think one thousand eight hundred; and beside that the gall-bladder was very much thickened by cancer. Here is a specimen of cancer of the liver which would have made a very large tumour; there is one of melanosis of the liver. Here is one of tubercle of the liver—a very rare specimen; and here is one of hydatid of the spleen. These hydatid cysts occasionally lead to mistakes. In my work on *Diseases of the Ovaries*, there is a picture of a woman taken from a photograph, from whom I removed successfully a very large hydatid cyst which we had correctly diagnosed after tapping. The limpid fluid removed at once attracted attention. I examined the deposit, and found it characteristic of hydatid disease; so, after a time, as the woman seemed to be likely to die, I removed the hydatid cyst. She completely recovered.

Aneurism occasionally may be met with. Here are one or two good specimens of aneurism of the aorta. It is not likely that aneurism of the abdominal aorta will be mistaken for an ovarian tumour, but still it is well to bear this in mind. I know of one case in which an aneurism of the aorta low down, just where it bifurcates, was tapped through the vagina, believing it to be a pelvic abscess. That lady died upon the table in a very few minutes. So it is just as well to remember that these large aneurisms of the abdominal aorta should be considered in forming one's diagnosis.

With regard to hæmatocele and pelvic abscess, I need not say much here, except to put younger men upon their guard to remember these do form occasionally of so large a size as to be mistaken for ovarian or other tumours. I have seen a hæmatocele extend considerably above the level of the umbilicus, and a pelvic abscess almost as large.

Fæcal accumulation, too, but rarely leads to error. Occasionally one is called in to cases where accumulations of large quantities of fæces do lead to mistake, and the supposed tumour disappears after their removal.

Then, a word as to those resonant enlargements of the abdomen which have been called phantom tumours. There is now in the Samaritan Hospital a young woman with an apparently manifest abdominal tumour. The abdomen was prominent, and felt hard; but, on percussion, was distinctly resonant everywhere. She looked in perfectly good health, and, on putting her under the influence of chloroform, the swelling entirely disappeared. There has been a certain amount of doubt as to the exact pathology of these things, whether it is that the diaphragm is pressed downwards, the liver pressed forwards, and a certain amount of distension of the intestines accompanies the arching forwards of the recti; but certainly occasionally they do look very much like tumours which disappear entirely when the patient is deeply narcotised. I have seen the same thing in a man. I remember a soldier came down to Smyrna from the Crimea with a tumour which excited a good deal of attention amongst the surgeons at Smyrna, but, on putting the man under the influence of chloroform, it entirely disappeared.

With regard to pregnancy, the ordinary signs of pregnancy, of course, should be borne in mind in any case of abdominal tumour in a woman. Whether the woman is single, or married, or a widow, this complication may arise. I need not enter into the different signs of pregnancy; but I wish you to bear in mind that not only may pregnancy be mistaken for ovarian disease, or uterine disease, or the converse, but that in many cases pregnancy does complicate ovarian disease. A woman may have a large ovarian tumour, and then she may become pregnant; and the question of the treatment of a woman who has an ovarian tumour and is also pregnant is one I shall have to speak of when I have said something about ovariectomy.

I do not think there is a specimen here, I doubt whether there is in the Museum, of what is called "movable kidney". I believe there have been only one or two such specimens shown after death at the Pathological Society, but I have occasionally seen tumours in the abdomen which appeared, as far as one could tell, to be instances of movable kidneys, either enlarged or of their natural size. One case was such a remarkable one that I will detain you a moment to tell you about it. A lady came to me believing she had, or having been told she had, a movable right kidney. I saw her with Dr. Wilson Fox, and we both agreed that was the nature of the disease. For some years it went on, and I saw her occasionally, under the impression that she was suffering from a movable kidney. Then she became pregnant, and pregnancy went on to its natural termination, and a healthy child was born. Soon afterwards, she began to suffer from an ovarian cyst on the left side, the movable kidney still being on the right side; and the ovarian cyst increased so much that it was decided I should perform ovariectomy, which I did. I said at the time "I will see what that movable kidney is now"; and, after I had removed the ovarian cyst on the left side, I felt what the supposed kidney was, and took it out; and then I found it was the right ovary, but it was attached by a pedicle

fully a foot long. It had been held up under the right false ribs by the merest little film of adhesion. Quite a small patch of adhesion kept this right ovary, which was about the size of my fist and very much of the shape of a kidney, just in the position of a movable kidney. The patient recovered, and remained in good health.

