with the upper lip, and anchored to the periosteum with four silk-worm-gut sutures passing through the skin. The lower incision was sutured bringing its ends together, thus causing it to assume a vertical direction, and forcing the lower bridge of skin up to cover the entire wound left by the removal of the upper bridge. The patient returned to business in three weeks, and photograph No. 2 shows him as at present.

My method differs from Regnier's in two particulars. The directions given by Regnier for estimating the width of the bridge of skin—one centimeter wider than part removed—would often bring the cicatrix visible on the chin. The average width of the

skin from the margin of the lip to the border of the chin is two inches. I would therefore recommend that the bridge be always two inches wide in order to cover the whole chin and bring the cicatrix below it.

In the second place, leaving the raw surface to granulate is most objectionable, not only on account of prolonging convalescence and leaving a scar, but also on account of ultimate contraction drawing the lip down. Grafting would likely fail owing to the discharges, and in a male would leave a bald spot. My plan utilizes the loose skin of the neck, leaves no part uncovered and hastens recovery.