these were more or less acutely infected cases whose present discomfort may reasonably be explained as due to adhesions (or to the appendix remaining in No. 33), except in case of 5 persons, 2 of whom are neurasthenics and may have had other overlooked pathology (previously referred to); for the discomfort of the other 3 no explanation appears.

Six persons say that a *hernia* exists in the wound. I am inclined to think that a hernia is present in more than six instances, because in the average drainage case attention was directed to the securing of ample drainage with very little attention to the prevention of subsequent hernia.

These patients have all been inquired of to discover if *any unfavorable symptom* has developed which was not present prior to operation. Two report that they are weak and nervous from overwork; 1 has been operated on since for cholecystitis, 1 is now suffering from the menopause, one has fissure of the anus, one is troubled with an unexplained diarrhoea, and 1 complains of weighing ten to fifteen pounds less from no apparent cause.

In two girls about sixteen the abscess was drained per vagina with excellent results. In one instance (a male) preparation was

being made to drain per rectum when the abscess emptied itself spontaneously by this avenue.

One patient was known to be pregnant at about the tenth week. Operation was done because of several previous attacks and because of appendix warnings at the time. Her pregnancy was not interrupted.

During this period one abscess in the abdominal wall at McBurney's point was opened. The patient was a child six years old. There was no history of trauma and no known infection elsewhere in the body. The abscess lay underneath the external oblique. The peritoneum was not opened.

A perinephritic abscess was also drained in a boy of twelve. It was very highly probable that a month prior to my seeing him he had suffered an appendix attack, and this view is borne out by a report that he has abdominal trouble of a suspicious nature since.

Operation was declined in three instances in the belief that the patient had typhoid. Such developed to be true in case of two of the patients, while the third probably had tuberculous peritonitis. The leucocyte count was a deciding factor in all three cases.

205-6-7 Fourth National Bank Building.

BENIGN TUMORS OF THE STOMACH*

By EDWARD A. BALLOCH, M.D.,
Washington, D. C.

Benign growths of the stomach are comparatively rare, yet the aggregate of those reported is large enough to compel us to consider them as factors in the diagnosis of intra-abdominal disease.

All varieties of benign growths have been reported—instances of myoma, lipoma, adenoma, fibroma, myxoma, lymphoma, papilloma polypus and cyst. Indeed, one observer reported what he thought was an osteoma of

the stomach, but which proved to be cartilage with spicules of bone interspersed.

According to their nature these growths may originate from one or another coat of the organ. They seldom give rise to symptoms unless they project into the stomach, or are so situated as to give rise to obstructive symptoms. Naturally, pyloric growths come in the latter category. A small growth in the pyloric region will cause more trouble

* Read before the Southern Surgical and Gynecological Association, Washington, D. C., Dec., 1911.

than a larger one elsewhere in the stomach. For this reason none of the pyloric growths reported has been very large.

The main question of interest in connection with these growths is that of diagnosis. No one reporting a case seems to have made a correct diagnosis. In every instance the growth has been mistaken for something else. With pyloric growths the suspicion has been that the obstructive symptoms were due to malignant degeneration. In the case of growths elsewhere in the stomach they have been referred to the kidney, the intestines, the omentum or to the pelvic organs.

Spencer's case will illustrate this point. The patient was a hospital nurse, forty-eight years of age, who had suffered from abdominal troubles for some time. The symptoms were referable partly to the stomach and partly to two movable kidneys. At the first operation he fixed the right kidney and pushed the left one into place. How he expected it to stay there he does not state. The symptoms were not relieved, and a second examination showed two reniform tumors, one the left kidney and the other lying over the promontory of the sacrum. This latter tumor had been discovered by Mr. Barling at a previous examination, but had been overlooked by the operator at the first operation. At a second operation he fixed the left kidney and found the second tumor to be in the stomach. He opened the stomach and found it empty, but the mucous membrane on the posterior aspect was rugose and pushed forward. It moved freely over a solid tumor. He split the mucous membrane and shelled out a fibroma weighing 500 grams.

I desire to report two cases of fibroma of the stomach, one a personal case and the other presented through the courtesy of Dr. William A. Jack, Jr.

