thought to be stupid, and there is no doubt that their faces often wear a vacant expression the silliness of which is not diminished by the mouth being held half open for purposes of respiration. But a really stupid child will often grow much more intelligent when the growths have been removed. These patients generally complain of headache, giddiness, and noises in the head. The tinnitus and perhaps the vertigo are probably dependent upon the ear mischief, but the headache, I think, is often a consequence of general weakness. It is an important fact that the majority of children who suffer from adenoids show very evident signs of defective nutrition. Sometimes they are ill-grown, and almost always their circulations are languid and their feet cold. Moreover, they are pale and thin or flabby, and although not, perhaps, physically indolent are easily tired. The common explanation of this unsatisfactory state is that, on account of the obstruction to the nose and the persistence of the patient in nasal breathing in spite of all difficulties, the lungs are ill-provided with air, so that the blood is insufficiently oxygenised and becomes loaded with carbonic acid and other impurities. But this explanation is far from conclusive. I have often been struck by the fact—of the truth of which I am convinced—that the degree of anæmia and malnutrition, and, indeed, the amount of general physical disturbance excited by the vegetations, is no just measure of the extent to which the nasal passages are obstructed; in other words, that the children whose nasopharynx is most completely blocked are by no means those whose nutritive deficiencies and nervous symptoms are the most pronounced. I believe their weakened state to be a natural consequence of the curious tendency to take cold shown by all the subjects of adenoids. They are like hot-house plants in their extreme susceptibility to trifling changes of temperature. A slight draught of air; a little too-prolonged exposure during the morning's bath; leaving the house on a raw day with cold feet, even although carefully clothed—all these are means by which chill may be incurred; and the consequent catarrh not only increases the worry in the post-nasal region and pharynx, but also invariably affects the digestive organs. These children may be said to live in a state of gastric derangement. Their stomachs are habitually out of order, and however much they eat—and often the appetite is little impaired—their food seems to do them curiously little good. The natural consequences of this chronic dyspepsia follow: the child gets thinner and paler, and suffers not only from insufficient nourishment, but also from all the discomforts and evils arising from the passage along the bowels of undigested and fermenting food. There are few children with adenoid growths who do not give evidence of some of the ill consequences which have been described. A certain amount of collapse of lung, with consequent retraction of the chest wall, may be said to be always present, and in most cases the nutrition of the child is unsatisfactory. But it is the neurotic children who suffer the most. They may not, indeed, give evidence of direct nervous irritation and spasm, but they are almost always anæmic and thin, and habitual sufferers from gastric derangement. In such children early removal of the growths is, of course, indispensable to improvement, and if nervous symptoms be present an operation is all the more urgently called for. So, also, in children of phthisical tendencies surgical measures should not be delayed, on account of the influence of the vegetations in checking nutrition and hindering the proper working of the lungs. In other cases, if the general health seems to be quite unaffected an immediate operation is not needed; but wherever adenoids are known to exist the child should, if possible, be kept under observation, so that they may be removed at any time when they seem to be doing harm. The danger of deafness alone is one which it is of the utmost importance to guard against.

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THE DIAGNOSIS OF RETRO-PERITONEAL SARCOMA, WITH CASES.¹

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ANYONE who has performed many laparotomies must have met with retro-peritoneal tumours. I have twice found this embarrassing condition. In neither case was it diagnosed before the operation. Had a diagnosis been made there is no doubt but that a useless operation would have been avoided, and in one instance I should have been spared a fatality, which was a matter of much regret. I am, however, convinced that a diagnosis ought to be possible in this class of cases, and it is with special reference to this point that I propose to narrate my own experience. At the same time, others may be warned against a pitfall into which I fell and escape a similar disaster. The tumour to which I am about to refer—namely, retro-peritoneal sarcoma—is worthy of more attention than it has received. It is not mentioned in the various indices, or in the larger works upon abdominal and general surgery. So far as can be learnt no specimen of it has been shown at the Obstetrical or Pathological Societies. Hitherto the Medical Society of London has had no opportunity of discussing its peculiarities. By the expression "retro-peritoneal sarcoma" is implied a sarcomatous tumour growing behind the peritoneum and into its folds, and not connected with any of the great retro-peritoneal organs and unaccompanied with ascites. This definition excludes, therefore, sarcomata which grow from the kidney. They are retro-peritoneal, it is true, but owing to their origin they are always called sarcomata of the kidney. Similarly, one which grew from the adrenal body would be retro-peritoneal, but would be called a sarcoma of the adrenal body, and so forth. In the class of cases of which I am speaking such precision cannot be attained, because in both of the cases to which I am about to allude, and in others of the same kind, the origin of the growth was unknown. The narration of the first case will give an idea of some of the clinical and anatomical features of these retro-peritoneal growths.