Then, as to cancer of the ovary. Here are some specimens. Here is cancer of the ovary; and here is cancer of the kidney. There is a specimen also of a tumour of the abdominal wall. This illustrates a mistake occasionally made in practice: in the treatment of a supposed abdominal tumour, it is found that the tumour is not of the abdomen at all, but is simply a tumour of the abdominal wall. I remember years ago being called to see a patient, who came from Portugal, supposed to have ovarian tumour, and I expressed a strong opinion that it was not ovarian, but simply a tumour of the abdominal wall, and decided that it should be left alone; but Mr. Baker Brown afterwards saw the patient, and removed it. He removed a very large portion of the abdominal wall with it. He removed a bit of the peritoneum as large as the palm of my hand, and yet the patient made a most complete recovery. The tumour was a fibro-plastic tumour of the abdominal wall of a considerable size, and the portion of the abdominal wall removed with it was two or three inches in breadth and three or four in length. Yet the abdominal wall, which was brought together without much tension, healed up, and the woman recovered almost as well as if the operation had been one of the most simple character.

THE POLYURIA OF GRANULAR KIDNEY.

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HAVING neither time nor inclination for a controversy on the above subject, I am nevertheless anxious not to be misunderstood. In my paper in the JOURNAL of May 25th, I expressed my dissent from the theory which assumes that the copious secretion of urine by a granular kidney is the result of increased pressure on the Malpighian capillaries consequent on obstruction in the intertubular capillaries. I maintain that this theory is utterly inadequate to explain the phenomena, and that the attempt to give them this merely mechanical explanation tends to mislead and retard the progress of actual knowledge. I believe, too, that the results of the impeded renal circulation consequent on cardiac disease are fairly comparable with those which would follow upon an intertubular capillary obstruction. The results in both cases would be, of course, a general diminution of the blood-current through the kidney, a gradual increase of pressure on the Malpighian capillaries, a scanty secretion of water, and ultimately a more or less copious transudation of albumen into the uriniferous tubes. These are the phenomena which are commonly observed in cases of large Bright's kidney, when the swollen uriniferous tubes compress the intertubular plexus, and thus cause a backward strain upon the Malpighian capillaries.

It is to be borne in mind that there is no relation whatever between increased pressure on the Malpighian capillaries consequent on an obstruction in front and such increase of pressure as may result from relaxation of the afferent arterioles. It is to the latter phenomenon that reference is made by Dr. M. Foster in the chapter of his *Text-Book of Physiology* to which Dr. Saundby directs attention, and this phenomenon is not now in question. While I believe that no trustworthy inference can be drawn from such an experiment as that of Dr. Grützner to which Dr. Saundby refers, I feel called upon to correct the erroneous assumption that the contraction of the hypertrophied muscular arterioles must render the kidney anæmic. Dr. Saundby, in raising this objection, overlooks the fact that the resistance offered by the arterioles is more or less completely counterbalanced by the increased injecting force of the hypertrophied left ventricle. And, again, it is not to be supposed that the renal arterioles are in a constant state of extreme contraction, or that their muscular walls, even in the advanced stages of a granular kidney, are beyond the control of the vaso-motor nervous influence by which circulation and secretion are co-ordinated. We may reasonably suppose that, while the regulating influence of the hypertrophied afferent arterioles prevents undue strain upon the Malpighian capillaries from the injecting force of the strong left ventricle, "there is no shutting off of the blood from the glomeruli", but the blood-supply to the gland is sufficient for the purposes of secretion to any amount.