is, for we frequently find it perforated even without operation, and when perforated it always occasions more or less distress to the patient. How will these membranous septa stand the aridity of the fevers, the typhoids, and the pneumonias of the future? And will there not be a much larger percentage of perforations among the people during future years if every rhinologist considers it his duty to do a submucous resection in every case of severe septal deformity?

It is in the light of these conditions that I venture to offer still another method of treatment for consideration, one in which the septal cartilage, when in extreme curvature, instead of being removed, can be relieved of all tension, and replaced with perfect healing in the central plane position. If this claim can be sustained it should be a better operation for the patient than the removal of the cartilage by submucous resection, no matter how excellently or scientifically this may be accomplished.

My former method, which I practised for years, was with a thick saw, to make two longitudinal cuts from before backwards through the septum. These were made obliquely from the convex side, and were about half an inch apart, passing through both mucous membranes, the lower cut being just above the superior maxillary ridge. This diminished the tension of the septum and enabled the operator with finger and spatula to force the central portion, as well as the adjacent margins, to their normal position. It did not, however, remove the central resiliency of the long curvature from before backwards. Still, my practice was to insert at once a pure rubber splint of sufficient thickness to retain the septum in its new position. The rubber being smooth, aseptic, compressible, and incapable of absorbing germs, was allowed to remain within the nasal cavity undisturbed as long as its presence was needed, cleansing being regularly attended to above and below the splint. In these cases good results were always obtained, but they were not perfect and the treatment was too prolonged.

Hence, to secure better and quicker results, I have added to the two cuts already mentioned still another one. That is, to remove the antero-posterior tension, I have made a cross-cut completely through both mucous membranes and cartilage and extending beyond the other two cuts, converting the two straight lines into the figure of H. Hence this method of treatment might be called the "H operation." (Figs. 1—6.)

The points I wish to draw attention to in reference to it are these. First, that as the curvature of the cartilage from above downwards gives it a greater width than it would occupy if it were upright in its normal