ORIGINAL CONTRIBUTIONS.

THE TREATMENT OF THE CAPSULE IN EXTRACTION AND AFTERWARDS.

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OF *laceration* of the capsule as ordinarily done one need not speak; it is easily effected and generally suffices. In a rather large percentage of extractions, operations for secondary or capsular cataract are required. On this point Professor Hermann Knapp, of New York, a veteran operator of immense experience, says,—"Considering secondary discission an almost necessary supplement of an extraction whose aim is the permanent restoration of good sight, I cling to the peripheric opening of the capsule and the *simple* extraction . . . . . in other words, *I perform extraction with a view towards the necessity of a subsequent discission.*"

There is, however, another method of treating the capsule followed by a small minority of operators, and which the writer has practised steadily for about twenty years, namely, *removal* of a part, less or more, of the anterior capsule by so-called *capsule-forceps,* the teeth of which are on the lower surface of the short terminal limbs. Their special value lies in one's ability to take out of the pupillary area, once for all, not only the ordinary resilient membrane with its endothelial lining, but thickened capsule which it would be difficult to lacerate well; and which is wont to undergo further sclerotic changes that sadly mar the optical effect of the extraction. Hence, it is not surprising that operations for so-called secondary cataract are much less often required after *removal* than after *laceration*, and even in these days of aseptic surgery, this must be counted a distinct gain. Treacher Collins escaped the need of a second operation in at least 90 per cent. of all cases.

For discission in secondary cataract H. Knapp prefers his straight knife-needle and not needles cutting on both sides, or curved ones, and he rightly insists that "the knife-needles should be of the utmost sharpness both in point and edge, for they are intended to *cut* and not *tear.*" Non-attention to this point is, in the writer's opinion, a not infrequent cause of disappointment. Moreover, if the thinner and more translucent spots be chosen and as centrally as possible, one can generally rely on the knife-needle to give a satisfactory capsular pupil.

When thickened membranes or bands obstruct the pupil other means require to be adopted. If there are posterior synechiae from iritis following operation or trauma, a small iridectomy or iritomy may be necessary or a simple snipping by Luer's scissors of the sphincter pupillæ in