

and imbedded in the fat. There was no sign of new growth anywhere within the intestinal tract.

Beyond cedema of the lungs and interstitial nephritis, there was little calling for additional remark.

Upon microscopic examination the new growths here described were typically carcinomatous, of the medullary type. The great size of the mass in the liver, as compared with the minute nature of the nodules elsewhere, appeared to indicate that in the liver was the primary growth, and microscopic examination proved the correctness of this suggestion. More especially towards the growing free surface the mass could be seen to be composed of characteristic liver cells, large, tending to be cubical and pigmented, possessing a tendency to be arranged in an alveolar manner. Elsewhere, deeper down in the tissue, the cells became smaller and the collections were separated off from each other by well formed fibrous stroma. In parts there was a tendency for the cells to be arranged around a central lumen.

The sections, in fact, possessed all the characteristics of an adenoma, or new growths of the liver tissue which had taken on malignant characters. This malignancy was further demonstrated by the abundant new growths in the abdominal cavity.

Primary carcinoma in the liver may be of three types:

1. Generalized carcinoma, the cirrhosis carcinomatose, of Peres.
2. Localized carcinoma originating from the liver cells proper.
3. Localized carcinoma originating from the smaller bile ducts.

A fourth form, not truly hepatic, invades the liver after primary origin in the larger bile ducts.

Here in this case we are dealing with the second form, that is to say, with a true liver cell cancer, which is of sufficient rarity to be placed on record.

Finally, it is interesting to observe the relationship that in this case appears to exist between the inflammatory dis-