ded in its midst was found a small femoral hernia contained within its peritoneal covering. He records more than one case of a similar character, and speaks of the danger in dealing with such a condition; the possibility that the operator, whilst not recognizing the true condition of affairs, might be tempted to excise the tumor without reducing the hernia, thereby opening up the peritoneal cavity and possibly wounding the gut or omentum.

These cases recorded by Prof. Annandale were in the femoral region, where, in the neighborhood of the crural ring, the sub-peritoneal fat is usually well developed, it might easily occur also in the inguinal region the sub-peritoneal fat in extending downwards in the canal might tend to the protrusion of a peritoneal pouch into which a hernia might descend. Prof. Annandale, however, did not attribute the source of these fatty tumors to the sub-peritoneal fat, there was no proof at the time when his cases were recorded that such lipomata were developed from such a source. The possibility, therefore, of a hernia, accompanying a fatty tumor devoid of serous covering, should always be borne in mind in operating on lipomata in hernial regions. In distinguishing such tumors from omental hernia there is a possible source of error in mistaking the capsule of the lipoma for a serous sac, this is the more likely to occur when, as sometimes happens, the capsule is thickened and resembles to a considerable degree a peritoneal covering. The smooth glistening surface of the peritoneum would appear on opening a true hernial sac, and then again the capsule of a fatty tumor has, as a rule, septa which pass in between the lobules. By keeping these points in view one can generally distinguish between a tumor capsule and a peritoneal sac.

The fact that such tumors as I have described originate in the sub-peritoneal fat is not generally recognized. Sir James Paget suggested this view and it is put forward by Jonathan Hutchison, Junior,* in a paper read before the Pathological Society of London. I cannot, however, find any reference to it in the English text books on surgery which I have consulted. The tumor which I have dissected and described proves conclusively the possibility of the occurrence of such tumors and their source; and the case of ventral so-called hernia which I have narrated suggests that they may be looked for in other hernial regions as well as in the inguinal canal.

I need only but refer to the other fatty tumors which are found in the inguinal region. Omental herniæ are common. Last year I narrated before the Toronto Medical Society the history of a case of imperfect transition of the testis operated on by Dr. Cameron. In that patient we found an omental hernia lying above the testicle in its own peritoneal sac. The omental mass was the size of a duck's egg, and was almost exclusively confined to the inguinal canal, the walls of which were expanded over it. Then again there are occasionally, but rarely found, tumors in the region of the canal, although not within the coverings of the cord, developed from the sutcutaneous fat and extending down towards the scrotum. An interesting case of this kind is reported by Henry Gray,* in which the fatty growth continued downwards and was continuous with the dartos tissue of the scrotum. These tumors, however, lie outside the inguinal canal, and therefore can hardly be included in the group indicated by the title of my paper.

It is an accepted fact that fatty tumors are only found in situations where fat is normally developed in the body, and that they originate from the pre-existing adipose tissue. The possible sources of such growths occurring in the inguinal region, therefore, are first, those found within the coverings of the cord, their source, being either (*a*) omental or (*b*) from subserous fat; and secondly, those lying outside the coverings of the cord developed from the subcutaneous fatty tissue.

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Reports of Societies.

GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

APRIL MEETING.

The President, Dr. Henry M. Wilson, in the chair.

Dr. Wm. P. Chunn related a case of ascites, which he treated by tapping and permanent drainage with apparently good results.

Dr. B. B. Browne, more operated than a year ago upon a woman with ascites, who also had an

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