bronchus, near a bronchus or in the lung itself. The nodules in the right lung were well circumscribed in the parenchyma away from the bronchi and were definitely metastatic. We were quite certain that we could rule out bronchiogenic or primary carcinoma of the lung. The bronchial lymph nodes contained no tumor. We searched every organ for a primary source, but we were unable to find any.

The histology of the tumor was typical of what has been described as a mesothelioma (Fig. 5). The cells in some areas were cuboidal and arranged around fibrous stalks giving a pseudopapillary pattern. In other areas the cells were large, irregular and closely packed. Some were multinucleated, and others seemed to be forming mucinous material.

A number of papers have been written to the effect that there is no such tumor as mesothelioma of the pleura, that the cells lining the pleura do not form tumors and that these tumors really arise from a small focus in the lung. We have held a similar opinion for a long time. This is perhaps the first case in which we believed that there was actually such a tumor. It certainly fits in with most of the cases of mesothelioma of the pleura that have been reported.*

DR. KING: I do not consider that it is fair to have given me a case with a diagnosis against which you, as pathologists, have been talking for twenty years. I could never make Dr. Mallory accept a diagnosis of mesothelioma of the pleura.

DR. CASTLEMAN: He has been sold on this one. The lesion in the abdomen was retroperitoneal tumor, but there was no tumor elsewhere.

DR. ADAMS: What was the large lesion in the left lung?

DR. CASTLEMAN: It was merely nodularity due to the pleural tumor.

*Klemperer, P., and Rabin, C. B. Primary neoplasms of pleura. *Arch. Path.* 11:385-412, 1931.

CASE 33112

PRESENTATION OF CASE

A seventy-two-year-old Polish housewife entered the hospital in coma.

Eleven days before entry the patient had received a slight back injury in an automobile accident. A physician examined her at that time and found only slight spasm along the lumbar muscles. Three days later the physician was called again because the patient complained of slight bleeding supposedly from the vagina; he could find no evidence of bleeding. Six days before entry the patient began to have frequent episodes of abdominal cramps. These continued daily. Three days later the abdomen was distended, with marked tenderness and a mass in the right lower quadrant. The patient was taken to another hospital, where a plain film of the abdomen and a barium enema showed an abrupt, shelf-like obstruction in the lower sigmoid, with a markedly dilated large bowel, particularly on the right, and beginning small-bowel dilatation. Routine urine examinations were said to have been negative. There was a slight leukocytosis, and the blood sugar was 196 mg. per 100 cc. On the following day the patient appeared acutely ill. The abdomen was greatly distended, and the patient complained of abdominal pain. No organs or masses could be felt. The pulse was about 115. On the same day an emergency cecostomy was performed under a local anesthetic. There was an increased amount of clear, straw-colored fluid in the peritoneal cavity. The colon and cecum were greatly distended, and a large amount of fluid and gas was removed by trocar suction. A glass Mixter tube was fixed in place by sutures. Following the operation the patient was said to have improved for a while, but the abdominal symptoms subsequently reappeared. She was transferred to this hospital on the afternoon of the second postoperative day.

The patient was known to have hypertension. A sister had diabetes.

Physical examination revealed an obese, disoriented woman. The left border of the heart extended beyond the midclavicular line, but the heart sounds were normal. There were coarse rhonchi, which cleared on coughing, in both lower lobes. The abdomen was distended, tense and slightly tender. Peristalsis was limited to a few tinkles. The diaphragm was high on both sides but moved to percussion. The cecostomy appeared to be functioning well.

The temperature was 100°F., the pulse 120, and the respirations 30. The blood pressure was 110 systolic, 70 diastolic.

A Levine tube was passed immediately on entry, and 500 cc. of brownish fluid, as well as considerable gas, was aspirated from the stomach. The patient also received 600 cc. of 5 per cent dextrose in water and oxygen. During the night she became extremely disturbed, tore up the oxygen tent and pulled out the intravenous drip and stomach tubes. The cecostomy drained 1680 cc. of fluid, and 646 cc. of urine was passed on the first hospital day. On the morning of the second hospital day the distention appeared to be slightly less, and peristaltic tinkles were somewhat more frequent. The tongue was dry.

The temperature was 102°F., the pulse 130, and the respirations 30. The blood pressure was 100 systolic, 60 diastolic.

Examination of the blood showed a hemoglobin of 16.3 gm. per 100 cc., a hematocrit of 50 and a white-cell count of 9700, with 85 per cent neutrophils. The total protein was 8.5 gm. and the nonprotein nitrogen 100 mg. per 100 cc.; the carbon