CASE 1.—The patient was a robust, unmarried woman aged forty-seven years. She said she had been short of breath for nearly a year, and for three months had had a feeling of weight in the hypogastrium. Her abdomen was always big, but of late it had seemed unusually distended. Her left leg had recently become swollen. Beyond this there was nothing in her history to point to the nature of her disease. Examination showed that the abdomen was so tightly distended that the skin was shiny and the umbilicus almost obliterated. A hard tumour could be felt filling nearly the whole abdomen, but projecting most beneath the left linea semilunaris. It seemed to rise up out of the pelvis and to extend more into the left flank and upwards into the left hypochondrium than into the right side; but the rounded edge of the growth could be felt reaching beyond the umbilicus almost into the right hypochondrium and nearly into the right flank. It was said that the tumour was dull everywhere and that the area of dullness did not vary, but I doubt whether this observation was quite correct for reasons which will be given presently. There was no ascites, and no thrill could be felt or fluctuation, and nothing was heard with the stethoscope. My colleague, Dr. Remfry, said the tumour had no connexion with the uterus, and, although the signs were anomalous, thought that it might be a tumour of the left ovary. For myself, I thought that the tumour was solid and probably connected with the ovary. I opened the abdomen by the usual incision and came upon a tumour which looked and felt like a thick-walled cyst. The abdomen was so tight that the hand could not be properly introduced; but, so far as could be felt, a thick-walled cyst, with a good deal of solid growth, seemed to be in question. A trocar was thrust into the tumour, but nothing came out. I then incised what seemed to be the wall of a cyst, and scooped out a quantity of semi-solid contents. Soon some large vessels were met with, but were easily secured. By this time there was room to explore the abdomen properly, and then the left colon was found upon the surface of the tumour, lying almost beneath the left linea semilunaris. It

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.—The annual general meeting and congress of this society will take place at 20, Hanover-square, W., on Thursday, May 30th. The following arrangements have been made:—4 P.M., address by the President, Dr. Pye-Smith, F.R.S.; 4.30 P.M., annual general meeting, election of officers &c.; 5 P.M., paper by Dr. H. Radcliffe Crocker on the Internal Therapeutics of Psoriasis and some other Diseases of the Skin. An exhibition of living patients, drawings, microscopic specimens, &c. will take place afterwards.

¹ A paper read before the Medical Society of London on May 13th, 1895.

is probable that its attachments were a good deal injured. The suspicions which this aroused were confirmed by the discovery that the mesentery and transverse mesocolon were incorporated with the upper part of the tumour, and that the pelvic organs were free. Moreover, at the sides of the abdomen the hand could not be passed behind any part of the growth. These points were made out with much difficulty, and the growth was clearly beyond the possibility of removal. The abdomen was therefore closed in such a way as to shut off the wound in the growth from the peritoneal cavity. A drainage-tube was inserted and an antiseptic dressing applied. For the first two days the patient seemed to be progressing well; but her temperature rose, sickness and other signs of obstruction set in, and she died upon the fourth day. An examination was made, which showed that the retro-peritoneal tissue was occupied by an enormous new growth. This reached from the brim of the pelvis to the diaphragm, and had thrust its way into the root of the mesentery, into the transverse mesocolon, and towards the hilum of the spleen. It enveloped but did not infiltrate the pancreas, kidneys, and supra-renal bodies. The vena cava inferior was incorporated with its posterior surface, and the mesenteric vessels ran through its substance. The mesenteric lymphatic glands were not seen, but might have been involved in the tumour. Towards the sides of the abdomen it had reached beneath the right and left colons. From this examination it was clear that the tumour was beyond removal. The organ or tissue whence it grew was, however, left obscure, but I thought it probably originated in the retro-peritoneal tissue. Both Dr. Galloway, who made the post-mortem examination, and myself were of opinion that this growth was a myxosarcoma. I regret that the report of the histological examination has been mislaid, but I have a distinct remembrance that no epithelial structures were found in the sections. The physical characters of the growth were those of a sarcoma. It was yellowish-grey in colour, with a red mottling in places. It varied from a soft solid to a gelatinous consistence. It was not very vascular except where it had involved the great vessels. It did not possess any capsule, but in places its lobes had pushed the tissues before them without infiltration having occurred. No enlarged lymphatic glands could be discovered. There was no peritonitis or suppuration, but the broken-down interior of the tumour had probably become infected. Before commenting upon this case I will narrate another of the same kind which was met with last year.

