On the patient being put back to bed, the drainage tube was connected with a rubber tube leading to a vessel placed beneath the bed; this drainage acted well. Lieutenant Orr Wilson, R.A.M.C., under whose charge the patient then was, notes that the patient now made a rapid and continuous progress towards recovery. He was discharged from hospital on March 24, 1910, with the incision practically healed, no discharge, and he had gained nearly 2 st. in weight since the operation. From March 6, 1910, to March 14, 1910, a small quantity of bile was present on the dressings over the wound when they were removed daily.

I think this case is interesting:

(1) From the somewhat unusual position in which the abscess was opened and drained. Although Rendu in his table, quoted by Manson, gives the lung as the commonest position in which an abscess of the liver ruptures spontaneously, still it is not usual to find the signs of the pulmonary abscess most marked in the front of the chest.

(2) The common experience that after spontaneous rupture of a hepatic abscess, pus is not found on exploration of the liver with an aspirating needle.

(3) The large size of the pulmonary abscess. When I first saw the patient he was coughing up nearly two pints of pus in the twenty-four hours.

(4) The pleural complication—a dry pleurisy at the base of the right lung is very common in conjunction with an abscess of the right lobe of the liver pointing upwards; a pleural effusion is not nearly so common, and is apt to mislead one, in that either the case is thought to be one of pleural effusion only, or that the hepatic abscess has ruptured into the plural cavity in a patient whose symptoms have pointed strongly towards hepatic suppuration.

(5) Owing to the pleurisy and the fact of the pulmonary abscess having existed for some time before it was opened, the parietal and visceral layers of the pleura were adherent in the situation where the abscess was opened, so that pneumothorax did not result.

(6) The rapid and complete convalescence of the patient after the pulmonary abscess was drained.

RETRO-PERITONEAL TUMOUR.

By Captain R. H. Bott.
Indian Medical Service.

Sepoy S. S., 14th P.W.O. Sikhs, aged 30, thirteen years' service, was admitted to the Combined Indian Troops Hospital, Quetta, on May 25, 1910, suffering from epilepsy.

History of the Present Condition.—Patient stated that he had suffered from fits at intervals for about nine years; they never occurred when he was on military duty. On the day previous to admission he had a typical
Clinical and other Notes

epileptic fit in the lines. He stated that the fits had occurred much more frequently during the last six months than formerly.

Past History.—Epilepsy; duration nine years. Over-indulgence in alcohol. Nothing else of importance elicited.

Condition on Examination.—Patient thin and wasted, muscular powers much reduced. Slightly anaemic. Tongue clean, bowels regular, slight evening pyrexia up to 99·4° F.

The abdomen is unduly prominent, the superficial area of liver dullness is diminished, and both the liver and heart appear to be displaced slightly upwards. Liver and spleen not palpable. Flanks dull on percussion.

Potasii bromidi, gr. xx., t.d.s., ordered.

May 30, 1910: Patient does not sleep well, inclined to talk irrationally at night. Temperature rose to 101° F. last night. Passed four loose motions this morning containing some mucus. At 3.30 p.m. he passed into a cataleptic condition, muscles flaccid, tendon reflexes absent, pupils dilated, breathing slow; pulse 116 per minute, regular, of good volume and tension. He remained in this condition until 10.30 p.m., then roused, and early the following morning became violently delirious; potasii bromidi 5i. was given. Abdomen has become larger, percussion note is now resonant all over except in hypogastrium. Liver dullness extends up to fourth rib in the nipple line. June 1, 1910: Another cataleptic attack, lasting seven hours. Patient has no recollection of these attacks.

June 13, 1910: Patient seems better, abdominal measurements vary slightly from day to day, girth at level of umbilicus ranging between 35 in. and 38 in. Paracentesis performed to-day in linea alba below umbilicus, but no fluid was obtained. June 20, 1910: I saw the patient; beyond the enlarged rather flabby abdomen nothing abnormal could be made out. Patient is still getting slight evening fever, urine normal. An exploratory laparotomy was suggested, but the patient would not agree.

July 7, 1910: On deep palpation in the left hypogastrium a soft rounded swelling with ill-defined edges, the size of a small cocoa-nut, can be felt. There is a feeling of resistance on deep palpation in the right hypogastrium, extending upwards in a line with the outer edge of the right rectus muscle. The swelling in the left hypogastrium appears nodulated in places. July 11, 1910: Both Calmette's and von Pirquet's tuberculin reactions were tried with negative results. There has lately been slight morning diarrhoea. July 15, 1910: Slight bronchitic attack. The hypogastric swelling is more distinct and nearer the surface, and the resistance in the right hypogastrium has developed into an ill-defined swelling. It was thought that the swelling might arise from the bony wall of the pelvis; per rectum there was nothing abnormal to be felt. As the patient is still getting evening pyrexia, the blood was examined for malarial parasites with a negative result. A differential leucocyte count was normal.

