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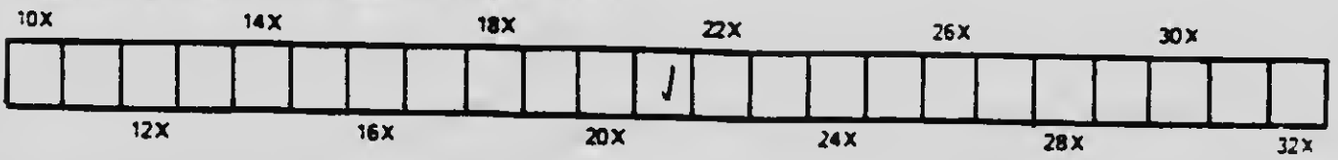

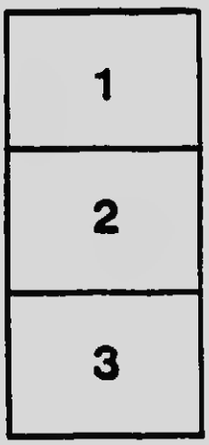

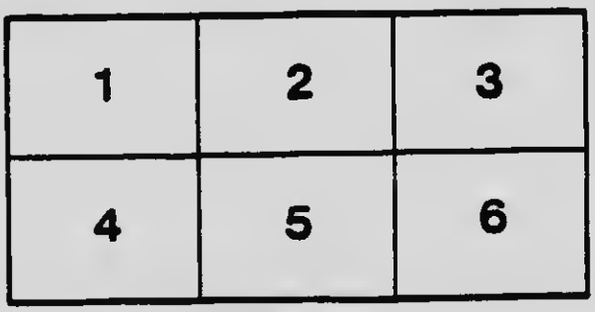

TUMOURS OF THE RIGHT ILIAC FOSSA.

BY

L. COYTEUX PRÉVOST, M.D.,
Gynæcologist to St. Luke's Hospital, Ottawa.

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TUMOURS OF THE RIGHT ILIAC FOSSA.

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The abdominal cavity, to my mind, is a deceitful surprise-box, and an interesting novel could be written dealing with the analysis of the varied emotions which this region of the human body causes every day to the surgeon. One thinks he has to deal with an ovarian cyst and comes upon tubercular peritonitis; we look for what we thought to be a biliary calculus and we find tumour of the pylorus; an abdominal section is made to remove a fibroid of the uterus and we are suddenly face to face with a fœtus which stretches out its hand; we expected to find appendicitis, it is pyosalpynx or ectopic gestation.

And this interesting abdomen is not content with humiliating us in a general way; through the most refined cruelty it keeps set apart a small corner of predilection where the most Bonapartist clinician is bound sooner or later to find his Waterloo.

That little corner is the ileo-cæcal region, contained in a triangular space whose extreme boundaries are, internally from the umbilicus to the symphisis and externally, Poupart's ligament and the anterior superior spine of the ileum.

We are consulted by a patient bearing a lump in the right iliac fossa; the lump may be hard or soft; at times accompanied with temperature, at other times entirely apyretic. In certain cases, it is a painful tumefaction, in other cases, the tumour is indolent. What is the origin, what is the nature of that lump? I know perfectly well that there are cases where the diagnosis is extremely difficult if not impossible, notwithstanding all the means brought into use to arrive at it, but still we must confess that frequently errors are committed owing to the carelessness exhibited by the physician in the research and the analysis of the symptoms.

In order to recognize the nature of a disease, it is not indeed sufficient to lend a more or less attentive ear to the very often inaccurate relation which the patient makes of his sufferings; it is absolutely necessary to control his tale of woe by a well directed interrogatory and a methodical interpretation of the facts which he brings to our knowledge. The objective examination should be carried out in a

Read before the Ottawa Medico-Chirurgical Society

systematic manner and we must never hasten to jump too soon at a conclusion, always bearing in mind that exceptions to general rules are numerous. Symptoms apparently similar may belong to very different affections, but their characters are never entirely identical and it is of the greatest importance that we should endeavour to discriminate the various shades of their signification. An epigastric pain does not always mean cancer of the stomach; constipation and vomiting are not in every case the signs of intestinal obstruction; and again, a patient coming to us with fever and a painful lump in the right iliac region may suffer from anything else than appendicitis or cancer of the intestine.