Dr. Jack's patient was a colored woman, sixty-three years of age, who first entered the Freedman's Hospital in March, 1910, complaining of an abdominal growth. She was sent to the gynecological ward, where a

diagnosis of ovarian cyst was made and operation advised. She refused operation and went home. She returned shortly afterward upon the advice of a physician who had been called to see her during an attack of severe and protracted vomiting. He had made a diagnosis of intestinal obstruction. This time she was sent to the surgical ward and came under the care of Dr. Jack. The points of interest in her history were that the growth was first noticed thirteen years before. There had been occasional vomiting spells, usually from six to twelve months apart. No pain or inconvenience from the tumor. Recently the attacks of vomiting had become more frequent. The tumor had increased in size during the past year and the patient had lost weight, probably because of the inability to retain food. Upon examination a tumor was found in the right lower quadrant. The mass was freely movable and could be pushed from the ribs to the pelvis. To the palpatating hand it had a fluctuating feel. There was no pain on pressure or on moving the tumor about. Dr. Jack's diagnosis was omental cyst. Operation was done on April 22, 1910. The growth was found to be in the anterior wall of the stomach, involving the muscular coat. It did not project into the stomach. It was easily enucleated. The pathological examination by Dr. Van Sweringen showed it to be a fibroma.

My own case occurred in the person of a woman, fifty-six years of age, unmarried. Family history negative. The only item of interest in the personal history is that she had a severe fall twenty years ago. In attempting to hang a picture she had placed a chair upon a table. While trying to stand on the chair it slipped and she fell heavily, striking her left side against the edge of the table. The fall was followed by pain and soreness in the left side, which gradually disappeared. For some time she has had vague dyspeptic symptoms, principally pain and nausea. The pain is worse after menstrual periods. In December, 1910, she first

noticed an enlargement of the abdomen. This has increased steadily and, at the same time, the pain has grown more severe and more constant.

Upon examination I found a mass in the lower left quadrant of the abdomen. This mass had the general size and shape of a kidney and could be pushed into the left kidney region without difficulty. When pressure was removed, however, it resumed its original position. With the history of a severe injury to the left side and the presence of a somewhat reniform tumor I was confident that I had to deal with a wandering left kidney, so confident, in fact, that I neglected to examine her as thoroughly as I should have done, and sent her to the hospital for operation. After she was anesthetized and on the operating table I made a further examination. To my amazement I could push the mass all over the abdominal cavity. It could be made to go into any quadrant and had a wide excursion up and down. Besides, under the anesthetic I could palpate both kidneys in position. After this examination I fancied that I had to do either with a uterine or ovarian growth with a long pedicle or with an omental tumor. At all events I was spared the chagrin of making the usual kidney incision, and exposed the growth through a median incision. The tumor presented as soon as the abdomen was opened. It was covered by the omentum, and had numerous large bloodvessels coursing over its surface. After separating the omentum the growth was found to come from the greater curvature of the stomach, nearer the cardiac than the pyloric end. The general appearance of the growth was that of a sarcoma. Accordingly it was excised with a liberal margin of stomach wall all around. The resulting gap in the stom-

ach was sutured and the abdomen closed. Recovery was rapid and uneventful. The dyspeptic symptoms disappeared after the removal of the tumor, and she has been in good health since. Dr. Van Sweringen examined this growth also and pronounced it a myofibroma. His opinion was confirmed by several other pathologists.

These two cases illustrate very well what seems to me to be the main diagnostic criterion in these cases, namely, the great mobility of these growths. When they are attached to the greater curvature, as many of them are, the range of their excursion is not limited. They can be moved anywhere in the abdomen. This should serve to distinguish them from movable kidney and from pelvic growths. This characteristic is shared, however, by intestinal and omental growths, and I know of no sign that will enable us to say that a given tumor is gastric rather than intestinal or omental unless perchance the accompanying symptoms should indicate the one rather than the other.

So far as dealing with these growths is concerned, there is nothing particularly difficult in their removal. If one suspected malignancy he would naturally remove a wide area of stomach wall in the effort to get beyond the area of malignancy.

Fenwick and Fenwick, in speaking of fibroma of the stomach wall, say: "We have not been able to find a single case in the whole of literature where a large fibroid tumor of the gastric wall was above suspicion of malignancy."

I am inclined to share this opinion. Certainly the macroscopic appearance of the growth in my case was that of a sarcoma, and in spite of the favorable report of the pathologist I shall await the final outcome with interest.