A point of very considerable interest was the result of the method adopted to obliterate the sac. After suturing the edges of the aperture and packing the whole interior of the collapsed sac with gauze, which was renewed regularly until the cavity shrank and healed up in the usual way, it was natural to suppose that there would be no possibility of a return of the hernia.

My astonishment was extreme when I saw how utterly the proceeding had failed. The silk suture had evidently quickly been shed into the interior of the sac and come away with the discharge and the dressings, allowing the orifice to resume its patency, whilst the only trace of the effects of the packing were some adhesions at the upper part of the pocket, which the pathologist almost unconsciously separated with his finger as he explored its limits and extent.

A CASE OF RETROPERITONEAL FIBROLIPOMA : OPERATION : RECOVERY.

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IN Mr. Alban Doran's admirable summary of the literature of benign retroperitoneal tumours,¹ comment is made on the scarcity of recorded cases, only 13 records being available for purposes of comparison. This circumstance is, I think, sufficient apology for the publishing of the account which follows.

My patient, M. A., was admitted to the Royal Victoria Hospital on August 27th, 1904. She was married and a 3-para, aged 38, but older looking; her last confinement was eleven years previously. She first noticed the tumour six months before admission; it had increased in size rapidly for three months, and had since remained quiescent. It caused no pain, did not interfere with her appetite, or with her daily work. Menstruation had been always regular from the age of 15, was 4 to 5 weekly in type, lasted as a rule four days, and was copious. The menses came on three days after admission, and the loss, which was fairly profuse, continued for a week. She had typical "facies ovarica," was rather thin and anaemic, but heart, lungs, and kidneys were sound. The abdomen was distended by a tumour reaching from the pelvis to within 2 in. of the ensiform cartilage, rather more prominent below than above the umbilicus. It was roughly globular in shape, irregular on the surface, some of the projections being distinctly firmer than the general mass. There was no true fluctuation, but here and there one got a sense of elasticity, like that given by a small tense cyst. The whole tumour was dull on percussion, a clear note was got above it, and in the left flank. Per vaginam the uterus could be felt fairly normal in position, the pelvis was empty. I diagnosed an ovarian tumour, perhaps a multilocular cyst with almost solid contents, or more probably a fibroma.

On September 10th I opened the abdomen by an incision 3 in. long midway between the pubes and umbilicus. The tumour was greyish-pink in colour and quite solid, the uterus and both ovaries perfectly normal. The incision was rapidly extended up to within two inches of the ensiform cartilage, and the tumour thus fully exposed was found to spring by a broad base from the right flank, its attachment ending below at the right iliac fossa. The front and sides of the tumour were covered by peritoneum, the ascending colon lying on what one might call the left brow of the tumour. The peritoneum was incised along a line parallel to and about 1½ in. to the right of the ascending colon, which was then carefully stripped off the tumour, my assistant making traction to the right on the mass. When this had been done the right ureter and kidney came into view, being apparently embedded in a deep groove on the inner and under aspect of the tumour, which was freed from them, a small piece of the kidney capsule coming away in the process. The tumour then shelled very easily out of its bed in the loin, and was completely separated by dividing the peritoneal reflection along its outer border. Only two leashes of vessels required ligature. The oozing from the large raw surface left was checked by copious douches of hot saline. The cut edges of peritoneum were then sutured, bringing the right colon and kidney into approximately normal position, and the abdominal wound closed.

There was some rise of temperature for the first five days of convalescence (101° F. on two occasions), due probably to absorption from the raw surface. Diarrhoea was present for

the first week, owing, I suppose, to interference with the blood supply of the ascending colon. The patient left hospital four weeks later, much improved in appearance, and with a sound abdominal scar. I saw her again nine months after operation. She had put on flesh, and expressed herself as "never better." Abdominal palpation showed no return of the tumour, and the kidney could be felt in its normal position.

The tumour weighed 20lb. on removal. On section it proved to be a lipoma with small myxomatous areas, and a fair amount of connective tissue, and this diagnosis was confirmed microscopically.

Fig. 1.—Ideal section to show relations of tumour: T., tumour; R.C., right colon; L.C., left colon; S.I., small intestine; R.K., right kidney; L.K., left kidney.

The case requires very little comment. Like most other surgeons who have reported cases of this kind, I had no idea of the true state of affairs until the abdomen was opened. This might be avoided, and a correct diagnosis reached sometimes at least by careful and repeated examination of the relative areas of dullness and resonance; but some cases, I am convinced, would, even after the greatest pains had been taken, be confounded with ovarian tumours. As regards the operation, I was surprised in my own case at the ease with which it was performed, but I have since then assisted Professor Byers in an attempt at the removal of a large retroperitoneal tumour, which turned out to be a myxosarcoma. The growth was so intimately connected with the vessels of the mesosigmoid into which it extended that removal was impossible without endangering the vitality of the gut; and in addition tremendous venous haemorrhage, which could only be checked by plugging with gauze, followed the separation of the upper part of the tumour, which lay to the right of the middle line below the mesenteric attachment. This patient, however, recovered from the operation, and left hospital comparatively well. It is easy to understand, therefore, that the ease and safety of the removal will altogether depend on the relations of the tumour to the viscera, and still more to the vessels of the abdomen. As regards the treatment of the capsule, I am firmly convinced that in a simple case, such as mine, the best practice is not to plug with gauze, but to suture the cut edges, close the abdomen, and rely on firm pressure with a binder to prevent, or at least to check, oozing and the formation of a retroperitoneal haematoma. Even should this form, with aseptic methods there is practically no risk, and every probability of its ultimate absorption, while the patient escapes a lingering convalescence, a troublesome sinus, and the increased chance of a ventral hernia.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, October 22nd, 1904.

PROFESSOR CZERNY has resigned the Chair of Surgery in the University of Heidelberg, which he has held since 1877, in order to devote himself entirely to the duties of Director of the Institute of Cancer Research. He will be succeeded in the Chair of Surgery by Professor Garré, who accepted a "call" to Breslau after the death of Professor von Mikulicz.