Very frequently it is only by the considerate attention paid to the complaints of the patient, the careful examination of the objective signs, the analysis of each symptom in particular and the study of the group to which they belong, and lastly, by the exclusion of other pathological conditions that we shall be enabled to protect ourselves against those errors, always prejudicial to the patient and oftentimes disastrous for the surgeon's reputation.

Omnis homo mendax et errare humanum est. This axiom should remain engraved in every one's memory to impose upon us the obligation to curb our pride, reminding us that there is a thing or two which we have yet to learn with regard to the diagnosis of diseases. But, the difficulties of the matter must not take away from our mind all hopes of arriving at the truth, provided we surround ourselves with necessary precautions, and, if physicians, in every instance, would use the circumspection dictated by their duty, errors indeed would be far less frequent, and, at any rate, we would certainly never hear, as recently came to my knowledge, of a senile gangrene of the foot being taken for an attack of gout.

However, in spite of all, there are unfortunately cases, in which we are bound to be led astray, and it is with this thought that I undertook the writing of this paper, which will demonstrate the difficulty at times in determining the nature of tumours situated in the right iliac fossa.

It seems that all the affections which constitute abdominal pathology have chosen as rendez-vous this privileged region of the human body. Let us, for instance, exclude inflammations of the appendix with all varieties and their complications, and also, in women, the diseases of the appendages, such as hydrosalpynx, pyosalpynx, ovarian tumours, ectopic gestation, that is, the affections of the organs which are really at home there and betray their sufferings by manifestations in the region we speak of. We might now be tempted to believe, I fancy,

that there remains but very few diseases liable to produce a tumour in the right iliac fossa. Well, I will only cite some of them; stop me, if you find the enumeration too long; psoas iliac abscess; abscess arising from the vertebral joint; abscess from the ilio-sacral joint; chronic interstitial myositis; præcecal suppurating adenitis; retro-peritoneal, retro-colic suppurating adenitis; gangrenous or tubercular omentum, cancer of cæcum; cyst of the mesentery; enterolith of the cæcum; hypertrophic tuberculoma of the intestine; hypertrophic ileo-typhlitis due or not due to stenosis of the gut; ileo-colic intussusception; foreign body of the ileum; perityphlitic abscess with integrity of the appendix; tubercular peritonitis; cancerous peritonitis; cholelithiasis; ureteral calculus; perinephritic abscess; floating kidney; certain varieties of hernia; osteo-sarcoma of the iliac bone.

These facts, you know as well as I do, and I merely wish to recall them to your memory. Nor have I the intention of dwelling upon the symptoms proper to these varied pathological conditions which the teachings of text-books as well as your personal experience have rendered more or less familiar to you. I only wish to relate a certain number of observations, where the differential diagnosis offered particular difficulties, especially between appendicitis, cancer of the cæcum and other abdominal affections.

For the last few years, the medico-chirurgical atmosphere seems loaded with appendicitis, and a tumefaction no sooner appears in the region which is about to immortalize the name of McBurney, than the diagnosis of appendicitis is immediately proclaimed. The number of those who have been mistaken in this respect is incalculable, and if you open the Annals of Surgery of June, 1902, you shall find an interesting article written by Spellissy, in which this author has gathered 194 cases of affections situated in the right iliac fossa with lesions of twenty varieties of structure and 68 species of lesions, not one of the numbered cases of appendiceal origin, and all so mistaken.

If in certain cases, the error can be avoided, it is unquestionable that sometimes, special circumstances contribute to render the diagnosis extremely difficult.

I was one day called in consultation to see an unmarried lady aged 41. To this extended virginity, she could boast of being able to add that of no therapeutic treatment whatever: she had never been ill in her life. Tall, robust, admirably built, the utero-ovarian functions had always been absolutely normal. She never had any menstrual suppression; no metrorrhagia; no dysmenorrhœa; no leucorrhœa.

