Soft cataract requires for its removal rupture of the capsule, or rupture of the capsule and division of the lens; the process of removal then proceeds from natural causes. Hard cataract may be displaced below the axis of vision or extracted from the eye. Displaced, it is liable to cause inflammation in the choroid retina or iris—to act something like a foreign body, and by its presence finally induce changes in these delicate structures, which are fatal to the vision. Generally, however, the lens is mostly dissolved or absorbed, even if quite hard, and thus good results are often obtained by the operation by *reclination* or *couching*, as it is called. This plan of operation has been extensively practiced, and has afforded on the whole very favorable results, but in hard cataract it is not the best operation which it is possible to make, and at the present time the best operators never adopt it. The less experienced choose it, since it is vastly easier of execution, and exposes the surgeon and perhaps the patient to fewer risks. Only the easy and expert operator should attempt operation by extraction; the plan by reclination or couching is undoubtedly safest and best with inexperienced surgeons, while extraction offers advantages when it is skillfully made.

Please observe the preparation and mode of making operation for cataract. Our first patient, Miss West, has had the lens very successfully removed from the right eye, by the same method, in May last. She has now returned for a similar operation upon the other eye. No general preparation of the patient is necessary; she was directed not to take breakfast this morning, hoping thus to avoid vomiting from the chloroform, and the iris has been dilated with atropine. When *completely* under the influence of chloroform, and not until anæsthesia is complete, the cataract knife is made to enter the anterior chamber of the eye; to pass rapidly and steadily through it, and thus to make section of the upper third of the cornea near its union with the sclerotic. The manner of this section is one of the important steps in the operation, and attention is directed to it. The knife is to be passed through the chamber so steadily and quickly that the aqueous humor does not escape until the section is *nearly* complete, otherwise the iris may be protruded before the knife, and embarrass the procedure. When the opening in the cornea has been made, and the water in the chamber has escaped, the next step necessary is to rupture the capsule of the lens, which is done with a cataract needle or other sharp instrument introduced through the corneal wound and passed through the pupil to the lens. When this is completed, the opaque body often presents itself at the corneal opening, and with very little assistance makes its escape; in this instance it is so, and I pass the lens to you for examination. The upper eyelid is now raised, and the cornea adjusted with care, so that there may be early union. The lid is drawn carefully over the wound, a graduated compress placed over the eye, and roller bandage applied to afford pressure and support to the globe. The removal of the lens in this instance has been entirely satisfactory, and no accident of any kind has embarrassed the procedure. So far as can be judged, the highest expectation of its success may be indulged; but there are yet sources of danger and failure which no operative skill can remove; these will be fully explained to you hereafter.

You have this morning had opportunity to observe the operation for extraction of cataract in three eyes, but I regret it could not have been afforded you after having fully studied the subject. There are several other modes by which the diseased lens is removed from the field of vision, and it would have been instructive to have varied our process to these various ways which surgeons have adopted for this purpose. My sense of duty to my patients has alone prevented it, and I have chosen the one which my experience and judgment dictate as the best. It has been proposed of late years to make iridectomy —section of the iris—previous to, or in connection with, this mode of removing the lens, the idea being that the lens would escape easier after a part of the iris had been removed. It appears to me wholly unnecessary in most cases, as the lens will pass readily through the pupil when it is dilated without any such section. A part of the iris can be removed with great safety, but it is a deformity to the eye, and, as a rule, is wholly unnecessary. There may be cases where such preliminary or accompanying operation is desirable, but I am convinced that it ought not to be made for the purpose of facilitating the escape of the lens, when the eye retains its normal condition in other respects. This field is too extensive for even a notice of the important questions involved, and I must defer further comments for future opportunity.—*Buf. Med. Jour.*

NEW YORK PATHOLOGICAL SOCIETY.

Stated Meeting, Nov. 25, 1868. Dr. B. H. Sands, President, in the chair. The Committee on Microscopy reported the specimen presented by Dr. A. Clark at the previous meeting, as one of encephaloid degeneration of the kidney.

ABSCESS OF BRAIN FOLLOWING OTITIS—PARALYSIS IN LAST HOURS OF LIFE.

Dr. A. Clark presented a brain which had been the seat of an extensive abscess, the results of otitis. The abscess was situated in the inferior portion of the cerebrum, in about the middle line of its measurement from before backward, and almost its entire thickness from without inward. The following history of the case was drawn up by Dr. Tracy of Bellevue Hospital:

John Barton, 26, N. Y. Sailor. Single. Admitted, Nov. 21st. Patient had always been a healthy man, with the exception of a suppurative otitis of the left ear, the duration of which could not be ascertained. Two weeks before admission he was seized with vertigo, and fell, losing consciousness for an instant. He had ever since suffered from severe pain in the head, increased on the slightest motion, and most intense when he lay in a recumbent position. He also complained of pain in the back of the neck and between the shoulders. The scalp was tender to touch, and the spine sensitive to pressure, down as far as the third dorsal vertebræ. The slightest blow upon the spine greatly intensified the cephalalgia. Some intolerance of light. Complains of numbness across the hips, and weakness of the lower extremities, though sensation appears perfect. Pupils about normal in size, contracting equally and readily to light. No lesion of hearing. Tongue heavily coated with a white, pasty fur. Breath foul. Appetite poor.