vertically, crossing the centre of the previous incision. With the finger placed in the convex nostril the four fragments are pressed into the concave side, effectually breaking them at their base. Septal compression forceps are also used. After cleansing by sprays, hollow vulcanite tubes are inserted. The patient is put to bed for four days. Iced cloths and cold antiseptic sprays are used. The tube for the concave side should be removed in twenty-four hours; the other, taken out and cleaned after forty-eight hours, should be used for four weeks.

Roe believes that in the majority of cases, the anterior portion of the bony septum, which is nearly always involved in the deviation, should be broken without laceration of the tissues. For this he recommends fenestrated comminuting forceps. For the elastic cartilaginous septum he uses vertical and horizontal incisions, and places the septum in position by the use of flat-bladed forceps. His splints are metal covered with cotton.

Watson. Any operation to be successful must eliminate redundant tissue. There are two general angles of deflection—one or both being present in any case—the horizontal running low down from before backwards, the other perpendicular and situated well forward. Under cocaine anesthesia a bevelled incision is made with a tenotome from behind forward, just below the horizontal angle. If a perpendicular angle exists, another bevelled incision is made from above downward in front of it. When the angle is thick a wedge-shaped piece is removed. The whole upper portion of the septum is then pushed over into the opposite nostril and retained by a piece of gauze. The incision should not penetrate the opposite mucous membrane.

Gleason. Redundancy and resiliency are the factors that interfere with the success of operations. This author's operation utilizes septal redundancy as a splint, resisting the spring action from the neck of a U-shaped flap, and is best adapted for vertical deviations. On account of the narrowness of the flap and the consequently small tension, no support is needed in these cases after operation. Cocaine anesthesia is required. A thin saw is used below the deviation, cutting in horizontally and deeply; then it is turned upwards, cutting vertically. The flap so formed is next thrust with the finger through the septal perforation.

Douglas. Unless deflection shows symptoms, it should not be treated. When operation for deflection becomes necessary, all existing exostoses, enchondroses, and turbinal enlargements, on either side, should first be removed. Then under ether, the septum is perforated with a special spear-knife at the point of greatest convexity, and cut along the lines of deflection with a