whole of the abdominal cavity and obscuring the other viscera. It was adherent to the abdominal wall, diaphragm, liver, spleen, kidneys and intestines. The diaphragm, the liver and the spleen were pushed up. The right kidney and suprarenal gland were completely incorporated in the mass and on tracing the ureter they could be dissected out from within the lobules of the mass. The left kidney and suprarenal gland were compressed behind the mass. Both the kidneys and suprarenal glands were, however, quite free from the growth. The large and small intestines were firmly adherent with the tumour and were at places markedly compressed within it but the lumen was patent though narrowed. The mesentery and its lymph nodes were not seen being apparently incorporated within the tumour mass. There were about 2 ounces of straw coloured fluid in the abdominal cavity. On opening the pleural cavity no adhesion or fluid was noticed. Both the lungs were congested and œdematous at the bases. A metastatic nodule was seen in the mid zone of the right lung just under the pleura. Another metastatic nodule was seen in the body of the twelfth thoracic vertebra. All other expected sites of bony metastasis were explored but no such deposit was found. Other organs particularly the prostate, testes, thyroid, stomach and intestines, inspected for the primary growth, were found to be free.

The tumour mass (Plate Fig. 2) had a serous covering and was found to arise from retroperitoneal tissue near the vertebral column. It was an irregular lobulated mass weighing 31 lbs. and measuring 16′ × 12½″ × 10″. The cut surface of the tumour had a yellowish cheesy appearance with a few pale fleshy areas and was soft and pulpy. It was degenerated at places but no hæmorrhagic area was seen.

Histology

Tumour—Section showed the picture of lipo-sarcoma. The nuclei of the lipoblast cells were bizarre looking and hyperchromatic and a few mitotic figures were seen (Plate Figs. 3 and 4). The vacuolated areas in the paraffin preparation could be stained with Sudan III in the frozen sections. The number of malignant cells varied in blocks taken from different parts of the tumour and in some they were almost absent.

Lungs—Section from basal area showed œdema and congestion. The structure of lipo-sarcoma similar to the parent tumour was present in the metastatic nodule (Plate Fig. 5).

Kidney—Glomeruli were hylinised at places with degeneration of the surrounding tubules.

Liver—Slightly congested.

Suprarenal glands, thyroid, testes, spleen, intestines, pancreas and cerebral cortex showed no abnormality in the histological picture.

Body of 12th Thoracic vertebra—showed invasion by the tumour tissue, the histological picture of which was the same as that of the primary growth (Plate Fig. 6).

Discussion

The diagnosis of lipo-sarcoma was established by the presence of lipoblast cells in the histological section. It arose from the retroperitoneal tissue possibly in the perirenal fat of the right kidney, which was buried in the tumour mass. This is a common site for such tumours which usually arise from lower limb, retroperitoneal tissue and inguinal canal though no site is exempted (Willis, 1948). It seems from the long history (5 years) that the tumour first arose as a lipoma which subsequently underwent malignant change. The relative infrequency or even absence of malignant cells in some areas of the growth also points to this. Clinically the cystic feel was apparently due to the mass of fat but the absence of free fluid inspite of a huge malignant growth was rather striking. Lipo-sarcoma of this dimension is unusual but even larger tumours may occur as one of 50 lbs. described by Windle (Ewing, 1942).

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A CASE OF HYDATID CYST OF THE BROAD LIGAMENT

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THE larval stage of Taenia echinococcus in the form of Hydatid cyst if it occurs is commonly seen in the liver of man. Literature shows it can be noticed rarely in other parts of

the body especially lungs, bones and brain. As far as reference goes very little is mentioned of the possibility in the pelvic organs, hence the impetus to publish this case.

Case Report

Patient named M. D., aged 30 years referred to the Gynaecological Clinic for pain in the lower abdomen since six years.

Family History.—Two full term children were born; the first was a boy who died of Pneumonia at the age of one year. The second was a girl who died of debility at the age of two years. Following this there were two miscarriages, the last one 6 years back.

Previous Illness.—Patient gives a history of two operations. The first operation was performed 12 years back at the Mayo Hospital, Lahore for a lump in the right hypochondrium. A drainage tube had to be left in from which, in the words of the patient "small eggs" were taken out for a long time, and it took six months for the wound to heal up. One and a half year after this she was admitted again into the same hospital for what she describes as gall stone removal. Six years later she went to the Brindavan Mission Hospital, U.P. for pain in the pelvic region for which she was advised operation which she refused.

Present History.—Complains of pain in the lower abdomen felt more during the menstrual periods for the last five years. Menstrual periods regular.

On examination

General condition good; heart and lungs N.A.D.; Liver and Spleen not palpable. There is an old operation scar on the abdominal wall in the right paramedian line eight inches long. On P. V. cervix perched to the left, uterus antiverted and normal in size. There is felt a hard mass in the right fornix aand left fornix is clear.

Laboratory investigations

Blood for W.R. & Kahn—Negative.			
Total R.B.C. 4.4 Mill per c.m.m.			
Hæmoglobin	..	13 gms. %	
Total W.B.C.	..	8,900 per c.m.m.	
Diff. W.B.C.	..	Neutrophils	.. 66%
		Lymphocytes	.. 28%
		Monocytes	.. 2%
		Eosinophils	.. 4%

Operation Notes.—Under NO_2 & O_2 (intratracheal) abdomen opened by a right lower para median incision. A big cyst, the size of a tennis ball, was in the right broad ligament with fairly marked adhesions all round. While separating the cyst from the adhesions the cyst burst open and several smaller cysts were found to come out along with an opalescent fluid suggesting the tumour to be a hydatid cyst. This was confirmed by the demonstration of hooklets in the cover slip preparations. Bleeding points were ligated. Pedical peritonised. Appendisectomy done and the abdomen closed in layers.

Post-operative notes.—The patient made an uneventful recovery. Casoni's test done 6 days after the operation found to be strongly positive.

Comment

From the history it is quite evident that the patient suffered from hydatid cyst of the liver to start with. Subsequent to this a swelling in the broad ligament started which is proved to be a hydatid cyst. The cyst in the liver must have been marsupialised and stitched. Probably the cyst contents escaped. But what cannot be explained is how the cyst could have started in the broad ligament unless the contents escaped into the blood stream. Thus the possibilities are that it is a primary infection through the alimentary tract or through the blood stream secondary to that of the liver, or it is a peritoneal implantation from the primary hepatic lesion. Instances are on record of multiple hydatid cysts in the same organ or involving different organs like the brain, liver, bones and rarely in the pelvic organ, infection being through the alimentary tract *via* the blood stream. Of these two possibilities peritoneal implantation as a result of ruptured cyst of the liver seems to be more feasible.

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