On examination, I found narrow, slit-like nostrils with almost complete nasal occlusion on the left side, caused by semi-globular curvature of the cartilaginous septum, which in the central part was attached to the inferior turbinated. On the right side there was a deep, irregular, angular cavity, which was filled by a compensatory hypertrophy of the inferior turbinal, making that side almost as occluded as the other. There was a stale malodor from the secretions, complete anosmia, and some muco-purulent discharge. On using the rhinoscope, the posterior end of the septum was found to occupy a nearly normal position.

The first operation was to reduce the size of the right inferior turbinal. This being done, several days were allowed to elapse, then the septum was operated upon at St. Michael's Hospital under chloroform anæsthesia, solutions of cocain and adrenalin being also applied to the convex side to shrink the tissues and increase the space required for operation.

As I purposed doing all the cutting from the left or convex side, I first inserted a wide strip of rubber one-eighth inch thick in the right or open cavity as a protective. Then the two longitudinal cuts were made with a thick nasal saw, and the cross-cut to complete the H operation was done by mallet and chisel. All the cuts were bevelled and penetrated completely through the septal cartilage and both mucous membranes.

Next, with a blunt dissector, the central part of the convex side was separated from the outer wall, and the index finger passed in. The parts were all readily adjusted, the resistance to movement was slight, and once in place, a broad rubber splint three-eighths of an inch thick was inserted to retain the fragments in position until union could take place.

Bleeding was comparatively slight. The temperature rose the following day to 100 degrees, but the next day it fell again and continued normal throughout the treatment, which consisted chiefly in leaving the splint in position and removing the secretions by the use of aseptic absorbent cotton often enough to prevent accumulation.

There were a couple of slight scissor operations, subsequent to the major one, and while the splint was still in position. These were to remove redundant tissue below the site of operation. I did not remove the splint until it came loose, which was on the twenty-fifth day, then it slipped out easily without traction or bleeding. The passage was wide and almost normal in appearance. No ulceration was present, and cartilaginous union had taken place. The sense of smell had already returned.

There was, however, a bony maxillary ridge remaining. But I delayed removing it until January 2nd, six weeks after the operation