of cysts, both pancreatic and retroperitoneal. Furthermore, this tumor appears to be adherent to the abdominal wall, while a cyst of the pancreas lies behind the inflated stomach and colon. A retroperitoneal cyst is immovable and lies directly behind the inflated colon.

Seventy-five per cent. of all tumors of the mesentery are cystic. The larger ones usually appear in the region of the umbilicus, and though not adherent to the abdominal wall, are not freely movable. Symptoms of stenosis or even intestinal obstruction are frequently caused by their pushing the intestines aside. Though not adherent anteriorly, they often become adherent to their neighboring viscera. The sense of fluctuation is sometimes very doubtful, and it is extremely difficult to differentiate between them and one of a solid variety. The tumor in this case is evidently quite adherent anteriorly ,and has every indication of being solid, therefore the presence of a cyst of the mesentery may be ruled out.

Carcinoma in a young man of twenty-six is uncommon. When present it is either primary or secondary. This could scarcely be primary. If on either of the colic flexures it would have produced stenosis, which is not apparent. If of the great omentum the tumor would be not only adherent to the abdominal wall, but would be distinctly nodular. This one is comparatively smooth. Furthermore. omental cancer is very rarely primary, but rather secondary, to pyloric involvement. There is no evidence of any primary focus anywhere. The question of cancer may confidently be dismissed.

This condition, evidently acute from the onset, is probably infective—is either an abscess formation or an infective peritonitis, probably tubercular. If of abscess formation, where is the focus of infection? The two most likely conditions would be either a huge empyema of the gall-bladder or a subdiaphragmatic abscess from an acute or subacute perforation of a gastric ulcer. The position of the tumor would not conform to the location of the gall-bladder, and as there has heretofore never been the slightest symptom of any gall-bladder disease, we may feel reasonably assured this organ is free from trouble. Subdiaphragmatic abscess is usually the result of an acute or subacute perforation of a gastric ulcer. This man has never had at any time even the faintest suspicion of stomach trouble. Until the time of his accident he had been perfectly well. At the present time his meals are taken without the slightest discomfort.

I wish to state here, however, that it is not absolutely necessary for a patient to exhibit any typical symptoms of ulcer, or even any symptoms of indigestion, in the presence of even extensive ulceration. I have on two occasions operated on acute perforation of a gastric ulcer, where be-