

such cases as these are the rubber splints especially useful; and it is to Mr. Lake that we owe the suggestion. He does not, however, mention the nature of the cases in which its use is advisable, nor the operation to which it serves as an adjunct. Still the shape of the splint and its advantages are spoken of by him in these words:

"Rubber sheeting should be kept in three thicknesses, one-eighth, two-eighths and three-eighths. The exact shape and size varies with each case. It may be either straight or boomerang, the latter enabling one to get pressure higher up the septum. If the thickest sheeting be used, the edges should have a long bevel given them by cutting with a sharp wet knife. These splints cannot become septic any more than can vulcanite; while they exert an elastic pressure which is less apt to cause sloughing and is surprisingly effective."

The class of cases in which I have personally found them most useful is the one that is the title of this paper; but the splint is rarely inserted without previously incising the cartilage. The usual method of procedure is the following:

The nasal passages are first sprayed with a one per cent. solution of cocaine. This shrinks the tissues and renders the passages more open, enabling the operator to more thoroughly cleanse them. To accomplish the latter, I prefer using an albolene or glycolene spray under pressure as less likely to produce abrasion of the mucus membrane than are the alkaline solutions when similarly used.

A five per cent. solution of cocaine is then applied on a cotton holder to the septal cartilage on both sides, chiefly to the convex one. Also a solution of adrenalin 1 to 5,000. Local anesthesia being induced, the hypertrophied tubercle is removed if present, by knife or saw. Then a tetotomy knife is passed from behind forward in one or two straight lines over the convex surface and through the cartilage—the lines being a short distance apart and parallel to each other. These incisions are usually made on the bevel, enabling the cut edges to glide over each other. The finger is next passed into the nostril and the cut septum pressed with little difficulty toward the median line. A splint is now chosen that after insertion will produce a slight pressure upon both inferior turbinated and septum when straightened. I like to have a fairly tight fit, with a splint not too wide, so that the elastic pressure will keep it in position. There should be room enough above the splint to pass a light cotton holder armed with a small pledget as far as its posterior end; and the inferior meatus sufficiently free to allow a similar cleansing right through to the pharynx. After insertion, as a rule, the splint should not be removed at all until healing and solidity have been accomplished, whether