case of C——e, probably owing to the removal of a tough, opaque piece of capsule with forceps after laceration with the cystitome,—an expedient sometimes required: on applying the usual pressure to evacuate the lens, a bead of vitreous presented and the lens receded. A small "spoon" was at once passed through the cut directly backwards and then downwards behind the lens, which was brought quickly out with but moderate loss of the vitreous; straps and bandages being then applied. The eye was opened on the third day, when the wound was found closed, and on the fourth day the patient was allowed to get up. There was a slight reaction, but the inflammation subsided under atropine drops and hot fomentations. In a fortnight the pupil was clear, and there was no pain or irritation. The loss of vitreous is made up by aqueous humour, and one-fourth or more sometimes escapes, a good result finally ensuing. When, however, much vitreous is lost, detachment of the retina, or hæmorrhage from the intraocular vessels from want of support may be feared. In the case of Mrs. P——, the orbicularis was forcibly contracted just as the lens was emerging, and a good deal of vitreous was lost. The recovery was tedious and the sight imperfect.

The chief bad results following extraction are suppurative keratitis, iritis, and so-called secondary cataract. Suppuration of the cornea is generally a result as well as sign of impaired vitality, and is the more dangerous when it develops without acute symptoms. W. C——, admitted with double cataract, subject hereditarily to rheumatic arthritis, a sufferer from chronic alcoholism, had fallen from a highly respectable position in society to that of tally-keeper in a billiard-saloon; was kept on good diet and constitutional treatment for six weeks or more after admission. Then extraction by Liebreich's method was done, that is, the incision was made across the cornea, about midway between its lower edge and the pupil, and the lens was evacuated without an iridectomy, the pupil being quite dilatable. The lens came out entire, and there was no prolapse of iris. There was no inflammatory reaction, but on the third day the anterior chamber was turbid, and the lips of the wound were grey, and on the fourth day the cornea also had become infiltrated. Atropine and hot fomentations were applied, but the cornea shortly necrosed and the eye atrophied. This case teaches the lesson that both eyes should not be operated on at one sitting. Fearing that the patient's system was radically vitiated, another method was tried with the other eye, which, at any rate, would not seriously jeopardize it. Needling, *(keratonyxis)* was practised, and repeated at intervals during many months. The pupil being fully dilated, the lids were separated by a speculum and the eye steadied with forceps, the needle being then passed through the cornea near its margin and made to pierce the lens capsule and enter the lens as gently as possible so as not to disturb it in its bed. The eye was afterwards kept closed for several days and the pupil dilated. This patient's form became a too familiar one in the wards. The lens proved to be very hard and practically insoluble in the aqueous humour. Eighteen needlings were done without having drilled a hole through it or reduced it materially. At last, hoping that the regimen of the hospital had restored a fair degree of vigour, extraction was decided upon and done. The eye healed kindly, and five weeks afterwards the vision was $\frac{5}{10}$ with a + 3 lens. Finding, however, by oblique illumination that the posterior lens capsule was not quite transparent, a clear pupil was made in it opposite the normal one by means of a cataract needle, atropine being used for a few days. As some of you saw, vision finally reached $\frac{20}{xx}$ Snellen, with a + 3 lens, and with + 2 the patient could read the finest print. C—— is now a sober, reputable member of society, and engaged as a grain-buyer. It not infrequently happens that the posterior capsule becomes translucent, appearing under oblique illumination as a delicate gauze; and though it may be clear enough to enable one to see the optic disk and retinal vessels, its division with a needle is advisable as soon as the eye has healed thoroughly, namely, in from two to eight weeks.

The term, secondary cataract, is more properly applied to an opaque pupillary membrane resulting from a deposit of lymph on the posterior capsule from iritis or due to sclerosis of the capsule following retention of pieces of