The anthracoid organisms were isolated and found to be true virulent *B. anthracis*. The animal inoculation was carried out by Dr. J. A. G. Burton of the Royal Infirmary, Glasgow, who reported the organism to be very virulent, a small dose killing a guinea-pig in 36 hours.

The unusual features of this case are (1) the long period intervening between the exposure to infection and the development of the first pustule, and (2) the presence of a second and younger lesion. The incubation period usually given for malignant pustule is from one to three days, but in this case eight days elapsed before the pustule appeared. However, it is possible that, although the patient changed his shirt and underclothes, spores had already been transferred from these to his jacket and infection of the skin may have taken place subsequently. Clinically the second pustule was much younger than the primary one, and its development is probably to be explained by auto-inoculation, as the patient admitted scratching the first one when it appeared. Also to be noted is the absence of general symptoms and the slight local reaction, although the primary lesion had been present for four days before admission, and the organism was proved to be very virulent to the guinea-pig.

TWO UNUSUAL CASES OF ABDOMINAL TUMOUR.

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BOTH these cases are of sufficient rarity in the surgery of the abdomen to warrant their being placed on record.

CASE 1. Large Splenic Cyst.—This patient, who had never suffered from any illness, was the mother of a boy aged 6 and twins aged 4. After the birth of the twins and when she got up she noticed that her figure was not quite as it used to be, it was a little fuller on the left side than the right. The swelling on her left side gradually got larger during the next four years, but she suffered no pain or discomfort. She was admitted to the Radcliffe Infirmary in February, 1918, and examined by the late Sir William Osler, and the notes which he dictated while examining the patient I give in his actual words.

"A healthy woman, aged 44, not anæmic, pulse regular, arteries good. On examining the abdomen there is a large irregular prominence in the epigastric, left hypochondriac, and left lumbar regions, which lifts the costal margin and bulges the left flank; there is also a marked prominence just above and to the left of the umbilicus. The tumour crosses the mid-line and extends nearly to the right mammary line, and descends with inspiration. No intrinsic movements could be seen, there is slight diffuse pulsation, and coils of intestine are visible at the navel. On palpation the mass occupies upper left quadrant of the abdomen, it is irregular and extends to level of left anterior superior iliac spine, and passes under left costal margin; the finger can be placed between it and the costal margin. It is soft and elastic in front, there is no edge to be felt, it is harder on the right side. Where it is more irregular it descends freely with inspiration and the fingers cannot be placed above it. Behind, with fingers in the renal region, it can be pushed forwards and grasped between the hands and pushed down. The colon cannot be felt over it, the upper limit of dullness is in the mid-axillary line on the seventh rib. It feels soft, elastic, and mobile, and is probably a soft elastic cyst hydronephrotic in origin; the renal region is definitely occupied by the mass. The right kidney is quite palpable and is not enlarged."

Examination of Urine.—Acid, specific gravity 1020, urea 2 per cent., no abnormal constituent. **Cystoscopy.**—Both ureters secreting; ureters catheterised and normal urine collected from each.

Operation.—March 5th, 1918. A long para-rectal incision was made on the left side; the tumour proved to be a cyst of the spleen about the size of an association football. The spleen, much elongated, lay on the outer or left side of the cyst, and the splenic pedicle was stretched out over the convex cyst wall. There were numerous adhesions of the cyst to the left vault of the diaphragm, these were clamped, divided, and ligatured, some of them with a little difficulty; the splenic pedicle was divided and ligatured and the spleen removed.

There was no difficulty with the operation, except in the ligature of some of the strong vascular adhesions to the

diaphragm. The patient made a good recovery, was discharged from hospital on March 31st, 1918, and is in good health at the present date.

The pathological report by Dr. A. G. Gibson was as follows: "Specimen consists of a spleen with large cyst wall attached; there is moderate fibrosis of the splenic tissue; the cyst itself is full of blood-clot undergoing degeneration. This is probably an infarction cyst."

This case is an example of the real difficulty that often faces one in making a diagnosis of an abdominal tumour. The tumour was without doubt a cyst, and the diagnosis of hydronephrosis was justifiable until after cystoscopy and catheterisation of the ureters; even then a cystic tumour of renal origin could not be excluded. A splenic cyst was considered, but one was unable to feel anywhere the crenated border of the spleen. Moynihan¹ divides splenic cysts into (a) serous cysts, blood cysts, lymph cysts; (b) hydatids; (c) dermoids. This was a blood cyst, and it is suggested that it may have been due to an infarct, which appears to have originated at the end of the last pregnancy, as it was directly after the latter that the swelling was noticed.

CASE 2. Large Extra-peritoneal Fibro-myoma.—D. S., a married woman, aged 49, had noticed that her abdomen had been increasing in size for the last nine years, in fact, ever since she gave birth to her last child. She consulted her medical man because of large veins in her legs, chiefly the left, and at that time it was thought that she was pregnant; for the past two years she had suffered from frequency of micturition and difficulty of control. On July 10th, 1919, she was seen by me at the Radcliffe Infirmary, Oxford. On examination there was a large firm abdominal tumour springing apparently from the pelvis and reaching up to the umbilicus. The surface of the tumour was firm, hard, and non-elastic, and there was slight lateral movement. On vaginal examination the uterus could be felt pushed back behind the tumour; it appeared to be of normal size and to be separate from the tumour.

Operation.—A mid-line incision was made between the pubes and the umbilicus, and in doing so the tumour was slightly cut into; the peritoneal cavity could not be opened until the incision had been carried well above the umbilicus. The tumour was found to be extra-peritoneal and to be filling up the abdominal cavity by pushing the peritoneum in front of it; the peritoneum had been raised in front as high as the umbilicus. The uterus and all its appendages were identified; they were normal and had been pushed down into the pouch of Douglas by the tumour.

The latter was hard, encapsuled, and firmly attached to the apex of the bladder, some of the muscular fibres of the bladder being divided during the process of separation; there was a second point of attachment at the umbilicus. Elsewhere the tumour shelled out readily, but some of the invaginated peritoneum had to be removed with it. The gap in the peritoneum was closed and the abdominal wall sutured. The patient's recovery was uneventful. The tumour measured 10 in. in its long axis; the pathological report described it as a fibro-myoma undergoing colloid degeneration. It may have originated from the apex of the bladder or the urachus; seeing that the tumour was firmly attached to the apex of the bladder and the umbilicus, the two attachments of the urachus, it is reasonable to assume that it originated in the latter structure.

Thomson Walker² states that fibromyomata of the bladder may be intra-vesical, interstitial, and extra-peritoneal, and that about 20 cases have been collected. This case may then be regarded either as an extra-peritoneal fibromyoma of the bladder, or a fibromyoma of the urachus.

A CASE OF PARALYSIS OF THE SOFT PALATE FOLLOWING NON-DIPHTHERITIC TONSILLITIS.

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THE following case is of sufficient interest to merit permanent record.

L. W., aged 19, consulted me on July 1st for a sore throat. On examining the fauces, the left tonsil was found

¹ Sir B. Moynihan: Abdominal Operations.

² J. W. Thomson Walker: Genito-Urinary Surgery.