A few days previous to my visit, after an afternoon of shopping, she experienced quite a severe pain in the right iliac fossa, went to bed

and suffered all night. The next day, the family physician was called in and prescribed hot fomentations. In the evening, the temperature went up; pains, always severe, were paroxysmal. During the night, vomiting appeared and continued all next day. For five or six days, the symptoms remained the same; spontaneous pain was quite severe, the right side of the abdomen was tender on pressure, and the temperature reaching 102 in the evening. Eight or ten days after the onset of the disease, the physician noticed in the right iliac region, the presence of a semi-fluctuation tumour and, being naturally convinced that an abscess had developed about the appendix, the patient was brought to Ottawa for operation.

Examination:—At the outer extremity of a line drawn from the antero-superior spine to the umbilicus, a large bulging was seen, three or four inches in all its diameters; fluctuation was evident.

Although the characters of this abscess appeared to me somewhat unusual, owing to its dimensions and the rather high situation compared with that of purulent collections due to appendicitis, I lent little importance to these irregularities and I decided to operate.

Incision at the base of the tumour was made; the skin, muscles, fascia and finally the peritoneum were carefully divided. The dark brown wall of the collection appeared, the knife was plunged into it. Not a drop of pus followed, but a stream of limpid serous fluid squirted out; 18 ounces were withdrawn. It was a cyst. I immediately seized its wall with a clamp and proceeded to separate the adhesions, soft, recent, which united it to the peritoneum. I then looked for the pedicle, but the latter seemed to be so low down that I decided to make another incision in the median line, in order to be in a better position to see what I was doing. The abdomen rapidly opened, I made a new exploration. To my great surprise, I fell upon a multitude of fibroids with which the uterus was literally studded. The cyst proved to belong to the right ovary and was adherent to the intestines, the pelvic floor and the abdominal wall. The whole thing was removed; uterus and appendages, and this operation, begun for the mere opening of an abscess, terminated in an abdominal hysterectomy.

And the appendix? It is true, I forgot that. Well, it was entirely normal, not even a trace of the least emotion. I considered the risks which had just threatened its existence as a well deserved appeal to my clemency and I left it in the abdomen.

I humbly confess that, in this case, a thorough examination might have permitted me to avoid a mistake. A vaginal examination would surely have allowed me to detect the presence of the uterine tumours. However, without trying to minimize the extent of my error, I beg to

claim the benefit of extenuating circumstances. I always hesitate to examine the vagina of virgins. Besides, nothing in this case had caused me to suspect the existence of a neoplasm in a woman who never had any metrorrhagia, never had any pain previous to the present illness, never noticed any abdominal development, the length of the pedicle allowing the largest of the uterine tumours to treacherously conceal its presence under the promontory.

And again, why this elevation of temperature? I know perfectly well now that it was most likely due to partial peritonitis as shown by the adhesions found between the cyst and the peritoneum, but, adding this fever to the tumefaction in the iliac fossa as well as to the other symptoms, could I think of anything else than peri-appendiceal purulent collection?

Finally, that cyst, instead of remaining at home and simply satisfied with raising the abdominal wall, as ordinarily do honest tumours of that kind, through what whimsical fancy did it deem proper to cunningly crawl along the rectus, hiding its dulness under the distended intestinal coils? Merely to lead me astray and inflict on my pride the most cruel humiliation.

In short: towards the utero-ovarian organs, negative symptoms. Positive and classical symptoms towards the appendix, accompanied with a tumour in the iliac fossa; inevitable result: phenomenal error of diagnosis.

During the month of July, I was called outside of the city to see in consultation a small sized woman, aged 27. She had been married two years and had a living child twelve months old. She had always been in good health with the exception of a coxalgia which occurred during her infancy and left her with the right inferior limb shorter, the foot in adduction.

She was three months pregnant and, three days before, she had had diarrhœa during a whole night. Feeling better the next day, she ate at dinner a gigantic cucumber. Two or three hours after, she was taken with excruciating pains in the right side of the abdomen. She rejected a part of her meal, less the cucumber which persisted in remaining inside.

The pain and vomiting continued until the evening, when a physician called, administered hypodermic injections of morphine. The pains were not relieved, the patient took to bed and had been suffering ever since. Incessant nausea and frequent vomiting prevailed. An obstinate constipation supervened and yielded only to reiterated purgatives.