CASE 2.—The patient was fifty-three years of age and had noticed a fulness and weight in her abdomen for two years. She had been married for twenty-eight years, but nothing in her history pointed to the nature of the abdominal swelling. This was considerable, for her abdomen was forty-eight inches in circumference at the umbilicus. The swelling was caused by a tumour which occupied chiefly the right side of the abdomen. It was a firm and rounded mass, dull on percussion, devoid of bruit, and projecting most beneath the right linea semilunaris. Both flanks and the right side of the abdomen were resonant, and there was no ascites. There was a zone of resonance betwixt the tumour and the liver, and its upper margin could be felt about midway betwixt the umbilicus and the right costal cartilages. Below it seemed to dip into the pelvis. My colleague, Dr. Champneys, found no obvious connexion between the tumour and any pelvic organ. He was inclined to think that it belonged to the upper part of the abdomen. He agreed that an exploratory operation was desirable. On the whole I myself thought an unusual ovarian tumour was in question. I did not understand the significance of an observation which was made a fortnight after the patient's admission. The note said on Sept. 17th that "the lump in the abdomen seems most defined both towards the mid-line and down into the flank"; and four days later the note said: "There is decided resonance now in front of the lump, extending six inches to the right of the middle line and eight inches below the sternum." When I opened the abdomen a few days afterwards such a condition was found that it is only to be wondered that the area of resonance was not more variable and irregular. There was a large solid growth behind the peritoneum, growing into the root of the mesentery and pushing the small intestines in front of it. In this process the mesentery had been partially obliterated, so that in places the intestines were distributed over the surface of the tumour, lying in grooves in its substance. The growth had lifted up the peritoneum of the iliac fossa, together with the cæcum. The tumour was probably lobulated in places; it was of the colour of fat, but rather firmer

to the touch. As the patient's condition was precarious nothing more was ascertained. The wound, which was extensive, was closed with buried silk sutures in the linea alba, and fishing gut sutures in the skin. The patient made a fair recovery, but her convalescence was retarded by an obstruction in the veins of the right leg. The iliac veins had probably been pressed upon by the tumour. I have lately endeavoured to communicate with this patient, but without success.

Remarks.—There can be no doubt whatever that had these cases been diagnosed an operation would not have been attempted. In the first the exploration forfeited the patient's life, and in the second it caused a grave and serious illness. When such a tumour as this cannot be removed at the operation the abdomen has to be closed in such a state of distension that the action of the heart and the respiration may be gravely embarrassed. In addition, every unnecessary and unsuccessful operation brings discredit upon surgery. Clearly it is of the greatest importance that we should learn to diagnose these retro-peritoneal sarcomata. In the early stages it is probable that this would not be a difficult task, especially if the abdomen was examined with the patient under the influence of an anæsthetic. The tumour would, I assume, be found to occupy some part of the centre of the abdomen near the root of the mesentery and to possess no obvious connexion with the kidneys or pelvic organs. But apparently the onset of retro-peritoneal sarcoma is so insidious that the patient is not seen during the early stages. In the cases above described the only symptoms at the beginning were breathlessness and a feeling of weight in the hypogastrium. The abdominal distension seems to have occurred so gradually that it attracted little notice. Therefore, we must reckon upon having to deal with these retro-peritoneal growths at a time when they have attained formidable dimensions and when the abdomen has become tightly distended. The difficulty of diagnosing abdominal swellings is notorious, but a solid growth which could not be attributed to any of the great organs ought, at least, to arouse suspicion. In both of the cases which I have narrated the uterus was at once excluded. The liver, too, was separated from the growth in each of them by a zone of resonance. The absence of urinary symptoms seemed to exclude the kidneys, although in one case the dullness extended into the loin. Nor could any reason be discovered for attributing the tumour to the spleen, pancreas, or supra-renal bodies. Its connexion with the ovaries was, however, in each case more difficult to decide upon and in each was strongly suspected. But not only did the tumour project into the true pelvis less than an ovarian tumour generally does, but its other characters were anomalous. Had I only suspected a retro-peritoneal growth in the first case the incision would have been prolonged and the nature of the growth revealed without putting the patient's life to an unwarrantable risk. Now, I cannot help thinking that we shall find the clue to the diagnosis of these retro-peritoneal growths in a correct appreciation of their anatomy. Let me recall what was found in the first case. In it the growth had spread behind the peritoneum and lifted up the intestines, so that the left colon ran down its front surface behind the left linea semilunaris. At the operation this part of the bowel was empty, but there must have been times when it was full of gas and capable of discovery by percussion. This information might not be obtained at one examination, but in a dubious case, such as this, no one would hesitate to defer an operation until several examinations had been made. In the second case this peculiar feature in the resonance of the tumour was actually observed, although its significance was not understood. The clinical notes said that after admission the tumour was dull on percussion; a fortnight later they said that there was a decided resonance in front of the lump, where none had been before. At the operation the appearance of this area of resonance in the front of the tumour was fully explained. The retro-peritoneal growth had extended into the mesentery, so that the small intestines were distributed over the surface of the tumour. Without question the variation in the areas of resonance was caused by one of these becoming distended. Doubtless retro-peritoneal sarcomata are rare, but others will be met with. It will be interesting to learn whether those who find them will be able to confirm my supposition that they will possess irregular areas of dullness and resonance, and, moreover, that their areas of resonance will vary from time to time.

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