middle line and down into the left iliac fossa. She complained of pain in the left iliac region and frequent micturition, accompanied by a bearing down pain. The tumour was slightly mobile, and was dull in the flank as well as elsewhere. The urine was normal. The diagnosis lay between hydronephrosis and an intra-abdominal cyst. Chromocystoscopy was resorted to, when both ureters were seen to be expelling coloured jets of equal intensity and equal frequency. The renal origin of the tumour was, therefore, negative, and the abdomen opened to the outer side of the left rectus muscle. It turned out to be a mesenteric cyst—one of the rarest of abdominal tumours. The contents consisted of the usual milky fluid. It was drained, and three months later, when the cavity had shrunk and it appeared that it would not close if left to itself, it was successfully dissected out. The cyst had taken its covering from the left layer of the mesentery, and had compressed the descending colon into the loin, thereby preventing gas from accumulating in that viscus and accounting for the absence of resonance in the flank.

I will not weary you by detailing any more of the many instances in which I have found chromocystoscopy of use in my practice during the last few years, for I think I have offered ample evidence in support of the proposition with which I started—namely, that the method is deserving of more extended recognition and general application than is the case at present. Indeed, I would go further, and urge that it should be included in the routine course of examination of all renal cases before operation, and of all abdominal tumours where there is the smallest possibility of their renal origin.

CYSTIC DISEASE OF KIDNEYS WITH PYURIA AND HAEMORRHAGES.

BY

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The following is an interesting summary of a case of cystic disease of the kidneys, in which a correct diagnosis was arrived at during life, although no tumour could be felt. In an analysis of 62 such cases by Lejars, a correct diagnosis was made during life in only 5 of them, and a tumour was present in only 18.¹ The case also has some bearing on the relationship of malaria to the disease. "Michalowicz considers that malaria contributes in a distinct manner to cystic degeneration both of the liver and kidneys."²

Whenever pyuria occurs in association with the general symptoms and signs of chronic interstitial nephritis, there is a probability of cystic kidneys; particularly if any other congenital malformation be present.

C., three months before his death at the age of 11, was seen in consultation with Dr. Bletchly, who has kindly furnished most of the particulars.

His mother had malaria before he was born, and though seeming all right at birth, he had "malaria" within six weeks, with temperature reaching 106° and extreme emaciation, but rapidly got well under treatment by quinine and change of air. At 5 months he had inflammation of the bowels and lung. He was subsequently in India till the age of 4, and it was found that he had an undescended testicle. At the age of 5 the undescended testicle was removed by Mr. E., and the wound finally healed after two or three months.

At the age of 6 it was noticed that his urine was offensive from time to time, and during these attacks his vision was bad and he was fidgety and irritable. At 8 he could not see properly, being apparently very near-sighted. He consulted Mr. B., who referred to bacilli in the urine.

At 9 his eyes were examined by Mr. C., who reported: Fundus suggestive of albuminuric retinitis; one or two haemorrhages in left eye; left optic post-neuritis; suggestions of old trouble and recent also; fields of vision narrowed in both eyes, more so in the left; signs like albuminuric retinitis, but equivocal. His urine was then examined on two occasions, and on each it contained numerous pus cells and sluggish motile bacilli, but no casts, blood cells, or renal epithelium.

At 9½ years he was seen by Mr. M., who examined him under an anaesthetic; found the bladder normal, the kidneys not enlarged, and diagnosed pyelitis. The urine was then acid, with a trace of pus, red blood cells, many bacteria (not tubercle bacilli), and a small number of hyaline casts. He then had measles, and returned to school six months ago looking well.

Two months ago he appeared to have slipped from the steps of a swimming bath, and was at the time thought to have meningitis. His urine had been very bad previously. He had no "fit," but is said to have drawn both arms up, screwed his face, and to have fallen off; then he scrambled and fell off again, and later shook his arms up and down. He was very ill afterwards; once fell out of bed, had severe right frontal headache for some time; there was no sickness or delirium,

but temporary retention of urine. Paralysis was noticed ten days after the fall, gradually diminishing.