August 2, 1910: Patient is getting weaker, the abdomen has increased in size and the swelling first noticed in the
hypogastrium has apparently extended into the abdomen, but its exact connections cannot be made out. There are no signs of peritonitis and no obstruction of the bowels, urine is normal. He has gained a little in weight during the last month. He now has a moderately high remittent type of fever ranging from 100° to 103° F. Cough still troublesome.

August 3, 1910: Patient has consented to an exploratory operation. He is very weak but his pulse is fairly good, though rapid (116 per minute). On palpation large soft doughy masses can be felt occupying the greater part of the abdomen; the bowels are freely open. August 6, 1910: I performed an exploratory laparotomy assisted by Lieutenant Jolly, I.M.S. Anaesthetic, chloroform. Incision, linea alba from slightly above pubis to umbilicus. On opening the peritoneal cavity the whole abdomen was found to be occupied by an enormous retro-peritoneal swelling extending from the pelvis to the diaphragm; the bladder was pushed to the right side of the pelvis. The movable abdominal viscera were in the right hypochondrium immediately beneath the liver, which with the diaphragm was markedly displaced upwards. The swelling had pushed the peritoneal covering of the posterior abdominal wall forward, and it was adherent to the bladder, abdominal wall in left hypogastric region, transverse mesocolon, liver and posterior abdominal wall. The abdominal incision was enlarged almost up to the ensiform cartilage. A trocar was thrust into the swelling, but no fluid found. It was found impossible to remove the tumour complete owing to the extensive attachments of its capsule, and an effort was then made to enucleate the swelling from its capsule. This was found to be easier than expected, and the tumour was eventually removed in four principal masses; there was not much hemorrhage. The tumour appeared to be a fibro-lipoma, the portion which was first noticed as a swelling in the left hypogastric region was harder than the remainder, and on incising this portion it was evident that there had been hemorrhage into this part of the tumour at some earlier date. There was some difficulty in stopping bleeding after removal of the swelling from the posterior abdominal wall, which appeared to be the main attachment of the tumour; the main vessels at this place were ligatured and the space formerly occupied by the swelling was flushed out with hot sterilized normal saline solution. The peritoneal covering of the tumour was then closed above and below, a small piece in the middle being left open and brought up to the abdominal skin incision, and anchored there for drainage. The abdominal skin incision was closed by means of a single layer of interrupted salmon gut sutures, passing through skin, fascia and peritoneum, a small opening being left in the centre of the incision for the purpose of draining the retro-peritoneal cavity. The removed tumour weighed 35 lb., and was just too large to go into an empty kerosin oil tin. The patient recovered satisfactorily from the operation: he was given hot coffee per rectum shortly after the operation, and later in the evening two pints of normal saline solution per
rectum. He had a troublesome cough during the night, which caused him a good deal of pain. August 7, 1910: Patient feels much better, no pain except on coughing, which is very frequent. Temperature normal; pulse 104, of good volume. Abdomen quite soft and moving with respiration. Slight serous discharge from drainage tube. Bowels open once naturally. Urine passed naturally. Towards evening pulse and temperature began to rise, cough became troublesome, and a few crepitations could be heard at the bases of the lungs. August 8, 1910: Patient had a bad night, cough very distressing, and has difficulty in expectorating accumulations of mucus from larynx and trachea. He is taking liquid nourishment freely every two hours, and stimulating expectorants for his bronchial trouble. This morning his temperature is 101°F.; pulse 136 per minute, and rather weak. Both lungs are full of moist sounds, and numerous crepitations are to be heard at both bases. The abdomen is quite soft and free from pain and the abdominal wound looks healthy and is quite clean. Patient died suddenly at 4.30 p.m. from respiratory failure, owing to the large accumulation of mucus in the bronchi. This patient was interesting in view of the fact that (1) he was admitted for epilepsy which had commenced rather late in life, there was a strong alcoholic history, and the patient had not noticed that his abdomen was getting larger; (2) the peculiar cataleptic condition into which he fell on two occasions after admission to hospital; (3) the rapid growth of the tumour; (4) the large size of the tumour; (5) the difficulty of coming to a correct diagnosis of the nature and origin of the abdominal swelling; various diagnoses were postulated, including a tumour arising from the bony walls of the pelvis such as a chondrosarcoma, &c., chronic peritonitis, possibly tubercular in origin, and a retro-peritoneal tumour; (6) the cause of death: before operation there was some bronchitis, and the sudden removal of so large a tumour from the abdomen relaxing the pressure exerted through the diaphragm on the bases of the lungs undoubtedly contributed to the pulmonary congestion which supervened. The photograph of the tumour was taken shortly after removal.