colic preceding the jaundice, and with gall-stone obstruction of the common duct we do not usually find an enlarged gall bladder. However, the swelling in this case was very hard, and not in the usual position of a distended gall bladder, nor did it move with respiration as freely as one would expect a gall bladder to do.

The patient was young for malignant disease of the head of the pancreas, pressing on the common duct, and the repeated attacks of jaundice were unlike obstruction of the duct from new growths, and were indeed suggestive rather of gall-stone obstruction. Gall-stone obstruction seemed the more likely cause, but it did not seem a straightforward case of this kind.

It is a very interesting question why the jaundice varied from time to time. It seems to me that the probable explanation must be that for days or weeks the amount of fluid in the cyst, and therefore the tension, varied, and as this varied so the pressure on the bile duct was diminished or increased. It was also very remarkable that before the patient was under the anaesthetic at the time of the second operation, neither cyst should have caused sufficient bulging to lead to its discovery, and that even with the abdominal wall relaxed under the anaesthetic the lower cyst could not be felt until the abdomen was opened. They both lay under the viscera and at considerable depth, and this was no doubt the explanation of the difficulty in their detection. It shows how retroperitoneal tumours of considerable size may escape detection, even when one is looking for them. The case also illustrates the difficulty which may be encountered in attempting to remove such cysts.

In the second case the fact that the cyst was not ovarian might have been suggested by the undue mobility upwards under the anaesthetic. I had not observed this before the anaesthetic was given, though I had noticed the possibility of lateral mobility.⁴ The inability to feel anything of the tumour on a vaginal examination was of no particular value as an indication that the tumour was not ovarian. The largest ovarian cyst I ever operated on I could feel nothing of either per vaginam or per rectum. I do not know how the two large bosses present on the tumour are to be accounted for, for the cyst was unilocular; possibly it bulged more at these parts.

I have recorded⁵ another case of cyst of the mesentery, and in that case the tumour grew in the mesentery in a hernial sac and caused the irreducibility of the hernia. It was a small cyst with dense white wall of fibrous tissue, and on laying it open some soft partitions of what looked like fibrin were seen stretching across it. The fluid from it was slightly blood-stained and a little viscid, and on standing spontaneously coagulated into a jelly. Microscopic examination of the wall showed only fibrous tissue.

Other cases in which mesenteric cysts have been diagnosed as ovarian tumours are on record.⁶ An exhaustive account of mesenteric cysts, with references to many recorded cases, will be found in the papers of Moynihan and Dowd in the *Annals of Surgery*.⁷

NOTES AND REFERENCES.

¹ Quoted by Mayo Robson and Moynihan in *Diseases of the Pancreas*, 1903. ² Loc. cit. ³ Loc. cit. ⁴ The lateral mobility has been considered a diagnostic feature of mesenteric cysts; also in some cases a band of resonance across the cyst has been observed. ⁵ *Lancet*, 1896, ii, p. 1678. ⁶ Carter. *BRITISH MEDICAL JOURNAL*, 1883, i, p. 7; and Knowsley Thornton, *ibid.*, 1882, ii, p. 1242. ⁷ Vol. xxi, p. 1, and vol. xxxii, p. 515.

"RETROPERITONEAL MANIPULATION":

A METHOD OF SEPARATING DEEP-SEATED, PLASTIC, PERICAECAL OR OTHER PERITONEAL ADHESIONS.

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Now and again the surgeon meets with cases of appendicitis in which the adhesions in the neighbourhood of the appendix are so extensive, solid, and deep seated that there seems to be no way out of the *impasse*. In the following case all the parts in the right iliac and pelvic region seemed to be massed together in one piece:

History.—G. E., male, aged 27, single, took ill with appendicitis for the first time in February, 1902, in a distant part of New Zealand. He had another attack in August and again in October of the same year. That month he was operated on by a medical man who had three others with him. The operator, after long and tedious work in tying omental adhesions, was unable to find any trace of appendix, and so the abdomen was closed up again. He suspected that the appendix was curled up behind the caecum somewhere, but was unable to get at the caecum owing to dense adhesions in the right pelvic and iliac regions. The

patient subsequently went to Melbourne and Sydney, and was in a private hospital in Melbourne, January, 1903, with an acute attack. On returning to New Zealand in February, 1903, he had another attack, and again in March and April. He had been taking hypodermic injections of morphine for the last seven months to relieve the almost constant pain.

