satisfactory convalescence. A pelvic abscess developed, but it burst spontaneously per rectum on the fourteenth post-operative day. She was eventually discharged from hospital on June 30.

The Specimen.—When opened, the resected bowel presented the following features: (1) The normal mucosal pattern was replaced by a grossly distorted and oedematous appearance. This oedema had considerably reduced the calibre of the lumen of the bowel. (2) The muscular coat was swollen with oedema to almost twice its normal thickness, but there was no evidence of loss of continuity or of commencing perforation of the bowel. (3) There was evidence of patchy submucosal haemorrhage with one or two ragged areas of apparent mucosal erosion.

Comment

It is interesting to speculate on the probable pathogenesis of this condition. Judged by all the accepted standards, at the time of the original operation the incarcerated portion of ileum was viable. Non-viability of a portion of the gut wall would inevitably have been followed by a perforation or the formation of a localized abscess. The absence of both these complications precludes the possibility of permanent ischaemic changes in the bowel having been overlooked. Viability, as judged by the external appearance of the bowel, however, does not exclude the possibility of a varying degree of mucosal necrosis.

Paget (1879) taught in his lectures on strangulated femoral hernia that, "short of gangrene, there may be ulceration of the mucosa of the intestine." Barry (1942), in a comprehensive review of intestinal stricture following strangulated femoral herniae, reiterated this point, and conjectured that cicatricial contraction arising as a result of permanent damage to the mucosa is the main causative agent in the production of obstruction.

The gross appearances of the affected segment in this case, however, were those of an acute localized phlegmon of the ileum. It is most likely that this arose as a result of infection reaching the submucous zone through the damaged and ulcerated mucous membrane of the incarcerated bowel, the causative agent in all probability being a streptococcus.

James (1942), reporting a case of localized phlegmon of the jejunum, stated that areas of suppuration in the gut wall were a common feature in this condition, though none was noted here.

The appearance of the bowel was not unlike that of Crohn's disease, except that the mesentery was not as extensively involved and there was no evidence of enlarged lymph nodes. This similarity in appearance to Crohn's disease was also remarked upon by Barry (1942) in the first of the three cases he reported. The similarity of the gross appearance of the bowel to that of Crohn's disease suggests the possibility of a common aetiology—namely, that the latter disease results from chronic inflammation of the bowel wall of enterogenous origin.

I wish to thank Professor R. St. Leger Brockman for permission to treat and record this case.

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Bladder Loculus Simulating Strangulated Inguinal Hernia

The following case seems to be of sufficient rarity and interest to merit recording.

Case Report

A negro aged 32 was admitted to hospital with a painful swelling in the right groin which he was said to have had for two weeks. He could not speak English, and no other accurate history was available. An impression, however, was gained that he had had some vomiting but no constipation.

The swelling had the characteristics of an irreducible inguinal hernia. The question of strangulation could not be excluded with certainty, and it was decided to explore the swelling immediately.

At operation a large mass was found in the inguinal canal and scrotum from which a medium-sized indirect hernial sac was excised after having been found to be empty. This completed, there remained the large mass still occupying the canal and scrotum; it was covered with fibrous tissue. During the examination it was opened and found to be hollow, with muscular walls, and to contain a liquid immediately suggestive of urine. Further exploration within this cavity confirmed that it was in fact a large loculus of a bilocular bladder. In the absence of information about the site of the right ureter and relative sizes of the two loculi it was decided to defer excision of the loculus, should this be feasible, until further investigation had been made. The opening in the bladder was closed, the wound drained, and a penile catheter inserted.

He made a satisfactory recovery, and four weeks later the large loculus was excised by Mr. A. Kirk Wilson uneventfully.

Comment

The absence of an adequate history in this case added to the diagnostic difficulty, and it is doubtful whether, without any definite relationship between the inguinal swelling and urinary symptoms, an accurate pre-operative diagnosis could have been made. It is unfortunate that the language barrier prevented any urinary history from being obtained, even after operation. Although the bladder should be suspected as being a part of any inguinal swelling, the large size of this—it reached and filled the scrotum—made its presence unlikely.

This bilocular bladder could be regarded as the para-peritoneal type of Wakeley (1939), though those discussed in his article dealt with only relatively small protrusions.

A case presenting many similar features was described by Stock (1947). In his case the patient was an African negro, and not until the bladder loculus was opened was a diagnosis made; the loculus was smaller, however, and was excised immediately.

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King Edward's Hospital Fund for London is to open a School for Hospital Catering at St. Pancras Hospital towards the end of May. The aim will be to illustrate new methods and ideas, and all aspects of catering will be covered. Four full-time courses, both refresher and basic, ranging from 10 days to eight weeks, will be run for roughly 30 students who are already employed in hospital catering.