I asked the family physician to give me his opinion concerning the

ease. "I thought at first," said he, "of indigestion, but, yesterday, I noticed quite a tumefaction in the right iliac region and I concluded that it must be a perityphlitis."

Outside of large centres, the fashionable appendicitis is still comparatively unknown; the people have remained faithful to the *inflammation of the bowels* of yore, which the rural physician, more learned, willingly calls typhlitis, peri-typhlitis and really, can we say that they are always wrong?

At any rate, the assertion of my confrere brought in a new support to the conviction already fixed in my mind. In fact, perfect health previously, sudden and persistent pain in the right iliac fossa, accompanied with vomiting and sluggishness of the bowels; finally, tumefaction and tenderness at McBurney's point we know what this means.

Had there been any fever? Here, I beg leave to make a short digression. There exist between practitioners two sorts of consultation. The first one, which most frequently occurs, is requested by the patient or those in his immediate surroundings. The physician is sure of his diagnosis and perfectly knows what to think of the whole matter, but, they have lost confidence; that cannot be helped. They get discouraged and, gossips helping, they insist in getting another doctor's opinion.

Beware—and here, I address myself to the younger men,—beware, and never commit the imprudence of refusing to acquiesce in the wishes of the family. Gracefully submit to the annoyance imposed upon you; after all, it may be nothing but a pardonable caprice. Consent with pleasant smiles to all they want; you have everything to gain by it. You shall be declared conciliating and charming, and the consulting physician, if he be neither jealous nor imbecile, will share your opinion in everything and this will add to your reputation. The patient will pay double fees and regain the confidence he had lost. Who knows? Perhaps this moral quietness might have a favourable therapeutic influence upon the subsequent evolution of the disease.

The other kind of consultation? This is another affair. An obscure point in the diagnosis; an abnormal and inexplicable feature in the cause of the symptoms; you belong to the privileged class of physicians who have studied enough to be convinced that there are in pathology a few things which one may ignore; you feel that it is your duty to seek the help of a friendly confrere whom you then choose *yourself* whose special knowledge in certain matters you are personally aware of; call him in consultation. But, pray! do facilitate his task which is often very difficult. If especially the question is to establish or confirm a

diagnosis, gather all the materials he may need; write down, if necessary, the detailed history of the case, mention all the symptoms you have observed and the puzzling points you desire to elucidate. In putting thus before the eyes of the consulting physician the complete picture of the disease, you will spare him the necessity of inflicting upon the patient always painful and frequently insufficient inquiries.

I hasten to add that the above remarks do not all apply to the case I am relating. Still, and although I do not attribute more importance than is necessary to the temperature in the diagnosis of appendicitis, I confess that I would have liked very much, all the same, to know whether there had been or not any fever since the onset of the disease. Unfortunately, the thermometer had not been used and all information in that respect was denied to me.

I found the patient all in tears and apparently a prey to the most excruciating pains. It was impossible to approach her, owing to the exquisite tenderness of the abdomen. She hardly allowed a mere inspection, which, however, permitted me to detect an evident tumefaction in the right lower quadrant of the abdomen. The left side could be palpated and was absolutely normal, but it was utterly useless to think of touching even with the tip of the fingers the other side of the abdomen, which she anxiously protected with both her hands against all sort of exploration.

She was immediately taken to the hospital where I decided to remove without delay that appendix which undoubtedly I would find perforated and perhaps gangrenous. I operated the same day. The abdomen was opened along the rectus; the omentum appeared in the wound; it was neither inflamed, thickened nor adherent. I pushed it back in the abdomen where a pad kept it in situ.

I soon fell on the appendix, hard, enormous, the size of the finger. Lying along the colon to which it was intimately adherent, it crossed obliquely the direction of the incision and was pointing north-west. Pursuing my investigation internally, I recognized the uterus, enlarged, soft, the fundus being situated two finger-breadths below the umbilicus. I then tried to ascertain the exact situation of the large intestine, taking for landmark the appendix, but the result of my investigation was not satisfactory. I decided to enlarge the incision in order to make a more perfect inspection of the battle field. I easily drew out of the wound the huge diseased appendix, which looked congested, bluish, almost black. Evidently, it was already gangrenous. I followed the organ with the finger, directing my exploration towards the free extremity which, instead of ending in a rounded, smooth surface, was uneven and shreddy. A closer attention made me suspect for the

first time that what I had taken for the appendix might well be the Fallopian tube. True enough, in plunging my hand into the pelvis, I readily reached its insertion on the right cornu of the uterus. Directing anew my exploration internally where I thought the appendix was adherent to the large intestine, I found out that this hard and elongated body seemed soldered to another, much larger and presenting the same dark blue coloration. I then discovered that, instead of being the bowels, it was a large fluctuating tumour, free from adhesions, and directed towards the umbilicus, posteriorly to the uterus.

