A CASE OF EXTIRPATION OF THE KIDNEY FOR
SARCOMA.By W. H. MAIDLOW, M.D., F.R.C.S.,
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THE scantiness of the literature on abdominal nephrectomy for so-called renal sarcoma in adolescence in comparison with the importance of the subject of these tumours, and the somewhat unusual pathological features of the growth under notice, are points which afford me justification in making this short communication.

Mrs. P., aged 25, primipara, after a normal confinement on August 9th, 1897, found that her abdomen still remained large, an enlargement which, on examination, I found to be due to a tumour having the usual characters of one connected with the left kidney. Its surface was bossy (the largest boss being as large as a golf ball), hard in texture, fairly movable, and only causing discomfort of a dragging nature. A small swelling had been noticed twelve months previously, but had given no trouble, and so was neglected. There was no history of hæmaturia, and the urine, except for containing a cupric oxide reducing body, due to lactation probably, was always normal on subsequent examinations. In the right axilla there was a supernumerary nipple which was secreting milk freely. Abdominal section was advised and performed by me on August 31st, three weeks after the confinement. No attempt was made to arrest lactation, which gradually ceased spontaneously after the operation.

After the incision and opening in the middle line of the abdomen, the tumour was found to be sessile, and attached to the left kidney, covered externally by a rather lax peritoneal capsule, which was divided, clamped at its base, and peeled off. Under this was a fibrous capsule continuous with that of the kidney, which was adherent to the tumour over an area the size of a penny, and expanded over for about $\frac{1}{2}$ in. on each side of this, like an egg-cup over an egg. Attempts to remove the mass from the kidney first led to such severe hæmorrhage that it was necessary quickly to ligature the renal vessels and remove the kidney with the rest of the tumour. She suffered much shock from the bleeding and length of the operation, but except for slight femoral thrombosis of both legs, which quickly passed off, and a curious remittent range of temperature (99° to 102° F.) for the first three weeks she made a speedy convalescence, and on October 19th walked unaided into the garden; and at this date (January 28th) her condition is very satisfactory.

The tumour weighed 7 lbs., and had an average diameter in any direction of $6\frac{1}{2}$ in. Its naked-eye appearance was typically sarcomatous, with patches of softening and blood extravasation, and was everywhere encapsulated. Microscopically (Clinical Research Society), it is a mixed celled sarcoma, with patches of mucoid change. Considering the obvious non-involvement to any extent of the kidney, and the very definite capsule continuous with that of the kidney, one would have expected to find some adrenal elements derived from one of those accessory or aberrant adrenal bodies described by Mr. Bland Sutton, but no such elements were found in the portions examined. Nevertheless, the growth has probably originated from some such source, as its subcapsular anatomy was very obvious. The future events will be interesting to note, and also very interesting is the association with the supernumerary nipple in the axilla. There was never the slightest anxiety concerning the opposite kidney, which could easily be examined through the very loose peritoneum during the operation. The kidney, except for about $\frac{1}{4}$ inch subjacent to the point of attachment of the tumour, seemed quite free from disease. It appeared to have been involved only secondarily.

THE BISHOP OF LONDON will take the chair at a dinner to be held at the Hôtel Métropole on Thursday, April 28th, in aid of the Hospital for Sick Children, Great Ormond Street, when a special appeal will be made for £30,000 for the purchase of the adjoining hospital of St. John and St. Elizabeth.

THE London County Council has resolved that from April 1st next coroners' juries in the County of London, when summoned by rota, shall be paid if they demand it 2s. each per attendance.

MULTIPLE CYSTS OF STOMACH AND SMALL
INTESTINES.*By HARRY B. ANDERSON, M.D., C.M. TORONTO,
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APART from mucous cysts, parasitic cysts, and cysts from degeneration in tumours, the walls of the stomach and intestines appear rarely to be the seats of these accumulations, in so much that I consider the present case worthy of presentation before this Association.

Mrs. A., aged 59, born in England, but had lived in Canada since childhood. Had one child. Health had always been good until about ten years ago. Since that time she had been troubled with chronic diarrhoea and bilious attacks, which were becoming progressively more frequent and severe, being much worse during the last few years. She was well developed and well nourished, maintaining her weight until about four months before her death, when she began to lose rapidly. This was coincident with and attributed to her more frequent attacks of diarrhoea and vomiting, and her inability to take food. She would often feel quite hungry, as if she could partake of a good meal, but on eating a small quantity her desire would be satisfied.

She was first seen on July 5th, 1897, by Dr. D. W. Macpherson, of Toronto, to whom I am indebted for clinical notes of the case and permission to report it. She had had a severe attack of diarrhoea about a week before, but for three days previous to his seeing her she had persistent constipation.

Examination revealed the presence of a tumour in the left umbilical and hypochondriac regions about 6 inches in diameter. It was movable upwards and to the left. There was no pain or tenderness in connection with it. Slight fluctuation could be made out. The area of the tumour was dull on percussion, the rest of the abdomen being markedly tympanitic. The patient had first noticed the presence of the tumour herself about six weeks previously, and she said it was slowly enlarging. Purgatives and enemata were resorted to, and on July 9th there was a profuse evacuation of a very offensive, slightly greenish-yellow material with some scybalous masses from the bowels. After this the bowels began to act well and the motions became normal in appearance. The vomiting, however, continued; she could take no nourishment and was continually getting weaker, and an exploratory incision was decided on, which was made on July 15th.

The abdomen was opened by a median incision above the umbilicus. The peritoneum was normal in appearance. On entering the peritoneal cavity, a tumour the size of an infant's head presented. It was intimately connected with the anterior surface of the stomach and adherent to the transverse colon and some coils of the small intestines, rendering separation impossible. The tumour was sutured to the abdominal incision and opened. About 500 c.cm. of reddish-brown fluid was evacuated. This was not preserved for examination. The vomiting ceased; the patient remained conscious, suffered no pain, but sank slowly and died twenty-four hours after the operation. Dr. Macpherson made a necropsy the same day and submitted the specimens to me for examination.

Besides the cyst opened at the time of operation five others were found, as described later. The mesenteric and retroperitoneal glands were slightly enlarged and dark in colour; the pancreas was much atrophied—chronic interstitial pancreatitis. The distal end of the pancreatic duct was greatly enlarged, resuming its natural size 2 inches from the opening in the duodenum. The liver, gall bladder, and biliary passages were normal. The other abdominal and thoracic organs were examined, but showed nothing worthy of special note. There is a large unilocular cyst in the posterior wall of the stomach 4 inches wide, extending from the lesser to the greater curvature, and 6 inches long, extending from the cardiac end to within 4 inches of the pylorus. It is situated between the peritoneal and muscular coats, and does not communicate with the in-

Fig. 1.—Anterior view (stomach opened along lesser curvature); a, lesser curvature; b, cyst in posterior wall; c, cyst; d, jejunum; e, cyst; f, cyst; g, colon.

* Read before the Pathological Section at the Annual Meeting of the British Medical Association held in Montreal, August-September, 1897.