Up to this time the pyuria and the central nervous condition had not been referred to a common cause, the former having been rather attributed to infection of the bladder from the sinus remaining after removal of the undescending testis.

Three months before death there was slight albuminuria; the heart's apex was external to the nipple line, and the pulse of high tension. There were paresis and slight wasting of the left face, arm, and leg. The knee-jerks were increased, more so on the left; and Babinski's sign was present on the left side. We thought the condition due to cerebral haemorrhage, and argued that the only possible common cause for this and the pyuria would be congenital cystic kidneys, although the kidneys could not be felt. There supervened orthopnoea, sickness, slight haematemesis, cardiac dilatation with enlarged liver and pulmonary congestion, scanty urine, and he eventually died in syncope.

Post-mortem Examination (Dr. Bletchly).—No meningitis; right convolutions somewhat flattened. Evidence of old haemorrhage into the right lateral ventricle. No abscess or sinus in connexion with the scar of operation for undescended testis. No cysts in liver. Right kidney: Very small, only capsule and a little fibrous tissue in the lower half; and the upper part was very small, with capsule adherent, and a few cysts on the surface containing clear fluid; ureter small but patent. Left kidney: Larger than normal; a few small cysts on surface, extending into the cortex; capsule adherent; cortex ¼ in. thick; kidney substance very hard; a little pus in the renal pelvis; ureter patent. No other sign of pus; bladder walls thickened.

REFERENCES.

- ¹ H. Morris, *Surgical Diseases of the Kidney and Ureter*, 1901, i, 558, 652.
- ² *Ibid.*, p. 656.

A CASE OF TORSION OF THE GREAT OMENTUM AND HABITUAL PARTIAL REDUCTION EN MASSE.

BY

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By collecting all the records of omentum torsion in some papers published with Dr. Pinches in 1905 and 1906,¹ it was found to be in reality by no means such a rare occurrence as had been thought, the real reason for its apparent rareness being that it was very easily overlooked. Having had a typical case under our care lately in the Passmore Edwards Hospital, Wood Green, we have decided to publish it, so as yet again to draw attention to the subject of torsion of the omentum and the type of case in which it will be found most frequently. In 1905 Dr. Pinches and one of us stated that "torsion should be looked for carefully in all epiploceles of old standing, especially when painful, irreducible, subject to attacks of pain, or strangulated."

Torsion of the omentum most frequently occurs in association with an inguinal hernia of old standing, which contains only omentum. This is the class of case in which, not only is it most frequent, but when it is most easily overlooked. There is a clinical feature which is useful to direct the surgeon's attention to the possibility of torsion when operating on an omental hernia associated with symptoms of subacute strangulation—namely, if the neck of omentum be easily moved within the inguinal canal, which is consequently loose and not strangulating the omentum. Therefore, when the cause for the symptoms is not found in the strangulation of the hernia, let torsion of the contents of the sac be carefully looked for.

The patient was a man, B., aged 54, who had had a left inguinal hernia for forty years. For thirty years he had worn a truss, and for the last seven years had been unable to reduce all the contents within the abdomen. He had had occasional pain in the hernia, but never anything so severe as the attack to be described. On June 5th, 1908, he went to bed in his ordinary health, and was awakened early in the morning with severe pain in the hernia, which had become greatly increased in size. There was no sickness, and the bowels were inactive, though flatus was passed. For thirty-six hours he lay in bed with the pelvis well raised and hot applications to the part, which became gradually reduced to its normal size, a portion remaining irreducible. He was seen by Dr. Grant on the night of June 7th, when the pain had very largely diminished, the temperature was normal, and the pulse quiet.

Five days later he was anaesthetized by Dr. Fergusson in the hospital. He was a short stout man, and under the anaesthetic