The abdomen was at once opened in the median line and I then easily succeeded in exposing the neoplasm, which was nothing else than a dermoid cyst of the right ovary, twisted five times upon its pedicle, strangulated, and the size of a large turnip. I untwisted the pedicle and could then clearly see the tube offering a pink coloration near its uterine insertion, but almost black from the point of strangulation towards its fimbriated extremity.

This case, I fancy, is most interesting. Evidently, the cyst had been in the abdomen for a long time without betraying its existence by any signs whatever. Considering that it was utterly impossible to examine the abdomen owing to its extreme tenderness, I had to make the diagnosis exclusively through the information supplied by the history of the case. That sudden pain in the right iliac region, occurring after a meal in a woman until then apparently in perfect health; the vomiting, constipation, fever, tenderness at McBurney's point; the persistence of the symptoms in spite of rest in bed, hot fomentations, opium and purgatives; and above all, the tumour in the ileo-cecal region; the difficulty of ascertaining the conditions of the organs contained in the pelvis on account of pregnancy; nothing more was needed to believe in the existence of appendicitis. Even after the abdomen was opened, the situation and the characters of the Fallopian tube, appearing in the very region of the appendix, contributed to confirm the likeliness of the diagnosis.

Allow me now, please, to relate briefly two cases of tumour of the iliac fossa in which the diagnosis of appendicitis had been firmly and obstinately maintained by the physicians who brought their patients to me, and where operation proved in a striking manner how imprudent it is to be too affirmative, whenever we have to deal with abdominal diseases.

During the month of April, I received one morning from a physician practising in the vicinity of Ottawa, a message announcing that he was bringing in a patient suffering from suppurated appendicitis, praying at the same time, that everything should be prepared for immediate

operation, because he wished to be present and wanted to return by the next train.

Patient arrived at 11 o'clock and was sitting in the hall when I went into the hospital. He did not seem very ill. I learned that he had driven six miles to go and consult his physician who saw him for the first time that same morning. He was complaining of a pain in the right iliac fossa. The doctor examined him and found at once a lump situated in the ileo-cecal region. The tumour was quite tender and the temperature was 100. Peri-appendiceal abscess was immediately diagnosed and the patient brought down for operation.

The patient was unmarried, 30 years old, with the exception of an attack of pneumonia six years ago, and some intestinal trouble which kept him under the doctor's care for several weeks, he has always enjoyed good health. Temperate habits; no habitual constipation; no diarrhœa. Eight days before, he went to town and took a few glasses of porter. The next day, he complained of slight abdominal pains which he attributed to the porter. However, he never was bad enough to go to bed and even continued to plough on the farm as usual. The pain persisted all the week, situated in the right flank and radiating to the umbilical region. No nausea, no vomiting; appetite not impaired; bowels regular.

The night before, having suffered more than usual, he decided to go to the village with the result already stated. Temperature was normal; the pulse quiet, regular, below 100. General condition good. The abdomen was not distended; no muscular defense. In the right iliac fossa, a tumour, the size of a hen's egg was seen bulging under the integuments. It was quite tender on pressure, hard, not fluctuating, very slightly movable. The limits were ill-defined, and on percussion, a decided resonnance showed that the intestine was situated in front of the tumour. The presence of that lump had never been noticed until the doctor attracted patient's attention upon it.

I declared to the physician that the diagnosis was far from being clear, but none of my arguments could succeed in shaking his conviction that we had to deal with suppurating appendicitis, and I, therefore, decided to open the abdomen immediately.

