The surface is deeply lobulated, one process resembling the fore paw of a mole. The general colour is reddish brown, while in some parts the lobules are greyish and appear translucent, in other parts they are of a yellow colour and look like wash-leather. A portion of the sheath is seen attached to the under surface of the tumour.

The late Dr. Sewell reported the specimen to be a myeloid sarcoma. The section has since been re-examined by Professor Stuart McDonald, who reports "This appears to be a true myeloid sarcoma. The predominant cell is small and spindle-shaped, but there are numerous typical giant cells—in some fields, under the high power, from six to twelve of these are present. It is fairly vascular, and the vessels are of the usual sarcomatous type. In almost every part of the tumour there are extensive deposits of blood pigment, the result of hæmorrhage. The tumour is indistinguishable from the myeloid sarcoma arising in connection with bone."

The patient has remained quite well and free from recurrence or dissemination.

A CASE OF THROMBOSIS OF A CONSIDERABLE PORTION OF THE SUPERIOR MESENTERIC VESSELS WITHOUT ANY DISCOVERABLE CAUSE.

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The following case seems worthy of record —

Mrs. S., age 42, was waked up by a sudden severe pain in the abdomen at 3 a.m. on May 2, 1916. The pain continued without intermission during the day, and the abdomen became swollen. She vomited once, soon after the onset of the pain.

Patient had had no previous illness, and had gone to bed feeling perfectly well. The only possible exciting cause she could think of was that three or four days previously she had made herself very stiff and had felt 'seedy' after carrying some heavy flower-pots.

Patient, a slim, well-made woman, was admitted to the West London Hospital at 5.30 p.m. on the same day. She was pale and collapsed, with a very weak pulse of 100. The lower half of the abdomen was made prominent by a rounded, tender, elastic swelling looking like a five or six months pregnancy. The remainder of the abdomen was somewhat retracted. There was no visible peristalsis. Some dullness was present in both flanks. Examination of the pelvis was negative.

OPERATION at 6.30 p.m.—Condition at commencement very poor. On opening the abdomen a large quantity of blood-stained fluid escaped, and the swelling was seen to be formed by distended coils of small intestine lying transversely. The intestine was a dark plum colour, and about one and a half inches in diameter. On lifting the mass of intestines out of the abdomen there was no evidence of any kind of constriction of the mesentery, but all the vessels in the mesentery were thrombosed. The line of demarcation of the affected gut was absolutely abrupt, and ended below about three inches from

the ileocæcal valve. The gut immediately above the thrombosed part was empty and somewhat contracted. Clamps were applied, and after the removal of the affected gut with its mesentery, a lateral anastomosis was made to the colon just above the ileocæcal valve by simple suture. Owing to the collapsed condition of the patient a thorough examination of the upper half of the abdomen was not made, but the appendix and pelvic organs were seen, and appeared to be healthy. On account of the large amount of free fluid and the damaged intestine a small tube was left in for a few days, and the wound healed without infection.

Intravenous and subcutaneous saline were given during the operation, and rectal saline for two or three days after. The patient rapidly recovered from the operation, and next morning appeared to be, and said she felt, 'perfectly well.'

The temperature for the first four days did not rise above 99°, and the pulse remained 84-100. On the fifth and two subsequent nights the temperature rose to 100°, but afterwards remained subnormal. The bowels acted on the second day and afterwards there were two or three loose motions daily.

No cause for the thrombosis was found. The patient was examined several times by Dr. Sidney Owen, but beyond a few carious teeth with no obvious pyorrhœa, a weak first sound and short apical systolic murmur, slight cardiac dilatation and weak myocardium, nothing was found. Dr. Owen did not consider that the cardiac condition was primary. The Wassermann reaction was negative. Patient left the hospital in three weeks, still rather pale, but feeling well.

Unfortunately, the piece of bowel removed was not measured at the time, and was by accident put into a strong solution of formalin. When measured four or five days later it was found to be nine feet in length. Seeing how much a piece of intestine contracts after removal, apart from the effects of immersion in strong formalin for four or five days, I think the original length cannot have been less than twelve feet, and was probably more. All the vessels of the corresponding mesentery were thrombosed, but it was not determined whether the condition was primary, or secondary to an embolism.

The most striking feature about the case was the rapidity with which the patient recovered from an apparently moribund condition—due chiefly, I think, to the fact that there was no distention of the bowel above the affected part with consequent absorption of toxins, and also to the use of spinal anæsthesia, which acted perfectly until near the end of the operation, when a very small amount of ether was given by the open method. The day after the operation the patient certainly appeared to be better than the majority of patients after a radical cure of hernia or an interval appendix operation.

The patient was seen ten months later, and seemed well, though rather pale. The weight had remained normal, and the bowels were still loose, acting as a rule twice a day. At intervals of three weeks there were attacks of griping abdominal pain followed by six or seven loose motions. She had not been able to influence the looseness of the bowels by diet. Recently she has had palpitation and some attacks of asthma, and menstruation has been irregular.