traumatic element oftener than is usually supposed.

I have observed, moreover, that women relate more precisely the history of a bad blow or fall upon the face, as if, the event being comparatively rare among them, they took more notice of it, while with men, a frequent answer to the interrogation is that they had an average amount of knocking about the face at school. In these cases I consider it sufficient to assume a fracture of the septum to account for all the appearances.

When the deflection is great, the most prominent symptom is twisting the nose to one side, usually to the side opposite from that effected. This deformity is sometimes very marked from bending to the side of the anterior edge of the cartilage, even though there is but little deflection farther back. More or less difficulty in nasal respiration is experienced according to the amount of obstruction. Interference with the free passage of air through the obstructed side causes the secretion to collect behind the convex portion and in the naso-pharynx, giving rise to post-nasal catarrh, and I have frequently observed that pressure upon the external wall, especially when associated with exostosis, induces atrophy of the turbinated body of that side, while the inferior turbinated body of the other side is usually found to be hypertrophied, and thus it often happens that patients find respiration easier through the cavity which, upon inspection, seems most obstructed. Of course, as further consequences of the obstruction, the voice acquires a nasal twang, and mouth breathing becomes necessary, with all its attendant evils. There is no disease with which deflection of the septum is liable to be confounded if a careful rhinoscopic examination is made. Most of the evil results of the obstruction can be remedied by a suitable operation, and the external deformity may be largely removed if the nasal bones have not been crushed so as to cause depression of the bridge of the nose.

Now as to the kind of cases requiring surgical interference. It is undoubtedly bad surgery to hold that every deviation from the middle line in the position of the septum demands treatment, and it is probably equally faulty to assume that surgical means should always be adopted, even when one nasal fossa is almost completely occluded. I have found, by experience, that many individuals tolerate partial, and sometimes nearly complete, nasal obstruction on one side without any inconvenience whatever. It is only when actual symptoms are produced in consequence of pressure on contiguous surfaces or interference with nasal respiration that operation is demanded. Whenever, for instance, there is a chronic laryngitis, with enough nasal stenosis to cause even a partial buccal respiration; whenever there is paroxysmal sneezing or hay fever, even although there be but little interference with nasal breathing; whenever there is post-nasal catarrh or eustachian occlusion; whenever there is dry rhinitis of the open fossa, we may operate with perfect propriety and with the best hope of success. The essential feature of deflections of the nasal septum which demands treatment is the stenosis, as from this arises all the sequelæ and complications which accompany them. Where the deformity is the result of a fracture, this may be accomplished, either by removing the projecting portion of the deviation, or by restoring the fragments to their normal plane.

The earliest effort (1750) in this direction is the method of treatment by which the patient is advised to push the septum firmly over to the opposite side several times daily: but unfortunately this simple plan is seldom capable of accomplishing any good. About a century later (1845) Dieffenbach advised that the projections be sliced off with a knife, but this proved rather unsatisfactory. In 1851 Cassaignac recommended a form of treatment especially applicable to deviations, with thickening of the cartilaginous septum. This consisted in dissecting up the mucous membrane and paring off the superfluous tissue. It is not easy of accomplishment, but in certain cases no better operation, perhaps, could be devised. Blandin, of Paris, first advocated punching out a portion of the septum and establishing free connection between the two nares, but this operation rarely affords the desired relief and cannot be recommended.

An easy operation, and one which has given me great satisfaction in several cases of simple cartilaginous deflection, is an incision through the projection following its long axis. Considerable hæmorrhage takes place as soon as the incision is made, but it soon ceases. The end of the finger being introduced into the nostril, the septum is forcibly pushed beyond the centre and maintained