The peritoneum, considerably thickened was incised; no pus escaped, but the cœcum appeared at once, covering a huge tumour, hard, not fluctuating and apparently situated on the posterior surface of the gut. No adhesions internally and above; adhesions below and externally. A portion of the omentum was adherent to the internal side of the cœcum. The transverse colon was pulled down by adhesions to the ascending colon near its origin. The appendix could not be found, the

inferior part of the tumour being actually soldered to the thickened peritoneum below and externally.

The whole lump was freed everywhere. Two clamps armed with rubber tubing, were applied, one on the ascending colon and the other on the ilium near its termination and the mass was removed, the intestine being afterwards united by lateral anastomosis.

The tumour when examined, showed that there was no obstruction of the bowel, the neoplasm being situated in the posterior and lateral walls of the cœcum and a part of the ascending colon. A section made at the inferior part of the cœcum from Gerlach's valve right through the tumour, split the appendix in two longitudinal halves intimately set, as it were, in the solid tissues of the tumour, resembling old fossils found imbedded in stones. Microscopical examination showed the neoplasm to be composed of fairly young fibrous tissue, the processus having spread to the walls of the cœcum and caused the thickening.

Although no tubercle baccilli were found, I incline to believe that this was a case of hypertrophic tuberculoma of the cœcum, because the tumour offered the clinical characters of similar cases published by Dieulafoy in the October number of *La Semaine Médicale*, 1902; unless it belongs, perhaps, to the class of cases described by Marchand, Schwartz and others and constituted by the inflammatory hypertrophy of the ileo-cecal segment of the intestine.

The other case of tumour of the ileo-cecal region mistaken for peri-appendiceal abscess is that of a man, aged 57, brought in to me for operation. Here again, I was informed of the arrival of the patient by a message accompanied with the earnest request that I should perform the operation at once, so that the physician might go back the same day.

Gentlemen, I avail myself of this opportunity to declare that I am one of those who think that, unless there be extreme urgency it is, to say the least, imprudent to do any abdominal operation before the patient has been at least for a while under observation. The diagnosis of abdominal diseases is generally surrounded with such difficulties, that we are in duty bound to put all the chances on our side. We must endeavour to gather all the information we can, in order to enable us to acquire the most complete knowledge possible of the conditions liable to be encountered.

In thia case, I refused to resort immediately to the operation because the symptoms, both objective and subjective, left too much doubt in my mind, concerning the existence of a purulent collection in the abdominal cavity and this, in spite of the peremptory conviction expressed by the family physician.

The patient looked comparatively well. The abdomen not distended,

seemed quite normal with the exception of a bulging readily seen in the right iliac fossa. The lump, pretty well defined, hard, movable, not fluctuating, moderately tender on pressure, filled a triangular space formed by a base extending from the spine of the ilium to two inches below the umbilicus, the right side of the triangle following the median line, the left parallel to Poupart's ligament and the apex reaching down to about the level of the internal abdominal ring. The mass, dull on percussion, was evidently situated in front of the intestine, being, in fact, superficial enough to make me think of its possibly being located in the deep parts of the abdominal walls. Temperature normal; pulse 76; bowels constipated.

Three weeks before, he had begun to suffer in the right lower quadrant of the abdomen, from a pain which he attributed to constipation, bowels not having moved for several days. No chill, no nausea, no vomiting. Constipation remaining obstinate in spite of purgatives, he left the shanty where he was working and drove down to Sudbury where a physician ordered purgative pills which succeeded in moving the intestines.

At the end of two or three days, the pain, although not entirely gone, was somewhat relieved and the patient went back to the shanty. Constipation soon returned, and the patient feeling miserable, decided to go home where the family physician was consulted. After examination, the physician attracted patient's attention to a tumour quite apparent in the right iliac region, which until then had never been noticed. Fomentations were applied, but conditions remaining practically the same, the patient was taken to Ottawa to be operated.

An incision was made along the rectus. The skin divided, the subjacent tissues appeared thickened, lardaceous. The abdominal muscles were fully two inches thick, the peritoneum so intimately adherent to them that it was almost impossible to find out the anatomical relations. No serosity, no pus in the abdomen. The transverse colon with its omentum appeared first in the wound. Following the upper end of the colon, I soon reached the termination of the ileum. Grasping then between my fingers, the internal lip of the incision, I clearly ascertained that the whole tumour was caused entirely by the inflammatory infiltration of the abdominal muscles.

