to suit the operator. The patient is at rest, and has none of these fainting attacks that so frequently happen when the patient is in the sitting posture. Neither does the patient suffer the discomfort of holding the head in a fixed rigid position.

One disadvantage of the reclining posture is, that some little blood may pass into the throat. This may be arranged for by allowing the patient to have a towel into which he may expectorate when it is necessary. By this means the patient does not need to lift his head off the table, and, therefore, does not disarrange any of the sterilized towels and instruments that may be on his chest.

Another objection that some operators might advance is, that it is more difficult to get a good view of the floor of the nose, and therefore more difficult to remove the incisive crest, which, by the way, should usually be removed in order to get a good result. However, this objection is soon overcome by a little practice in operating with the patient in the reclining position.

Incision in the Mucous Membrane.—Always operate on the convex side of the septum. A single vertical incision is usually all that is required in a simple case. This incision should be one-quarter inch in front of the point you intend to go through the cartilage. If there is a ridge or spur in addition to the deflected septum, a horizontal incision is required as well; but never make the horizontal incision unless it is really necessary, for it increases the risk of injuring the mucous membrane during the remaining part of the operation, and also lessens the chances of getting good apposition when the operation is finished.

The reason you operate on the convex side is because the mucous membrane on the convex side is more difficult to free. Knowing this, you attack it from the most favorable position. The mucous membrane on the convex side is usually very thin, and has a great tendency to have a patch of rhinitis sicca on the most prominent part of the deflection, especially if the deviation is far forward.

First Cut Through the Cartilage.—There are two methods that I have used with about equal success. Killian's method is to "scratch" a hole in the cartilage with a sharp edged elevator. This is the method that I have usually adopted, but instead of using an elevator I use the point of a small scalpel.

A small slit is soon made in the cartilage by a few gentle strokes of the knife. You realize that the cartilage is gone through by the lessened resistance; then with one of Killian's blunt elevators, gently begin to strip off the mucous membrane on the concave side. Always try and keep under the perichon-