unable to say. One knows, however, that many of the variations from the normal observed in the bloodvessels generally receive their explanation in some such way, and there appears to be no valid reason why the vessels of the eye should furnish any exception to the rule. Be this as it may, it becomes of some practical importance to know that anomalies of a purely congenital nature are not very uncommon in the veins of the human retina. Out of every 1000 eyes examined I estimate, indeed, that at least three will show an anomalous arrangement of the retinal veins.

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CASE OF HERPES OF THE LARYNX.

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THE following case, which came under my notice during my admission period at St. Bartholomew's Hospital, from the curious character of the symptoms presented and the difficulty of finding an explanation for the same, may be of interest to the readers of THE LANCET, though I venture to think the case is anomalous.

S. A—, forty-one years of age, packing-case maker, came, or rather was brought, to the hospital by a fellow-workman on Nov. 18th last, suffering from a curious combination of dyspnoea, difficulty in swallowing, and nervous excitement. The history of his condition was that he was in good health up to about a fortnight previously, when he had a slight bilious attack with giddiness, which, however, did not prevent him from following his occupation. A similar attack occurred again a few days before admission.

On Nov. 17th the patient first felt a "tightness" in his throat, with some hoarseness and cough; he continued at work, however, till the 18th, when in the afternoon his throat became so much worse that he had to be brought to the hospital. He complained of intense pain on swallowing, with a difficulty in getting his breath, and a feeling of tightness about the throat. The patient presented a most curious appearance: he sat with a face expressing the utmost anxiety, his eyes seeming to protrude, swimming with tears, which ran down his face, his mouth was open and the saliva ran in large quantities over his lip down into his beard. The *alæ nasi* and lips appeared red and slightly swollen. The dyspnoea was not very marked, but his breath was drawn with fear and trembling. The most remarkable feature of the case, however, was that when he attempted to swallow, not only his face but his whole body writhed with agony, almost resembling a convulsion, and he had evidently the greatest dread of making the attempt. He spoke in a hoarse whisper, and not more than was absolutely necessary; but on pressing him to do so I found that phonation was not only possible, but was not even distinctly impaired. He complained of great pain on the left side of the neck, and pressure anywhere between the left side of the larynx and the ear was not only extremely painful, but also caused him to roll about in the most extraordinary contortions. One's first thought was of hydrophobia, but no evidence could be obtained in the least supporting this view. The man was certainly not in liquor, as his habits were most temperate, and his companions vouched for the almost sudden onset of the condition while at work. Family and personal history threw no light on the subject. He was temperate, married, family healthy, and had never had syphilis. External examination was equally negative, except that the glands on the left side of the neck were slightly enlarged, and the tenderness over them was extreme. On examining the mouth, the fauces were slightly reddened and the uvula somewhat cedematous, but there was no great tenderness and no sign of membrane or ulceration to be seen; clear and glassy mucus was, however, standing everywhere in beads, and pouring rapidly from the nasopharynx. His temperature was 103.4°; pulse 116, weak; respiration 25, drawn apparently rather with a sense of pain than with a desire for air.

With some difficulty I was able, after the use of cocaine to the fauces, to make a perfectly satisfactory laryngoscopic examination, which disclosed the following. The cords and ventricular bands were perfectly normal, as also was the right arytenoid and aryteno-epiglottic fold. The

left, however, was redder than natural, and presented a mass about the size and shape of three peas more or less fused together, and capable of being moved over with a probe either to the laryngeal or oesophageal side of the ary-epiglottic fold, to the edge of which they were attached. The surface was redder than natural, quite smooth, and glistening like that of a polyp or a polypoid degeneration of the mucous membrane, for which I at first took them. Posterior rhinoscopy revealed nothing further. From their position and displaceability they were, granting their tenderness, capable of creating the greatest trouble either in phonation or in swallowing, as, when the epiglottis was depressed in the latter case, they were pressed into the pharynx, while in the former they somewhat overhung the orifice of the larynx, the entrance or exit of air through which caused them to vibrate enough to produce pain. Of their real nature I had then no idea.

He was admitted, and an ether draught administered, with cold compresses to the neck. During the night he was most restless, taking only a little milk, and that with great pain and difficulty, expectorating about one pint of thin mucus, which was free from odour.—Nov. 19th: Condition slightly improved. Temperature 99.3°. Voice more natural; still great difficulty in swallowing. Urine: sp. gr. 1028; no albumen or sugar. No signs of disease in chest or lungs. The laryngoscope showed the tumour—if it may be called such—about the same, except that it was of a more milky colour, and there was more general swelling of the arytenoid, the right being also somewhat enlarged.—20th: Condition much improved in all respects; though still much pain on swallowing, there are none of the nervous symptoms with it. Temperature 98.6°. The condition now is that of a small bulla, filled apparently with pus, seated on the summit of the enlarged and swollen arytenoid. A patch of herpes was now observable, beginning about the left nostril and upper lip.—21st: Condition still improving. Temperature subnormal now. The bulla has now disappeared, and its place is occupied by a white patch of macerated epithelium, which could not be removed with a probe. Arytenoid not so much swollen. Herpes on lip and *alæ nasi* more extensive, and spreading to the other side. During the next few days he improved much in general health; pain on swallowing gradually disappeared, as also did the white patch and the swelling on the arytenoid. The voice became quite normal. The herpes on the lips and *alæ nasi* went through the ordinary stages of that eruption. It was rather extensive, passing up a little into the nostril. On Dec. 3rd the man was discharged with the herpes healed and the larynx normal.

It needs only to be remarked that I regard the case as one of buccal herpes, peculiar chiefly in the seat of the first vesicles, which were what I took for a polypoid growth; their course, however, through the milky to the purulent stage, bursting and then leaving a base which, becoming macerated by the saliva, looked like a white patch, points to this explanation. The pain in the neck, most marked at the onset, subsiding earlier than the eruption, the salivation and the rapid fall of the initial temperature, all confirm this view. I have since seen a case of herpes of the face and soft palate in which, though great pain was absent, the temperature and constitutional disturbance ran a similar course, being 103° when first seen, falling to normal on the third day, when the eruption showed itself. I hope that the case may not be without interest to the profession. It was certainly, to begin with, most puzzling; for though herpes of the palate, tongue, and cheeks is, I believe, not very rare, I can find no reference in the text-books to its attacking the larynx. I must, in conclusion, thank Mr. Howard Marsh for his kind permission to publish the case, which was under his care.

OCCLUDED OS AT FULL TERM.

By L. NASH, L.R.C.P. & S. Ed.

I WAS much interested in reading in a recent number of THE LANCET of a case of occluded os at full term. As so few instances have been recorded, I think it may be worth while giving brief notes of two such cases occurring in my private practice whilst I was in Sindh.

CASE 1.—In May, 1890, I was called to a multiparous