necessary—also to control the patient and to help with the iridectomy. The patient's lids and neighboring parts should be first washed with a disinfecting lotion. The operator's hands and his assistant's, the instruments and the water used, should also be rendered aseptic. It is advisable not to use sponges. A piece of absorbent cotton wool, moistened with boracic acid lotion, which may be discarded when soiled, answers every purpose.

The patient being fully under chloroform, we insert the speculum between the lids and secure it, Seizing a portion of the conjunctiva with our forceps, just below the vertical meridian of the cornea, we draw the globe downwards, and, entering the knife exactly at the sclero-corneal junction, at a point corresponding roughly to the upper margin of the pupil, we pass it slowly and steadily across the anterior chamber on a plane with the iris. Transfixing the opposite point, we carry the blade, with a sawing motion upwards and slightly forwards, making a flap whose summit should reach within a line or so of the corneal border. The assistant now takes the forceps whilst we seize a small portion of the iris and excise it. Resuming the fixation forceps, we pass in the pricker and divide the capsule, making a cross cut, which sometimes brings away a portion of it. Whilst we are doing so, and during the subsequent steps of the operation, the assistant raises and holds suspended over the globe the stop speculum. By pressing on the upper lip of the incision with the spatula and passing a similar instrument from below upwards along the cornea, we start the lens from its bed, and bring it into the lips of the wound, through which it is gently squeezed, perhaps losing some of its cortical matter in transit. The speculum is now withdrawn and the eye closed for a few minutes to allow the chamber to refill. By manipulating the upper lid over the globe surface, we collect the remaining cortical matter in the centre of the pupil, and, reopening the wound, by drawing the eye downwards, cause its escape in the gush of aqueous humor. It now only remains to free our incision from shreds of iris or capsule, with the spatula, to cleanse the globe and sulcus from clots, etc., and to apply the bandage.

I first place upon each eye a piece of lint soaked in boracic acid lotion, then fill up each orbit with layers of cotton wool and tie over all a Moorfield's bandage. This bandage is removed and the dressings changed twelve hours after the operation, and is changed again twice a day for the first week. If all goes well it may then be discarded for a shade and protective glasses. I look at the operated eye (by oblique light, with a convex lens and a candle) on the second or third day. The patient is allowed to sit up after the first twenty-four hours; and to go out within the first ten days, should the weather permit it. The chief points in this operations as contrasted with the old flap extraction are: 1st, the antiseptic precautions; 2nd, the use of the narrow knife, which gives us great freedom in shaping our flap and allows us to correct a faulty incision even after penetrating the cornea; 3rd, by limiting our wound to the cornea, we get one which heals readily and we avoid a conjunctival flap, which by bleeding, etc., would interfere with the next steps of the operation; 4th, by doing an iridectomy, before opening the capsule, we free the iris from pressure during the escape of the lens, besides getting the undoubted prophylactic benefit of the operation—should we wish to be extra cautious the iridectomy may be done some weeks beforehand. 5th. The operation may be done without an anæsthetic—De Wecker never gives one, having once lost a patient under chloroform. The use of the spatula is also to be noted in cleansing the wound. Here eserine, as a pupil-contractor, may be also of service. Lastly I would draw your attention to our early examination of the wounded eye by non-irritating oblique light, and to the lessened confinement both to bed and to the house of our patient.

I enjoin a few cases illustrative of this method of operating.

Case I.—Mrs. McC., aged 70, residence, Chester. Double senile cataract, complete in both eyes; a dyspeptic subject. Operated on right eye, assisted by Dr. Farrell. Made usual incision upwards. When about to extract the lens the patient showed signs of chloroform collapse. The operation had to be suspended till she was restored by artificial respiration and subcutaneous injections of brandy and ether. On recovery, the lens (hard, dark and small) came away easily. The eye was cleaned and the bandage adjusted. All went well till the sixth day, the patient then sitting up and using protective glasses. She incautiously removed them and a prolonged exposure to light brought on a sharp attack of iritis, with opacities