excess is cut away. Sometimes the central portion may be cut into the shape of a V and the lateral flaps adjusted to it.

In those cases, however, where the intermaxillary bone projects the case is rendered much more difficult. In some cases, such as where the bone grows from the tip of the nose it must be sacrificed, but usually it can be broken back and forced into the cleft. Sometimes it is necessary to pare the edges of the gums, and I have been obliged in some cases to keep the bone in position with wire or silk sutures, It has been objected that the incisor teeth which belong to this premaxillary portion grow in crooked, if so they can be afterwards straightened by a dentist, or the teeth may be pulled out. It is also objected that the retention of the intermaxillary keeps open the palatal cleft. Always try and save the intermaxillary bone and so prevent a gap in the solid jaw. In cases where I have had to remove this bone, however, there was remarkably little deformity. Sometimes there is a double hare-lip and only a single cleft in the bone. In such cases the bony cleft of one side projects and has to be forced back with the thumb. In severe cases of operation in very weak infants where much paring has to be done, and the bleeding is excessive, the final stages of the operation may have to be postponed until recovery from shock takes place. In very young children bleeding is a factor which must be considered. (The different methods of operating were then described, such as Malgaigne's, Nelatons, Mirault's, Giralde's, Rose's and many others. All were illustrated by lantern slides.)