**RECURRENCE OF RETROPERITONEAL LIPOMA :
OPERATION : RECOVERY.***

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In the *BRITISH MEDICAL JOURNAL* of December 2nd, 1905, I reported a case of retroperitoneal lipoma weighing 21 lb., situated in intimate relation to the right kidney and ureter, which I removed with ease, the tumour shelling out of its bed apparently completely.

The patient, a woman aged 40, rapidly recovered from the operation, and put on flesh. She remained in perfect health for about two years, but at the end of that time, eight months before I saw her again, she began to suffer from stomach troubles, and from slight pain in the back and sides. Two months later the abdomen began to swell, and these symptoms went on for six months, when she consulted Dr. Kirkhope of Belfast, who sent her to me. She came into hospital on March 2nd, 1907. Her appearance on admission was much better than when she first came under my care, she was much fatter and more healthy looking. I found the abdomen distended and filled with a lobulated tumour; the individual masses were firm in consistence, one in the epigastrium in particular was so hard that I was led to fear that the recurrence which was evidently present was of a malignant type. During the four days which she passed in hospital before operation she was quite free from symptoms of any kind. It is interesting to note that the scar of the first operation, which measured over 9 in. in length, showed no signs of yielding.

On March 6th I opened the abdomen by an incision of about 9 in. in length, and found the following state of affairs: The tumour consisted of a number of lobes varying in size from that of a goose-egg up to that of a Rugby football, more or less pedunculated, and only united at their common site of origin, which was in the right flank in the angle between the outer border of the kidney and the iliac crest. The right colon lay internal to this, and several large vessels ran from its outer border into the pedicle. One small mass, burrowing beneath the caecum, had opened up the layers of the meso appendix, and extended into the iliac fossa. I removed all the masses, some for convenience sake being tied off and separated from the pedicle, and completely cleared away the perirenal fat, leaving the quadratus lumborum bare. I also removed the appendix when enucleating the mass which I have described as burrowing beneath it and the caecum. The peritoneum was then sutured over the denuded muscles, and the abdominal wound closed. Recovery was uneventful, and the patient left hospital on the twenty-first day after operation. I need hardly say that I shall keep a careful watch over her future history.

The tumour masses weighed altogether 12½ lb., were pinkish-white in colour when fresh, and microscopically showed typical lipomatous tissue, with no trace of malignancy.

The case is of considerable interest, both on account of the rarity of the original condition and also on account of the recurrence. Adami,¹ in his monograph on retroperitoneal lipoma, was able to collect 42 cases. Of these 26 were operated on, with only 12 recoveries. In one of these cases recurrence took place, but I do not know whether this case was operated on again or not.

I was surprised at the recurrence in my case, as the first growth shelled out with so little trouble, and as the tumour, which has been preserved, shows no cut or torn surface anywhere, and seems altogether encapsuled. I do not think the secondary growth can be malignant, both on account of the negative microscopic finding and also because there were no signs of haemorrhage or degeneration such as are almost invariably present in retroperitoneal sarcomata which have attained any considerable size. The clinical evidence, absence of cachexia, of loss of weight, and of signs of metastasis, is also entirely against any presumption of malignancy.

REFERENCE.

¹Adami, *Montreal Medical Journal* (January and February, 1897). Quoted in Nothnagel (English edition), *Diseases of the Intestines and Peritoneum*.

* Read before the Ulster Branch of the British Medical Association.

THE late Miss Caroline Everard of Salisbury, who died on August 28th, left £1,000 each to the Norfolk and Norwich Hospital; the Royal Hospital for Incurables, Putney; the Asylum for Idiots, Earlswood; and the Hospital for Consumption, Fulham Road; £800 to the British Home for Incurables; and £500 each to the South London Ophthalmic Hospital; the National Hospital for the Paralysed and Epileptic; Salisbury Infirmary; the Seamen's Hospital, Greenwich; and the West London Hospital.

**A CASE OF RETROPERITONEAL HAEMATOCELE
PRODUCING ACUTE INTESTINAL
OBSTRUCTION.**

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RETROPERITONEAL haematocele is a somewhat rare condition, and intestinal obstruction of acute character in association therewith is rarer still. The following case, therefore, seems worthy of record.

History.

In July, 1907, I was asked by Dr. F. Pershouse, of Johannesburg, to see in consultation with him a lady, aged 39, who the previous day had shown typical symptoms of acute intestinal obstruction. The history was that three years previously, shortly after confinement, she discovered a lump in the left lumbar region, which caused a certain amount of dull aching pain in the back. She suffered always from constipation, but could obtain relief by means of castor oil. A year ago while in London she had symptoms of obstruction, but apparently not of acute character. Under the advice of a surgeon whom she consulted massage was carried out, with complete relief to the symptoms. From time to time, however, she had left lumbar pain, and always more or less constipation.

Condition before Operation.

When I saw the patient she had been confined twelve days before, having a perfectly normal labour. The facial aspect was anxious; vomiting was frequent, the vomited material being greenish-brown and of inoffensive odour. The pulse was 100, and rising steadily. The abdomen was distended, though not greatly so, and in the left lumbar region a hard movable lump could be felt. It could be felt bimanually to extend into the loin, and was movable antero-posteriorly but not laterally. It was dull on percussion. The impression conveyed was that of a pararenal growth of some kind. There had never at any time been any renal symptoms. The lump extended from the left renal region down to the umbilicus, and over to the middle line. The nature of the swelling was quite uncertain, and beyond a vague suggestion that it was a pararenal "something" no diagnosis was made.

Operation.

The condition of the patient was critical, since no relief had been obtainable by enemata, and the acuteness of the symptoms was hourly increasing. She was therefore removed to a nursing home, with a view to operation. Four hours later, Dr. Pershouse anaesthetizing and Dr. Stanley Heberden assisting, I opened the abdomen in the left linea semilunaris over the swelling. There was no sign of peritonitis. The ascending colon was completely flattened over a large tense swelling, which bulged forward the posterior peritoneum, the colon lying to its outer side. Some large vessels, apparently supplying the colon, ran over its surface. Above, the swelling was apparently continuous with the left kidney, and it extended well over to the middle line. An exploring needle and syringe withdrew pure blood only from the swelling. An incision was made parallel with the vessels through the posterior peritoneum, and an attempt made to shell out the swelling. It was, however, completely fixed posteriorly and above, and a fresh layer was attempted in what looked and felt like a tumour capsule. Suddenly the finger slipped into a large cavity, from which rushed some fluid blood and large masses of blood clot, some recent and some old. The peritoneal cavity had been well packed off, and there was no soiling of the peritoneum. The cyst cavity being thoroughly emptied and sponged out, the cyst wall was stitched all round to the peritoneum of the anterior abdominal wall and the cavity stuffed with gauze. There had been free oozing from the wall of the cyst but this ceased on pressure with the gauze packing. None of the cyst wall was removed, since there was none to spare when the cut edges were brought forward.

After-History.

The subsequent progress of the case was uneventful. Flatus was passed on the following day, but there was no full action of the bowels for forty-eight hours. The cyst cavity gradually and completely closed in a month.

Contents of Cyst.

The material removed from the cyst was submitted to Dr. Pakes, Pathologist to Johannesburg Hospital, and his report was that it was old and recent blood clot with fluid blood.

It seems clear that the origin of the trouble was a retroperitoneal haemorrhage during the confinement three years ago; that at the recent labour a fresh haemorrhage occurred rendering the cyst tense and flattening the colon over it. Precisely the source of the haemorrhage it is difficult to determine—whether from a mesenteric vessel, a renal branch, or a pancreatic vessel it was impossible to decide.