

reaches from the Foramen of Winslow to the spleen, it reaches from the hepatic to the splenic flexures of the colon. The transverse fissure of the liver and a portion of the diaphragm form the upper limit. It will readily be seen, therefore, how an inflammatory exudate into the lesser sac would produce a tumor consistent with the one under consideration. But is this what has occurred? True it is that we have the history of an injury which would readily be responsible had this tumor occurred at a much earlier date and very shortly after the accident. But here we have a period of eighteen months elapsing, and not until six months ago was there any indication or even suspicion of serious trouble supervening. The lapse of twelve months before the onset of severe symptoms would be sufficient to rule out trauma as the cause. Cancer of the stomach or a perforated gastric ulcer could readily be responsible for the existing condition, but there is not the slightest evidence of the presence of either cancer or ulcer. Furthermore, the symptoms produced by the perforation of an ulcer of the stomach into the lesser peritoneal cavity are entirely wanting. In the latter case we have the onset sudden and abrupt. The pain is intense, and the vomiting often copious and bilious. Owing to involvement of the diaphragm, the respirations are frequently embarrassed. Obviously ulcer cannot have been responsible for the present condition; the typical symptoms are wanting, the lapse of time is too great.

An omental tumor, whether it be tuberculous or malignant, early becomes adherent to the abdominal wall. It is also accompanied by ascites and progressive ematiation. This tumor is apparently non-adherent. There is no ascites.

Regarding new growths in the peritoneum, two forms may be considered in connection with this case, tuberculosis and cancer. Either may develop as the result of an injury, or rather the commencement of the disease may coincide with the occurrence of an injury.

If tuberculous peritonitis is present in this instance, it must be of the chronic variety. What symptoms would be expect to find? Ascites, though probably with but a small effusion, the fluid sometimes being hemorrhagic. In a long-standing case such as this, tympanites may be present as the result of adhesions between the parietal and visceral layers. In the chronic form the temperature is frequently subnormal, often for days at a time running as low as 97°. The simultaneous presence of pleurisy is frequent. One of the most marked features of this disease is the presence of a tumor either by simulation or in reality, in which latter case it is due to the rolling of the omentum into a ball, to the collection of fluid which is confined between the coils of intestine by adhesions, or in somewhat rare cases by the actual thickening and retraction of the intestinal coils themselves.