

became very much alarmed, and about the first of July went to Cainhoy, S. C., and put himself into the hands of a quack living at that place. He remained in Cainhoy during July and August. The sore was treated with some kind of "salve," the application of which was so painful that he could not sleep at night unless it was removed. The "doctor" informed him that the "salve" was intended to "burn out" the cancer. About the first of September he returned to Charleston, the ulcer having at that time increased so as to occupy the whole of the right cheek, six by eight inches in size, and had spread down the side of the neck on the inner border of the sterno-mastoid muscle. At that time he suffered no pain, his appetite was unaffected, and his general health was not at all impaired.

He was admitted to the City Hospital September 3, 1879, under the care of Dr. Michel. A few days subsequent to this a slight hæmorrhage, which was con-



trolled by pressure, took place from the ulcer on the edge of the sterno-mastoid muscle, but on September 13th an alarming recurrence of the bleeding took place, and Dr. Michel being summoned ligated the external carotid artery just above the bifurcation. From this time Hansen was treated with dressings of carbolic oil to the sore, which would take on the healing process for a few days, and then break down and spread to its former site.

November 3d. Being a sailor he was transferred, at his own request, to the United States Marine Hospital wards, then under the charge of Assistant Surgeon W. C. W. Glazier, who was relieved by myself November 7, 1879. At this time the ulcer was very large, and increasing in size; it extended from the upper edge of the temporal process downward to the inner side of the chin and upper part of the neck, backward to the edge of the trapezoid muscle, and forward to the outer angle of the orbit. The auricle was entirely gone. The site of the ligature around the artery was suppurating profusely, and a large spreading ulcer had made its appearance on the index finger of the left hand. The patient had a good appetite, and his general health was excellent.

He was ordered iodide of potassium, one gram thrice

daily; the ulcer was thoroughly cauterized with nitrate of silver, and dressed with oxide-of-zinc ointment. From this date the iodide was gradually increased from three to nine grams daily, taken with compound tincture of cinchona.

The sore while healing in one direction would ulcerate in another, being serpiginous in its character. Whenever this tendency was manifested the silver nitrate was used, sometimes as often as three times in the day, and always once a day. The sore on the finger was first wiped out with caustic potash, and then treated in the same way.

January 10th, 1880. Portions of necrosed bone being visible, the mastoid process and a part of the superior ramus of the lower jaw were removed, and from this time the ulcer healed more rapidly. A little later a slight hæmorrhage took place from the lower part of the ulcer; a small vessel having been opened, the torsion forceps were used, and the bleeding was arrested.

February 1st. The ulcer on the finger was entirely healed, that on the face being about two by four inches in size.

March 1st. Facial ulcer entirely healed, and the patient discharged, recovered. He was kept under observation until April 5th, and at that time there was no sign of recurrence of the disease.

It seems fair in this case to attribute the recovery to the large doses of potassium iodide used, as there was no sign of healing until this drug was prescribed, and the more it was pushed the more rapidly the healing process went on. Fortunately, at no time was any intolerance of the iodide shown. The progress of the case, the absence of all constitutional trouble or lymphatic infection, and the result seem to indicate a diagnosis of rodent ulcer, or possibly lupus exedens. Mr. Gay, of London, in the *London Lancet* for December, 1871, reported an interesting case of lupus exedens treated successfully by large doses of iodide of potassium, and in February, 1872, the same journal reported in relation to the case that the cure was complete.

U. S. MARINE HOSPITAL OFFICE,
CHARLESTON, S. C., April 7, 1880.

DIAGNOSIS OF THE POSTURE OF THE CHILD IN UTERO.

BY JAMES O. WHITNEY, M. D., PAWTUCKET, R. I.

THE popular opinion that the child in utero may readily change its position is an error, except in cases where the quantity of amniotic fluid is very great in proportion to the size of the offspring. In the early months of pregnancy this proportion is far greater than later, and then, no doubt, the fœtus may change its presentation. Why, in the very great majority of cases, it assumes the "first position" of obstetrical writers is not a part of this communication; the fact is merely cited. As is well known in this case, the back of the child lays against the mother's left flank; its abdomen presents to her right flank, with its pelvic extremity of body upwards, and usually to the left of the median line of her body. The second position is the reverse of this, to wit, the child's back against the mother's right side, and its abdomen to her left, the vertex down in the pelvis. To ascertain which of the two presentations exists in a given case, assuming that the mother is not obese, and that there is about the