State on Examination.—When he arrived in Auckland on April 23rd, 1903, he looked very ill, and his weight was only 7 st. 8 lb. He had some trouble in emptying his bladder, and there was deep-seated tenderness in the right iliac region with some ill-defined thickening there. His temperature was normal. The blood count was normal.

Operation.—On April 26th I opened his abdomen, four other surgeons being present, and, having decided to get at the hidden appendix by the back way, I made an incision 3 cm. internal to the anterior superior spine of the ileum (and to the outside of the former incision), and extended it for 9 cm. above that point and 6 cm. below it (somewhat similar to Crampston's incision for ligaturing the common iliac artery). The condition found was just what I expected from the account given by the former operator—no sign of appendix, but just a close mass of adhesions, like a blank wall, lining the whole of that part of the abdominal cavity. The ileum disappeared into this mass low down, and below it again; the end of the caecum was attached by broad sessile adhesions to the right side of the bladder, which was pulled up somewhat. After a long and patient endeavour to separate the parts from the front I put into practice my plan of "retroperitoneal manipulation," and had it not been for this method of attack I should have had to abandon the attempt as the former operators had done. I first divided the posterior peritoneum over the iliac fascia for about 6 cm. just below the anterior superior spine, in the line of the skin incision, and then inserted my right little finger downwards (while the peritoneum with the intestines was held well forwards) till I felt it cross the external iliac artery, and then with my left little finger in the abdominal cavity in front, and as low down as the other finger, I worked one against another, and soon felt a lump which was the appendix. By gentle manipulation I could feel the adhesions giving way behind like broken cheese, and within ten minutes the front part of the adhesions to the bladder gave way, and up came caecum and appendix out of the wound. The appendix was removed, and after touching the mucous membrane with pure carbolic acid it was sutured and a patch of peritoneum fixed over it. The appendix was inflamed, and about the size of a small orange. The posterior peritoneal wound was united by chromicized catgut sutures soaked for four days in alcohol, and the same kind of sutures were used for the layers of the wound. Owing to the under surface of the caecum (which had been attached to the bladder) being denuded of peritoneum, the caecum was fixed higher up so as not to contract deep adhesions again, and a drainage tube was left in the lower end of the wound, reaching down to that part. The tube was removed in twenty-four hours.

The patient recovered with no bad symptoms and a normal temperature, and was discharged on June 13th, 1903. At the present date, July 26th, 1903, he is 2 st. heavier, has no pain at all, and is back at work managing a sheep station.

When long adhesions form in the abdomen, they are apt to be tense and fibrous if they are so placed as to be subject to constant movement, and they can be tied off as they have pedicles; but a sessile adhesion, although on its inner abdominal aspect it may be pretty firm, yet will be found to be quite friable if attacked from behind. Bleeding from sessile adhesions, especially when approached from behind, is rarely noticeable, or, if present, can be stopped by sponge pressure, as was done in this case. The procedure described above would, of course, not apply when suppuration is present.

SUBPERITONEAL LIPOMATA.

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Tumours of fatty appearance which have their seat in the subperitoneal tissue are comparatively rare, but are nevertheless interesting and important from the clinical as well as from the pathological point of view. They mimic tumours of every kind known to abdominal surgeons, and hence are liable to cause errors in diagnosis in the practice of even the most careful observers. When removed they are deceptive in appearance, so that they may belie the prognosis and cause great disappointment to both surgeon and patient. This latter tendency makes them specially interesting to the pathologist, for it has of late been observed that certain tumours in this situation, which in appearance are simple lipomata, prove to be really sarcomatous in character, and after removal, recur with a fatal result.

It has been my luck to meet with two cases of subperitoneal lipoma in my operative practice, and I take this opportunity of placing them on record:

CASE 1.—E. L., aged 55, single, was sent to me by Dr. J. Campbell Hall, of Monaghan, on May 18th, 1900. She complained of increase in the size of the abdomen for four years, and of emaciation for two years. She had a slight cough, and, in connexion with this, Dr. Hall called my