no fetus was found. She died of internal hemorrhage from a rup-

[1] British Gynecological Journal, August, 1892, p. 168.

[2] Transactions London Obstetrical Society, 1864, vol. v., p. 280.

tured ectopic gestation. At the autopsy the left ovary and tube were found to be normal. The right tube, at a distance of one and one-half inches from the uterus, was dilated so as to form a sac three inches in diameter, which had ruptured, allowing a three months' fetus and placenta to escape. To the outer edge of the sac was attached a solid mass, the size of a walnut, which contained the bones of a mummified fetus. The ovary was enlarged and adherent to the middle third of the recent sac. It contained a "corpus luteum of pregnancy," estimated at six months. The early fetus was supposed to have perished at two months, the recent one at three months—three months before rupture occurred (!). I have quoted this case not only because it bears such a close resemblance to mine, but also from its bearing on the subject which I shall now consider.

The fact of internal migration of the ovum having occurred, as I stated at the outset, is supposed to be established in a case of tubal pregnancy only when the fimbriated end of the tube in which gestation is found is entirely occluded by an inflammatory process *before conception*.[1] Schäffer[2] analyzes the evidence presented by Bischoff, Kussmaul, Scanzoni, Duncan, and Virchow, who affirmed that the fact of internal crossing must be inferred if a corpus luteum is found in one ovary and a product of conception in the *opposite* tube—a view opposed by Mayrhofer, on the ground that the presence of the so-called *corpus luteum verum* is not a positive proof that the corresponding follicle contained the ovum that became impregnated. He reviews the reports of cases by Kussmaul, Schultze, and Hassfurth, all of which he regards as doubtful. The forces which combine to carry the ovum toward the uterine cavity—ciliary and peristaltic motions—would hardly, he thinks, permit it to pass from the uterus into the opposite tube. Veit's discovery of active cilia in three cases of ectopic gestation proves that this argument is not a good one. "On theoretical and physical grounds," he concludes, "the possibility of internal crossing is positively denied, and no single case free from suspicion has been observed which proves that this actually occurs." Wyder,[3] who believes

[1] Veit, Zeitschrift für Geburtshülfe und Gynäkologie, Bd. xxiv., Hft. 2, p. 327.

[2] Zeitschrift für Geburtshülfe und Gynäkologie, Bd. xvii., 1889, p. 13 (vide this paper for bibliography of the subject).

[3] Archiv für Gynäkologie, Bd. xli., pp. 153–208. Id., Bd. xxvii., 1886, p. 325.

that the usual site of impregnation is in the uterus rather than in the tube, reports a case of ectopic gestation which he regards as "a positive anatomical proof of the possibility of internal migration of the ovum in the human female."

Veit[1] assumes a more judicial attitude, and, after sifting the evidence carefully, does not deny that internal migration may occur, although none of the specimens yet presented in support of the theory is absolutely above suspicion. He calls attention to the following sources of error: 1. Pregnancy occurring in a tubo-ovarian cyst. 2. Closure of the ostium abdominale *during* pregnancy. 3. Difficulty in finding the ostium, even when it is patent. 4. Occlusion of the distal end of the tube, after rupture of the ectopic sac, by retained products of conception. In Hassfurth's specimen (which the late Prof. Schröder regarded as furnishing positive proof of internal crossing) Veit demonstrated the presence of an accessory ostium in the affected tube, through which the ovum might have been discharged in the usual man ner.