usual quantity of liquid surrounding the child, is not a difficult problem when once the fingers are taught,—the *tactus eruditus* acquired. On the side that presents the greatest degree of firmness there the child's back lies; the abdomen of the child gives a notably less hard feel to the mother's flank to which it is applied. This fact is very palpable in the most of cases, so much so that removal of ordinary clothing is not required to demonstrate it. The feeling of firmness is greatest below, and lessens as the child's body is traced upward towards its pelvis. Where the child's back lies there the mother, if delicate, has a sense of weight, but no motions are perceived by her in this locality. Motions are felt by her on the side towards which the child's abdomen is turned, for they are made by its upper and lower extremities. No little dexterity in cross-questioning is often required to bring out the location of the motions,—the little blows of the feet and hands of the child against the uterine walls. There is a pushing or crowding feeling made by the child's pelvis (or vertex) high up, with "a bunch." These two kinds of motions must be clearly distinguished from each other, and it is rare that a patient, when her attention is pointedly called to the difference, cannot recognize it; if she fails to do so the chances are that the fault is with the questioner. So that if we find the mother's abdomen is firmer to the touch on the left, low down, that the little motions are on the right, the pushing of the child's pelvis high up and to the left, the first position exists; but to confirm it place the ear where the mother's abdomen is the firmest, and the child's heart-beat will be found. And if the pulsations of the child's heart are on the right (below the line of the mother's navel), and here it is found firmest to the touch, the blows of the child's feet and hands on the left, and this last locality notably softer to the touch, we may predict for a certainty that it is in the second position. Usually it is easy to distinguish between the head of the child and its pelvic extremity by touch alone in the upper part of the abdomen; but the safest mode is to place the patient upon her back, and the knees being drawn up, with the fingers of both hands, one on either side, press somewhat firmly into the pelvic cavity just above the pubes, and the child's head can be made out. It is lower than if the pelvis is downward. In cases of great obesity of the mother a doubt might remain; if it is a point of great importance the vaginal touch should also be practiced. These simple rules, clearly understood, are the key to the whole art of diagnosing the posture of the child in utero by external manipulations. Familiarity with them will enable any one to decide in a moment the existence of twins or a cross-presentation in the majority of cases. To recapitulate: that portion of the patient's abdomen which presents the greatest degree of firmness to the touch is the locality of the child's back; here also is found its heart pulsations. No motions exist here, but there may be a sense of weight, and perhaps a slight pushing. Opposite the child's back its abdomen must lie; here the mother's abdomen is far softer than where the child's spine is applied, and here also are the little motions of the child's feet and hands.

The scope of this paper does not include details of diagnosis of all possible positions of the child in utero, but it is believed that the landmarks here given are sufficiently complete to lead to the most satisfactory results attainable in actual practice. These rules may

be followed any time after the seventh month of pregnancy as unerring guides. The JOURNAL contained a communication upon this topic four or five years since¹ (I think from Dr. A. O'Donnel, of Charlestown) that is the best I ever have seen, but it is far too prolix for a beginner. My landmarks once mastered, his article may be easily comprehended.²

RECENT PROGRESS IN OTOLOGY.

BY J. ORNE GREEN, M. D.

CHOLESTEATOMA OF TEMPORAL BONE.³

THE patient, aged fifty eight, as the result of caries of the petrous bone from tympanic inflammation developed an abscess in the right temporal lobe of the brain, over the diseased bone, from which he died. The autopsy is given in full, but the chief points of interest are that the whole of the interior of the petrous bone, except the labyrinth, was converted into a large cavity filled with cholesteatomatous masses, the external osseous shell remaining outside of these being sclerosed.

Microscopic examination of the masses showed necrosed epidermic cells, some with and some without nuclei; between these were the irregular, round-cornered, lustrous corpuscles which have been described by Virchow and Lucæ, with small plates of cholesterine. The thickened mucous membrane from the tympanum showed a thin layer of yellowish epidermis, beneath which were the Malpighian cells, partly extending into the mucous membrane in undulating lines, partly investing papillary prominences of the mucous membrane. The mucous membrane itself was infiltrated with numerous round cells and had large vessels; its tissue stained quickly with iodine, while the Malpighian cells and epidermis remained uncolored.

This epidermoid metamorphosis of the epithelium of the mucous membrane has already been described by Wenot and Schwartz. The case without doubt belonged to those in which, "during a chronic purulent otitis media, the normal epithelium of the mucous membrane of the drum cavity, the mastoid antrum, and the mastoid cells undergo the above-mentioned metamorphosis; the stagnating masses of epidermis are constantly increased by new depositions, and exert, partly by pressure, partly by their products of decomposition, a continuous inflammatory irritation, perhaps also a direct chemical influence on the surrounding bone. Then a partly sclerosing, partly rarifying, otitis occurs, and, under favorable conditions, the bone is perforated."

ROUND-CELLED SARCOMA OF THE TYMPANUM.⁴

Hartmann describes a case which from its great rarity should be noticed. A boy three and one half years old, healthy and of healthy parents, without previous pain or inflammatory symptoms, had a serous discharge from the right meatus, and two weeks later the meatus contained a tumor, which was supposed to be an ordinary polypus. On removing this, with the snare, four weeks from the beginning of the discharge, the deeper meatus was filled with other similar growths, resembling granulation tissue, springing from all parts of the deeper meatus and tympanum; the drum membrane and ossicles had been

¹ May 16, 1872.

² We would refer our readers to the work of Dr. Mundé, *Obstetric Palpation*, recently published by William Wood & Co., New York.

³ H. Steinbrügge, *Archives of Otolgy*, March, 1880.

⁴ *Archives of Otolgy*, March, 1880.