CORRESPONDENCE.

Editors of THE LARYNGOSCOPE:

In the report of the meeting of the Section of Laryngology and Rhinology, New York Academy of Medicine, published in the August LARYNGOSCOPE, Dr. Newcomb states that what is known as Gleason's operation should be known as Watson's operation, because "Dr. Watson had told him that he had illustrated the operation before one of the societies before Dr. Gleason had published his paper."

As far as I know Dr. Watson NEVER illustrated MY operation except that he recently told me that he had described it and that of Ash to some students at the Polyclinic and explained to them how both these operations accomplished the same object as his own.

Because both operations probably are derived from an older operation, at one time extensively practiced in Philadelphia and described in most of the books on Diseases of the Nose including my own, there is a superficial resemblance that has induced Dr. Watson to imagine that the operations are identical. This superficial resemblance disappears as soon as the mechanics underlying successful operations for deflection of the nasal septum are considered.

Watson makes a straight, beveled incision "just at the crest of the deviation" in horizontal deviations, "cuts out" any vertical deviation that may be present, and pushes the upper flap over the lower so that the beveled edges hook over each other. My operation consists of a U-shaped incision not IN but AROUND the deviation. The tongue-shaped flap thus formed is pushed through the button-hole in the septum that it covers.

When a vertical deviation is "cut out" Watson's incision becomes L or J shaped and consequently resembles the Ash operation: so that it is presumable that only when the straight beveled incision alone is employed does he find a fancied resemblance to my operation. This resemblance is only apparent, because the position of Watson's incision being at the *crest* of the deviation, it is necessary to make a bevel as he states in his paper, in order that there may be any overlapping. When the incision is made UNDERNEATH instead of IN the

deviation, this difficulty disappears and there is abundant overlapping without any necessity for beveling, because all of the redundancy is then in the upper flap and is utilized to the greatest advantage as a means of support tending to prevent a return to the original position when the upper flap has been hooked over the lower. Hence my incision because of its *position* and *shape* is vastly superior to that of Watson inasmuch as it renders it possible to utilize all septal redundancy as a means of support not only in a vertical direction but horizontally as well.

Watson's operation is also extremely faulty inasmuch as it makes no provision for counteracting the resiliency of the septum except by the introduction of a pin which Watson states should remain in position for three or four weeks.

In my operation it will be observed, resiliency is only active at the neck of a comparatively long narrow flap, and hence has to overcome considerable leverage before the base or lower edge of the flap can be forced back through the hole in the septum. If the resiliency is greater, as it generally is, than just sufficient to hold the overlapping edges in contact, it can be reduced by bending the neck of the flap sharply toward the formerly unobstructed nostril. In my later operations, I have been careful to do this thoroughly and also to extend the U-shaped incision as high up on the septum as possible, sometimes using a knife in addition to the saw for the purpose of lengthening separately each vertical crus of the U. It is because of the great PRACTICAL difference in our operations that Dr. Watson finds it necessary for his patients to wear a pin for three or four weeks; while I presume that all but about 20 per cent of those operated upon according to my method are able to secure success without any tedious after treatment by pin or tube. I have written in this disparaging manner of Watson's operation in order to demonstrate that it is not *identical* with mine and would have more to say on this subject if I did not feel that my point has been sufficiently proven. I trust that I shall hear no more assertions such as are attributed to Dr. Watson by Dr. Newcomb to whom I am indebted for calling public attention to the matter.

Watson's operation is described in the N. Y. Med. Journal, Oct. 3, 1896, mine in the LARYNGOSCOPE, Nov. 1896.

E. B. GLEASON.