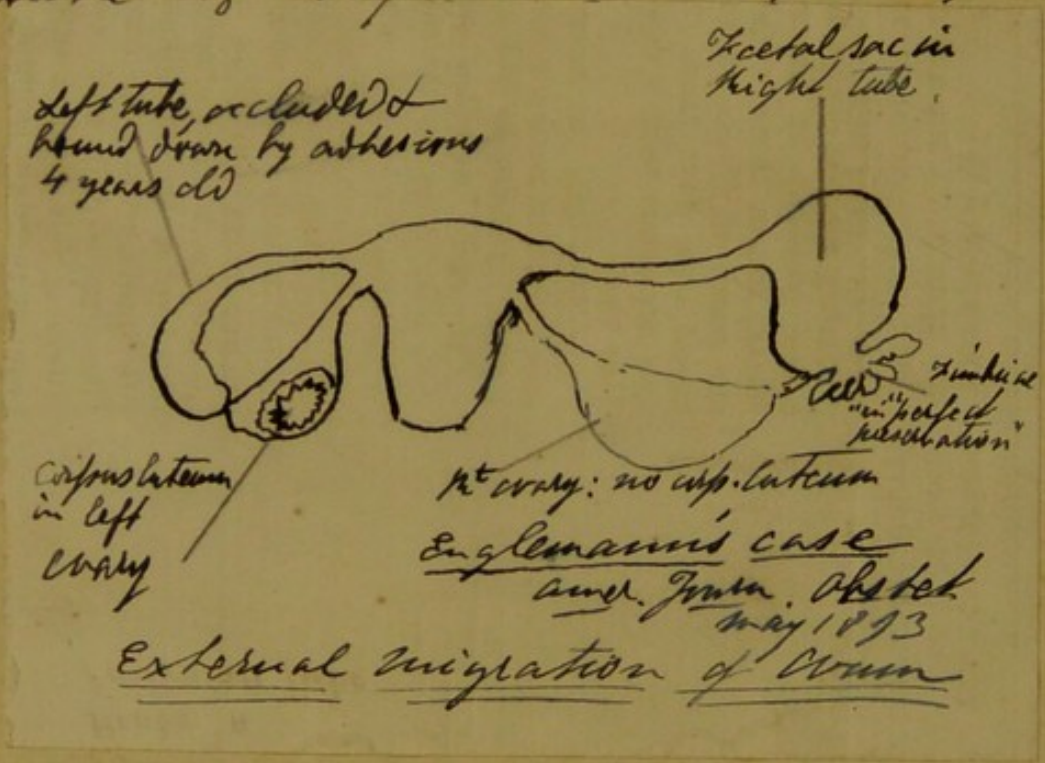
In presenting this specimen as one which at first seemed to furnish an argument in favor of internal migration of the ovum, I wish to call attention to the fact that, like all the others which have been regarded as supporting this theory, a critical examination shows that it is open to suspicion, for the reason that the distal end of the tube is patent—a condition which is regarded by Veit as strong negative evidence. Moreover, the apparent imperviousness of the proximal portion of the tube presents an equally puzzling problem. My own opinion is that the old sac may represent a gestation occurring in a diverticulum of the tube (the possibility of which has been demonstrated by Dr. Williams), which would not necessarily occlude its lumen so as to prevent the passage of either spermatozoa or ovum from the uterus. The possibility of external migration (*äussere Ueberwanderung*) is of course to be borne in mind, though it seems to be doubtful, by reason of the fixation of the left tube and ovary by dense adhesions, so that we are forced to the conclusion that the second impregnation was effected either in the ordinary manner, or by internal crossing of the ovum after impregnation in the left tube, or in the uterus. The presence of a corpus luteum in the *left* ovary would not in itself be regarded as positive evidence of the latter phenomenon, were it not for the atrophic

[1] Loc. cit.

condition of the right ovary and the appearance which it presents of having been functionally inactive from a period considerably antedating the last pregnancy. In this respect Haydon's specimen of double gestation differs essentially from mine, since the corresponding ovary contained a corpus luteum and the first fetus had probably been extruded from the distal end of the tube, thus leaving the tube practically as patent as it ever was. [Engelmann describes an interesting specimen, in the May number of this JOURNAL, in which he thinks that impregnation occurred by external migration.]

