then brings the point of the needle within a very short distance of the eye; and when the cornea is brought into an advantageous position, he suddenly strikes the needle into it, near its circumference. As I do not apprehend any opacity from the wound, I am not very particular with respect to the precise point where the needle pierces; I generally, however, enter it sufficiently near the margin to obviate defect from this cause. The point of the needle once fastened on the cornea, the surgeon has complete command of the eye; no action of the muscles can disengage it, and there is no danger of the needle slipping into the anterior chamber; an elevator or ophthal mostal is therefore altogether useless. The operator now pushes the needle through the cornea, which frequently yields like wet leather, and the eye often turns so much towards the inner canthus that the pupil is hid, and he must rely upon his knowledge of the course the needle necessarily takes, in order to conduct it to the lens. This is the principal difficulty to be surmounted. If the surgeon does not now steadily push the needle forward, whatever resistence he may feel, he will find, when the eye returns to its proper position, the point of the needle is still merely entangled in the cornea. This is also the period of danger to the iris: if the operator does not keep the flat of the needle to that membrane, with the point down and the convexity up, he will be very liable to injure it. Should it happen that the point of the needle has passed through the iris, it may be easily extracted by gently drawing back the instrument, without removing it from the eye. After the needle has been fairly entered, and that the operator sees its point at the opposite side of the pupil, he brings the cornea forward, merely by pulling it upon the needle, to which it is completely secured, in consequence of the blade being wedged into its texture. He now turns the point directly back, and gently tears open the capsule, pricking and scratching the surface of lens with a rotary or drilling motion of the instrument, not with a lever or cutting movement, which is necessary when Saunder's needle is used. If the lens be soft and friable, the fragments will fall like snow into the anterior chamber, and the surgeon may deal very freely with it, pushing the needle deep into its structure, and twirling the point round, so as to mash it into a pulp. If, however, it proves hard, and that he attempts to deal thus with it, he fixes his needle in its tough and glutinous structure, turns it out of the capsule, drags it against the iris, makes it necessary either to extract it or force it back into the viterous humour. As I have already observed, if the cataract be hard, the capsule should be opened, and the centre of the lens cautiously scratched with the point of the needle so as to expose its texture to the contact of the aqueous humour, by which it is softened and fitted for breaking up on a future occasion. In withdrawing the needle, the surgeon has to encounter the same description of difficulty which attends its