

The vision of the naked eye after extraction is quite defective, its refractive power being materially reduced and a very high degree of hyperopia produced by the absence of the lens. The aphakial eye requires, therefore, a powerful convex lens in order to focus rays from more or less distant objects upon the retina and secure correct vision.* Lenses of from $2\frac{3}{4}$ to $3\frac{3}{4}$ inches "focus" are generally necessary for ordinary wear; and as the accommodation is destroyed when the lens is removed, the clear perception of near objects as, print, &c., is only had by using still stronger glasses, namely, + $1\frac{1}{2}$ to $2\frac{1}{2}$. In some instances a cylindrical lens conjoined with the ordinary spherical improves the sight much more than the latter alone; and in the very exceptional cases where the eye was originally highly myopic a glass may not be required, or only one of a low power.

Advanced age is no bar to the operation, provided there be vitality enough to insure the healing of a wound so large as to give exit to the lens. I have had a patient aged eighty-five, and another eighty-three, both of whom did well and recovered good sight, being able, with proper spectacles, to go about as of yore, and also to read small print. Those who are inordinately fat or are prone to marasmus, and the victims of dyspepsia or alcoholism are not good subjects for extraction; but fair results are sometimes got by the modified linear operation in cases which would issue badly under the older flap method, for the latter, owing to the length of the cut and the less perfect coaptation of its lips, demands a much higher reparative power. Since sensibility becomes blunted in senility, extraction is generally well borne without anaesthesia; in fact, we have never employed it, and have seldom regretted dispensing with it.

Circumstances sometimes necessitate a departure from the ideal operation. You have seen that occasionally if the lens did not escape readily, the incision was enlarged a little at one end with fine scissors, the point of one blade being passed into the wound and between the cornea and iris. In some instances, again, where the patient was restive the knife was removed before the section was quite com-

pleted, a small bridge being left, which was divided after the iridectomy and laceration of the capsule. In the case of M. F—, whose palpebral aperture was abnormally small, the speculum and forceps were dispensed with. The upper lid was raised and pressed back against the edge of the orbit with the left index finger, the bulb of the middle one being placed against the inner side of the ball, to steady it. The section was then made *downwards*. No mishap occurred, and the patient recovered very good sight. The section at the upper edge of the cornea has the merit of hiding, more or less, the coloboma caused by the iridectomy. In the case of Mrs. R—, no iridectomy was required as that operation had been done several years previously for glaucoma, following ulceration of the cornea during gonorrhoeal ophthalmia. The iridectomy had saved the eye: and the final result was excellent, the patient going out with vision $\frac{1}{10}$ with a + $3\frac{1}{2}$ lens, and with a + $2\frac{1}{4}$ able to read ordinary print, though the haziness of the cornea from the old ulceration interfered somewhat with the sight. In K—'s eye the iris was largely adherent to an opaque cicatrix of the cornea (leucoma adhaerens), and partially also to the lens capsule. The knife was made to pierce the iris and pass through the anterior chamber behind it, and then cut its way out. The lens was with difficulty removed, but the patient finally recovered fair sight. In the case of J— the cortex was fluid and freely escaped when the capsule was opened, leaving a nucleus so small that it would not readily present, though it came away at last without the use of a spoon. Occasionally some blood flows into the anterior chamber after the iridectomy, and requires removal by gently stroking the cornea towards the wound, the lips being made to gape slightly. It should be observed that the less the lips of the wound are irritated, and the anterior chamber disturbed by instruments, the less likely is inflammation to develop.

The most common serious mishap that occurs during extraction is escape of the vitreous. If the lens be not well engaged in the wound before the hyaloid ruptures, it will give place to the escaping humour and sink down behind the iris. This occurred in the

* With proper lenses, the final visual result is satisfactory in about 85 per cent. of the cases of extraction.