27 EAST 64TH STREET.

See also Cullen & Wilkins. "Preg" in a Rudimentary Horn ... Probable migration of Ovum. Johns Hopkins Rep. Vol



Engelmann's case
amer. Journ. Obstet. May 1893

External migration of Ovum

Internal migration of Ovum

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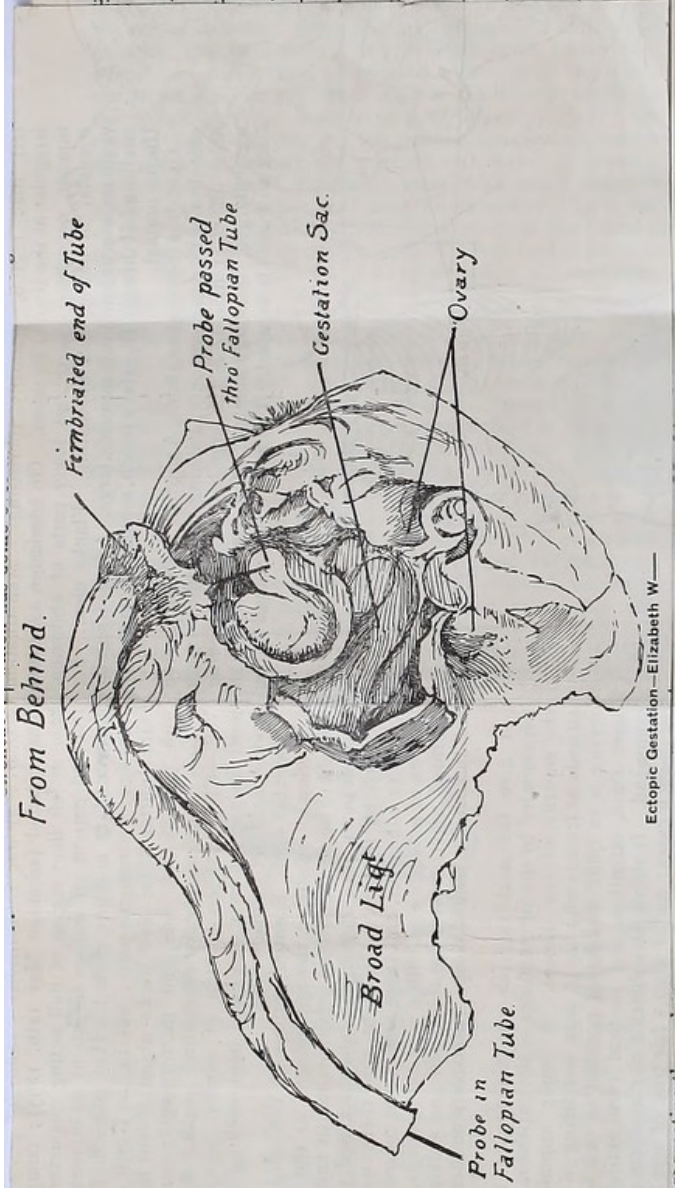
Fundus
Left Serum
Connecting Band
Left Müller's Duct
Sp, 2.
Sp, 1
Cullen & Wilkins' Base

and complained of intense pain in the right lumbar and inguinal regions, and a slight swelling could be seen. Percussion showed want of resonance, and to the fingers the swelling presented a hard feeling. Slight distention of the rest of the abdomen was present. Two hours after admission, ether being administered, operation was performed. An incision four inches long was made in the right



Ectopic Gestation—Elizabeth W——

there is in a very large majority an extraneous cause; and it is always well to bear this in mind before it is too late—and act upon it. I am quite sure that many lives have been lost owing to active treatment being delayed, and I have never yet had occasion to regret having operated too soon.

The next case is one which affords a practical illustration of some of the difficulties surrounding the exact diagnosis of pelvic tumours with an obscure history, and is of special interest to the general practitioner on whom devolves usually that most difficult task of diagnosis, on which so much depends. He has to decide whether it is a case in which nature assisted by the medical art can effect a cure, or whether recourse to some operative procedure may be needed. Safety lies no doubt usually in a tentative course, but only up to a certain point. Assuming a probability of ectopic gestation, whenever indications of rupture with intra-peritoneal hæmorrhage occur, not a moment must be lost in resorting to operation: but where rupture may have taken place sub-peritoneally, we can afford to wait for urgent local or constitutional symptoms, as was done in this instance. It is often very difficult to determine what is best to be done, and it is only after a careful consideration of all the circumstances of the case that a safe conclusion can be arrived at—though safety lies rather in action in most instances.

