For twelve months, however, no ill-effects were anticipated, but about this time he first consulted a physician for loss of appetite and a general feeling of lassitude. Subsequently diarrhoea developed, which, however, was of a very intermittent character, and on three or four occasions the stools were black and tarry as though they might contain some blood, but no such stool had been passed for the past five months.

Two months ago he had discovered a hardness in the left side of the abdomen, which in the meantime had given him a good deal of trouble. The pain was of a dull, boring, aching character, and appeared to be persistently worse at night.

Physical examination revealed only a slight degree of emaciation. The entire body had a sallow tinge and there was a rounded fullness to the abdomen. In the upper left quadrant of the abdomen could readily be left a rounded hard mass, in size slightly smaller than a cocoanut. Pressure on, or in the neighborhood of this mass, elicited but the slightest degree of tenderness, but in its region he suffered much from a constant boring ache. There was no spasmodic pain. There was no diarrhoea. There was no blood in the stools. The bowels moved every day, sometimes without and sometimes only by the use of a laxative. There was an occasional attack of nausea, occasionally accompanied by slight vomoting. The appetite was poor, the tongue was furred, the stools were foul. The heart, the lungs, the urine and the blood were normal. There was no history of cancer in the family.

Discussion.—The picture we have before us is one which presents considerable difficulty in deciphering. There are no clear-cut typical symptoms which would warrant one in readily arriving at a definite conclusion. We have evidence which on the surface would indicate one of many conditions, among which may be mentioned new growth in the peritoneum of either tubercular or malignant origin, enlargement of the spleen, cancer of the splenic flexure of the colon, cancer of the stomach, localized peritonitis with the possibility of abscess formation, or even chronic enlargement of the spleen due to cirrhosis of the liver.

A short analysis will suffice to eliminate at least some of these conditions. The presence of localized peritonitis in this location is likely to be induced by one of three conditions, perforation of a gastric ulcer, carcinoma of the stomach or trauma.

A localized inflammation in this region in the greater peritoneal cavity is rare—in the lesser, somewhat more frequently found. This is accounted for by the anatomical relationship of the structures permitting the collection and localization of an inflammatory exudate in the lesser cavity. It lies behind the gastro-hepatic omentum, behind and below the stomach, and behind the anterior layer of the great omentum. The upper layer of the transverse meso colon forms the lower limit of the space. It