The appendix was found literally imbedded in the peritoneum lining the internal surface of the abdominal wall, its tip directed south-east and so snugly adherent that I had to carve it out of its bed. It was thick, congested, but no pus, no fecal concretion were found in its cavity, the mucous membrane offering the normal lymphoid appearance.

If it frequently happens that tumour situated in the ileo-cecal region, are mistaken for appendicitis, on the other hand, suppuration due to appendiceal inflammation have, in several instances, been mistaken for other diseases, such as for example, cancerous or tubercular neoplasms.

In its classical forms, appendicitis is easily recognized; but, the disease at times presents in its course, its evolution, its behaviour, anomalies which produce a deceptive impression and readily mislead us. In the iliac fossa, a tumour, firm, hard, growing slowly; a progressive emaciation, a well marked cachexia cause the surgeon to suspect a malignant and inoperable tumour; and one day, a central softening seems apparent, the focus is incised and the tumour disappears. Such is the history of these cases of appendicitis, neoplastic in their form which not uncommonly lead to errors of diagnosis. In *La Revue de Gynécologie et de Chirurgie Abdominale* M. Vautrin relates the case of a woman aged 55, previously in good health who had been complaining for three months of severe pains in the right iliac region, where a lump had slowly developed. The physician pronounced it to be a tumour of the large intestine and Vautrin having corroborated the diagnosis, operated upon the patient. He found a retro-cecal purulent collection with a hard, sclerotic appendix adherent to the posterior surface of the cœcum.

Legueu and Bausserat also cite the case of a man aged 60, on whom the diagnosis of cancer of the cœcum had been made eighteen months previously by a surgeon who deemed all intervention utterly impossible. The tumour kept growing gradually, the patient becoming absolutely cachectic, and the family, informed of the incurability of the disease, expected early fatal termination, when a spontaneous opening supervened on a level with the umbilicus, giving issue to a large quantity of pus. Patient felt relieved, appetite returned, the emaciation disappeared. To-day, he is in perfect health.

The same authors again mention another case of that kind concerning a man, kept for a long time under observation in one of the large hospitals of Paris, in whom the resection of the cœcum had been decided upon. The patient was brought on the operating table and the abdomen opened. It was a case of suppurated appendicitis.

Finally, Pozzi, in March 1897, operated in Broca Hospital, on a patient whose observation is so interesting that I beg permission to relate it in a few words. A woman, 68 years old, had been complaining for several months of an unusual fatigue associated with a progressive emaciation, which nothing could explain, when, one day, she was suddenly seized with very severe pains, localized in the right side of the abdomen and very soon followed by tympanitis, nausea and vomiting. The latter symptoms soon abated, but weakness persisted,

appetite entirely disappeared, and excessive emaciation compelled the patient to keep to bed until the day when she entered the hospital.

Examination disclosed in the right iliac fossa the presence of a hard mass, dull on percussion, seemingly immovable and very tender on pressure. General condition very bad; fever with vesperal exacerbations. The diagnosis was uncertain, successively oscillating between appendicitis or degenerative affection either cancerous or tubercular of the cœcum.

The long evolution of the disease, the subacute course, the absence of fluctuation, the age of the patient, were very little in favour of appendicitis; but, on the other hand, the existence of fever with large vesperal oscillations, hardly agreed with the idea of neoplasm of the cœcum. Patient was examined under anesthesia, but then, the hardness of the tumour, its irregularities, its adhesions to the iliac bone brought out the diagnosis of osteo-sarcoma, and all idea of surgical intervention was given up.

The weakness, the emaciation increased every day; the complexion became earthy. However, very soon no doubt was entertained about the presence of suppuration in the iliac fossa and Pozzi operated. The skin and deep tissues being incised, he fell into a cavity containing three pints of pus with decided intestinal odour. Patient died the same evening. The autopsy showed that the collection was retro-cecal, due to a perforation of the appendix situated at the union of the appendix and the cœcum.