For the notes of the following case I am indebted to Dr. Drew, house surgeon:

Elizabeth W——, æt. thirty, admitted under my care in the North Staffordshire Infirmary, May 9, 1893.

Tubo-ovarian gestation, Retro-Uterine Hæmatocele.—Patient admitted complaining of pain in back and abdomen, of bearing down character, the pain is worse on right side of abdomen and extends into buttock. Present illness began five weeks before admission (May 9th). The onset was quite sudden, while patient was in bed, and began with pain in back and right side of abdomen, was very severe, and caused her to vomit; it was better the next morning, so she did not remain in bed, but was unable to work on account of the pain.

During the last twelve months health has not been good, being troubled at times with sickness and headache. Illness began three weeks after last period, a week after the onset of illness patient had a "slight show," which lasted three days, since then there has been bleeding on two occasions with a few days interval; this stopped on May 2nd.

On May 9th, on examination, it was found that there was a reddish brown sticky discharge, which continued for a week; previously had always been quite regular.

One child five years ago, says she had slight inflammation after it on the left side, and was in bed three weeks.

Healthy looking woman. Abdomen is of normal size and quite symmetrical. There is a small hard roundish tumour, about the size of a fist, rising up from the pelvis in the middle line, and extending upwards as far as 2½ inches below umbilicus, on the right side of this and above it, there was a soft elastic swelling which reaches almost to the level of the umbilicus on the right of the middle line; its limits, however, cannot be very accurately defined. Percussion dull over swelling. On introducing finger, there is felt a large soft elastic swelling protruding into vagina through Douglas's pouch, it is fluctuating and by pressing on abdomen an impulse is received by finger in vagina. The cervix is high up and pushed straight forward by the swelling, so that it was difficult to find, as it was

situated behind the upper part of the pubis. By pressing on the cervix the small tumour in middle line of abdomen is felt to move, and feels like a somewhat enlarged uterus.

May 19th, operation; ether. Mr. Spanton performed abdominal section. On opening abdomen, the uterus was seen as it was pressed forward and touched the abdominal wall; it was somewhat enlarged. On turning up some omentum there appeared on the right side and above the uterus a purplish soft swelling covered by peritoneum. The contents of this were partly withdrawn by aspirator, and consisted of brownish coloured blood, and the remaining fluid was removed by means of sponges; the cavity went straight down and backwards into the pelvis. The right tube was traced outwards from the uterus, and at the ovarian end was a fleshy mass, which probe passed into tube could be felt from the inside of the gestation cavity. The ovary formed the lower part of the mass, and the upper part of it was stretched out over the anterior surface of the gestation; in this part of the ovary is a graafian follicle, and half an inch below it an elongated swelling on the surface of the ovary; this on section shows a *corpus luteum* of pregnancy, measuring $\frac{5}{8}$ inch in length. The convoluted edge was very well marked, and of bright yellow colour, and inside it was a cavity. At the ovarian end of the Fallopian tube, on the anterior surface of the broad ligament, there is a small pedunculated hydatid (anatomical). The wall of the gestation was somewhat lacerated during removal; the swelling measures from $1\frac{1}{4}$ to $1\frac{1}{2}$ inches in diameter, and the wall, which is fleshy, is just $\frac{1}{4}$ inch in thickness. The cavity is

purulent. The patient left the infirmary ten days afterwards well.

Parts removed.—Consisted of right Fallopian tube with broad ligament, ovary and fleshy mass, of which the ovary formed part. The tube was about normal in size, and a fine probe could be passed along it as far as the uterine end, but here it was blocked (?); at the ovarian end the tube was torn through, probably by forceps put on it during removal. The fimbriated extremity was matted around the anterior part of the fleshy mass of the gestation; and the

This was probably the enlarged Fallopian tube, containing clot, and through this the sound passed into the peritoneal cavity. I saw the patient the next day, when the retro-uterine swelling was larger and tenser, and on passing in an aspirating needle only a few drops of fœtid bloody fluid escaped. There was clearly a swelling outside the uterus, and the general opinion was that it was an ectopic gestation; but the cavity to the right of the uterus with which the sound and the fingers so easily passed was mysterious. The patient was in a critical condition, so I