In the present case we have not the characteristic ascites, nor temperature, nor tympanites nor pleurisy. We have the tumor alone.

Is it peritoneal cancer? Secondary malignant peritonitis is comparatively common, primary very rare indeed. In fact, it is open to question if primary peritoneal carcinoma ever exists, that which is usually mistaken for it being in reality endothelioma.

As in tuberculous peritonitis, so in cancer we have a mass, usually in the upper abdomen, and associated with ascites. In tuberculosis it is formed by the rolling up of the great omentum; in cancer by spreading induration of the omentum from the primary focus, usually in the stomach.

With the history of a primary focus, the diagnosis of peritoneal malignancy is comparatively easy; in the absence of such focus, very doubtful. We have here neither primary cancer nor ascites. We are not likely to have peritoneal cancer.

Splenic enlargement may be the result of various causes such as leukemia, pernicious anaemia, pseudoleukemia, chronic malaria or syphilis. Chronic enlargement of the spleen is sometimes occasioned by cirrhosis of the liver.

The recognition of certain physical signs will almost invariably result in a definite diagnosis of splenic enlargement: the retention of its notched anterior border, the position of the organ anterior to the colon, and its retention of respiratory mobility; it is not fixed. Our tumor is evidently not splenic.

Cancer of the intestine is often primary. We have here a case of tumor in the region of the splenic flexure of the colon. He has a history of early diarrhoea, to be followed later by obstinate constipation, and later still by diarrhoea and constipation alternating. He has a history of blood in the stools early in the disease, though none has appeared for some months.

He has a great deal of pain concentrating at the seat of the tumor, is emaciated and has a sallow complexion. He has a mild degree of tympanites.

A diagnosis of cancer in this region must be made on general as well as localized symptoms. He has anaemia, he has a certain degree of cachexia, he is forty-eight years of age. He has no visible signs of stenosis as would be observed by visible peristalsis or ribbon-like tools, but he has alternating spells of constipation and diarrhoea. Ribbon-like stools would not be expected in this case, because the obstruction, if such it be, is too high in the bowel.

With all other possible conditions having one by one been carefully eliminated, and yet fully appreciating the impossibility of making a de-