Mistakes of that kind, gentlemen, will become less and less common according as surgeons learn not to consider appendicitis as a disease always presenting a uniform clinical aspect. We must, therefore, constantly bear in mind that this affection often assumes the most deceptive appearance and quite liable to divert our attention elsewhere than to the real seat of the pathological lesions. I still recollect the perplexed situation in which I was placed by a woman who entered the hospital during the month of June last. She had a hard, moderately tender and perfectly well defined tumour in the iliac region. There was no fever; general condition was excellent. Six weeks previously, she had been admitted in the hospital, complaining of some abdominal pains and a sanguineous discharge by the vagina. She was kept three weeks under observation by the attending physician who prescribed hot vaginal douches. Becoming apparently well, she left the hospital but returned two days later, owing to severe abdominal pains with which she had been seized the night before. She did not seem to be at all aware of the tumour which I readily detected in the iliac region at my first examination. She was then complaining of very little pain, had

no fever and remained sitting up in the ward, feeling comparatively well until the day of the operation. Laparotomy revealed the existence of a large cavity filled with pus and at the bottom of it I found a perforated and gangrenous appendix.

May I be permitted to end this series of citations by the relation of a case of tumour of the iliac fossa, comparatively rare and certainly offering the greatest interest? About the middle of the summer, a woman, aged 33, was admitted to the hospital, complaining of occasional pains in the right iliac region where a tumour had been slowly growing for several years. She traced the beginning of the illness to seven years ago, when one day she experienced in the right lower abdomen a sharp pain which compelled her to remain in bed for almost a week. No constipation, no nausea, no vomiting. She said that ever since that time, she had been subject to similar attacks of pains, coming on suddenly at various times and gradually disappearing. At first, these attacks seemed to coincide with menstrual epochs, but lately they had showed no particular connection with monthly periods. She had lost considerable weight; the appetite was impaired. The lump which did not seem to have much incressed in size of late, was moderately tender except during the paroxysms when it became very painful.

On the right side, midway between the umbilicus and the anterior spine of the ilium, a tumour was distinctly felt, hard, very slightly movable, the size of an orange, not lobulated and quite tender on pressure. During examination, gurgling noises were heard, produced by the displacement of intestinal gas. The abdomen was opened and the tumour appeared, situated at the union of the ileum and the cœcum, in the region of the ileo-cecal valve. The omentum, adherent to the upper part of the tumour pulled the neoplasm upwards, dragging at the same time the transverse colon downwards. Superiorly, the limits of the tumour were not clearly defined, the upper part was adherent to the meso-colon, forming a mass whose anatomical relations were difficult to ascertain. In trying to detach some of the adhesions I perceived that the gut was perforated. Introducing my finger in the perforation, I could feel inside of the bowel the rough surface of the tumour and thought for the first time of the possibility of its being a large enterolith. However, the bowel being perforated, I made the resection of the cœcum including the tumour, uniting afterwards by an end-to-end anastomosis the termination of the ileum to the ascending colon. Fully six inches of the bowel were removed.

The parts examined after operation showed the presence of a large globular mass, the size of an orange and composed of hardened feces. The mass perfectly smooth, was free in the cavity of the cœcum and

fell out of its site, which must have been almost entirely filled by the enterolith, and it is a wonder that the patient never offered any symptoms of intestinal obstruction.

This paper, which I have the honour of reading before you, has, I hope, contributed to a certain extent to demonstrate how varied and deceptive are the affections characterized by the presence of a tumour in the right iliac region. Thus, out of five personal cases, one was due to an ovarian cystoma; another, to a dermoid cyst with twisted pedicle; a third, to hypertrophic tuberculoma of the cœcum; a fourth, to interstitial myositis and finally, the last, to an enterolith of the large intestine.

The conclusions which we may draw from these varied observationa are as follows:—

1. The extreme difficulty of making an accurate diagnosis in several cases.

2. The facility of mistaking for appendicitis, cases of entirely different origin and *vice versâ*.

3. In presence of an abdominal tumour, never to take the knife in hand without being prepared for any kind of emergency.

4. Whenever a case has not been personally observed from the beginning, always to reserve the diagnosis, whatever may be the ability or the cleverness of the physician by whom we are called in consultation.

5. Finally, that the abdomen is a mysterious region of the human body, concealing a great many obscure diseases in the surgical treatment of which many a patient loses his life, and the surgeon, quite frequently, a good deal of his self-complacency.

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