growth has originated in its neighbourhood. My own case shows very clearly that these large tumours are composed of numerous distinct lobes, some of which upon the surface may be separate and freely movable over the main mass. These, it is true, were in my case small and from the absence of any degenerative changes would appear to have been more recent than the other portions of the growth. Still their existence indicates that there may be a development of multiple retroperitoneal lipomata which eventually fuse, and Dreschfeld's case is strongly in support of this view, as are also those of Balkowsky, Schiller and Spencer Wells.

One symptom mentioned in a large number of the reports needs but to be referred to in passing, namely, the eventual œdema of the lower extremities, due to the venous obstruction in the abdomen. It is noted more than once that this did not show itself coincidently in both legs, but appeared first in the side upon which the tumour originated.

Passing now to the histology of the tumours, the divergent descriptions are easily reconciled when we remember that every member of the group of connective tissue tumours may pass into or show areas of conversion into other members of the group. There are instances of enormous perirenal fibromata (Lathuraz,[1] D'Antona,[2] Bauby and Daunic[3]), and myxomata (Elben,[4] Gould,[5] Witzel,[6] and (?) Guyot[7]) while tumours mainly fatty may show more or less extensive conversion into fibroid, cartilaginous, osteoid, mucoid or embryonic (sarcomatous) tissue. We have thus cases of pure lipoma, fibro-lipoma, fibro-chondro-osteo-lipomata, lipoma myxomatodes, and lipo-sarcomata. On the whole when we are dealing with such large slow-growing tissues one must hold the view that originally they were overgrowths of highly developed tissue, and that where upon extirpation more embryonic tissue is found this is of relatively recent appearance. Thus I cannot agree with Wigglesworth who regarded his case as one of primary myxoma which had undergone later fatty change.

Not only may there be deposits of calcareous salts and *osteoid* appearances in older and degenerated portions of the growth (Péan, Alsberg,) but as Dreschfeld first pointed out there may be true *osseous*

[1] Lathuraz, Lyon Méd., 1895. p. 329 (fibroma 40 lbs. ? mesenteric).

[2] D'Antona, Atti. della R. Accad. Med. Chir. di Napoli, 1895, p. 142 (perirenal fibrosarcoma).

[3] Bauby & Daunic, *Le Midi. Méd.*, II., 1893, p. 532, ('pararenal' fibro-myoma).

[4] Elben, Wurttemb. Med. Corresp. bl., 1880, No. 14 (hæmorrhagic perirenal myxoma).

[5] Gould, *Lancet*, 1888, II., p. 518 (hæmorrhagic "perirenal myxoma").

[6] Witzel, *D. Zeitschr. f. Chirurg.*, XXIV., 1886, p. 326.

[7] Guyot, *Gaz. de Hôpt.*, 1870, p. 369 (myxo-chondro-fibroma).