within twelve hours of perforation and found a small opening where the oesophagus comes through the diaphragm. As it was impossible to apply a suture in that situation I determined to pack with iodoform gauze for thirty-six hours, and recovery was uninterrupted, and three years afterwards she was in perfect health.

I think it is quite possible that in this case Nature could have effected a cure if no operation had been done, because the opening was very small and in a position which would be in favour of only a small leakage of the gastric contents taking place. It is in the lower dependent positions along the greater curvature of the stomach that we get large quantities of the gastric contents rapidly effused into the general peritoneal cavity.

HERNIA OF THE BLADDER AS A COMPLICATION OF INGUINAL HERNIA.

By G. B. FERGUSON, M.Ch.Oxon., F.R.C.S.Eng.,
Senior Surgeon to the Cheltenham Hospital.

MR. H. J. CURTIS's paper published in the *BRITISH MEDICAL JOURNAL* of July 11th, on a case in the practice of Mr. Bilton Pollard, induces me to publish another example of the condition illustrated by him, and referred to above. Though uncommon, it is of sufficiently frequent occurrence to put all operating surgeons on their guard, with a view to its recognition. I must confess that I was not aware of such a condition, as of practical importance, before I was recently introduced to it in the case which I will now briefly narrate.

It is that of a young man who sought relief for a large irreducible left inguinal hernia, recurrent after an operation for radical cure. This hernia proved to be mainly omental, together with a small knuckle of the transverse colon. The operation done by me was made difficult by adhesions, though it was satisfactorily accomplished at last. Some pounds' weight of omentum was removed, and the neck of the sac was closed, though its total extirpation was impracticable. At the end of the operation a thin, blue, and distended cyst, about the size of a pigeon's egg, was noticed in the immediate proximity of the spermatic cord, and adherent to the remains of the sac. It was mistaken for a hydrocele of the cord, and was punctured, when a considerable amount of clear fluid escaped, and the finger introduced into the cyst passed, at a deeper level, through a constricted neck, into the bladder. The cyst was of extreme thinness, consisting of little more than attenuated mucous membrane. Regrettable as such a mishap was, I am glad to add that no harm followed it. The mucous membrane was stitched together continuously with fine silk, which I used in preference to catgut, feeling more confidence in its asepticity, and trusting that from its fineness it would not project into the bladder to originate incrustations therein; and this continuous suture was completely covered in by a layer of interrupted Lembert's. *Cæteris paribus*, catgut would, of course, have been safer for the mucous suture. A catheter was tied into the bladder for a few days, and I am pleased to add that uneventful healing by first intention ensued. Still and nevertheless the puncturing of vesical cysts is clearly a practice to be avoided, and I am grateful to Mr. Pollard for the simple suggestion that the diagnosis can be quickly cleared up by a sound passed through the urethra.

In the case treated by me the bladder hernia was extraperitoneal, and its mechanism was very evident. After the first operation there was inflammation with suppuration, and an adhesion resulted between the remains of the sac and the bladder, the former of which in its re-descent drew down with it a diverticulum of the mucous lining of the latter.

I suspect that there have been many more cases of vesical hernia observed than have found their way into medical literature, and I am permitted to refer to another case in the practice of my friend, Mr. E. Dykes Bower, Surgeon to the Gloucester Infirmary. Here an innocent-looking little cyst, projecting, as in Mr. Pollard's case, into the hernial sac, was removed, after ligaturing its neck. As in my case, the man had previously undergone an operation for radical cure, also on the left side, and fortunately here again no harm resulted from the injury to the bladder, and the patient made a good recovery, though during the next day, and for some time afterwards, there was a copious flow of

urine through the wound. Clearly, however, it must be the rule hereafter to leave all such suspicious cysts untouched, and surgeons are much indebted both to Mr. Pollard for indicating the proper treatment of such cases, and to Mr. Curtis for his clear and helpful diagrams and descriptions.

FURTHER OBSERVATIONS ON ALCOHOLIC AND ARSENICAL NEURITIS.

By ERNEST SEPTIMUS REYNOLDS, M.D.Lond., F.R.C.P.,
Assistant Physician to the Manchester Royal Infirmary; Visiting
Physician to the Manchester Workhouse Infirmary.

It will probably be remembered that in 1900 there was an outbreak of arsenical neuritis amongst beer drinkers, especially in the North of England and in the Midland Counties. This was due to the accidental contamination of glucose with arsenic. In various papers which I wrote in connexion with this epidemic, and in my evidence given before the Royal Commission on Arsenical Poisoning, I contended that by far the greater number of cases of so-called alcoholic paralysis, at any rate in the Manchester district, were in reality due to chronic arsenical poisoning, and were not due to alcohol, and that this had been the case for years, probably apart altogether from the use of contaminated glucose. Subsequent investigations showed clearly that malt, especially when prepared by the use of certain cokes, was largely contaminated with arsenic, and that beer prepared from this malt also contained heavy traces of arsenic. Indeed, a small epidemic of marked arsenical poisoning occurred in beer drinkers at Halifax last year quite apart from arsenicated glucose, and was probably due to the malt having been prepared with gas coke.

In evidence given before the Royal Commission in 1902 I stated that I had seen cases of peripheral neuritis in pure spirit drinkers where there was no evidence of arsenical contamination. These cases, however, are very different from the cases of so-called alcoholic paralysis with which we have been so familiar for many years. They show some loss of power in the legs and arms, absent knee-jerk, paraesthesiae of the feet and hands, only slight tenderness on pressure of the muscular masses, very little atrophy, no loss of memory, and no oedema. Such cases are, moreover, considering the large amounts of alcohol consumed in this country, very rare, and during the last two years I have certainly not seen half a dozen in my private practice, in a large out-patient practice at the Manchester Royal Infirmary, and at the Manchester Workhouse Infirmary, where I have 800 medical beds.

By the old so-called alcoholic paralysis I mean those cases of peripheral neuritis, with much paralysis and atrophy of the legs and arms, loss of knee-jerks, great tenderness on pressure of the muscles, and peculiar and typical loss of memory for time and place, and often oedema of the legs—sometimes general oedema—from dilatation of the heart. This was the type found so commonly during the arsenical poisoning epidemic, when with it there were also found various skin lesions—notably pigmentation, keratosis, various erythematata, and herpes.

These cases (even apart from the epidemic), I venture to think, were in reality due to arsenical poisoning and not to alcohol, but many observers have thrown doubt on this view. It is interesting, therefore, to be able to send a short report of what has happened in Manchester during the last two years, in which period Manchester beers have contained perhaps not $\frac{1}{10}$ gr. arsenic per gallon. A close look-out has shown that these cases have practically disappeared (up to about three months ago, about which more presently), and in this statement I am confirmed by the observations of several other Manchester physicians. The "alcoholic" heart has also practically disappeared. Now I think I may take it for granted that the people in Manchester and district are still taking alcohol in large quantities. If these cases are really due to alcohol, why have they disappeared? This is the negative evidence.

Now take the positive evidence. During the last two months I have seen six cases of the old so-called "alcoholic" paralysis type, five of whom are at present under my care.

CASE I.

Edward R., aged 40; has taken ten glasses of beer nightly, more at week ends. Has pressure pains well marked, loss of knee-jerks, some atrophy, paralysis of the legs, slight paralysis of the arms, no loss of memory, burning pains of the soles of the feet, slight general pigmentation.