account of the thickening of the posterior capsule or the hyaloid membrane, says: "In every such instance, I have found it absolutely essential to the successful result of the case to lacerate the posterior capsule and hyaloid membrane, and permit the escape of a portion of the vitreous humor." Coming nearer to our own day, I must say a few words about the distinguished surgeon who left his impress upon all who witnessed his wonderful skill as an operator. I have reference to the late Dr. Richard J. Levis, of this city. I have had the opportunity of examining quite a number of patients from whom cataracts were removed by this eminent surgeon. In nearly every instance the posterior capsule was evidently ruptured at the time of the primal operation. Whether this was a constant practice of Dr. Levis, I am unable to say, but I am sure he realized the importance of removing the posterior capsule at the time of the original operation. Pagenstecher, of Wiesbaden, is also an advocate of removing the lens and its capsule at one sitting. Hasner, another German ophthalmologist, is an advocate of this radical operation. It has recently come to me indirectly that Dr. Knapp, of New York, is also lacerating the posterior capsule at the first operation.

Is the operation always successful? Laceration of the capsule alone does not prevent the hyaloid membrane from becoming slightly translucent. When this takes place, we may follow with a needle operation, and not provoke cyclitis by trying to tear a tough, inelastic tissue.

I have been in the habit of performing this operation in alternating cases for ten years. In those patients upon whom the operation was performed, I had to repeat a needle or capsulotomy (scissors) in about 15 per cent. of the cases. Where it was not performed, in about 75 per cent. In the 15 per cent. of the cases where it did not succeed, I can only attribute it to a very thick posterior capsule, the vitreous receding after closing of the eyeball, and thereby not keeping the capsule separated, but practically closing again. My experience has led me to believe that there is less danger of inflammation of the eyeball in immediate capsulotomy than in a subsequent operation.

The elder operators recognized the gravity of puncturing an eyeball with a needle, and hailed with delight the improved method which completely revolutionized statistics. My own experience is fast leading me to adopt the cutting through the cornea with keratome and the incision of the capsule with a De Wecker's scissors, disregarding the needle altogether. With the preliminary treatment, and with the aseptic methods now employed, success is almost always assured, whilst, with the treacherous needle, almost every surgeon has had reason to regret his *modus operandi* in more ways than one.

A CASE OF EMPYEMA OF GALL BLADDER FROM GALL STONES—OPERATION, RECOVERY.*

BY H. MEEK, M.D.

On Friday, September, 1893, I was called by Dr. Smith, of Fingal, to operate on a case of abdominal abscess in a patient with the following history:

Mrs. M——, born in Canada; had been living in Chicago since 1890; came home on a visit to her mother, in Dutton, in July, 1893; for past three weeks living in Fingal; aged twenty-six years; married five years; two children; last child eighteen months ago; last menstration two weeks ago, lasted one week and was normal.

Family history good, with exception of one sister who has a large uterine myoma. Previous to present illness has always enjoyed good health, with the exception of an occasional bilious attack, and three years ago, in Chicago, an attack of abdominal pain, which the physician in attendance said was biliary colic.

History of present illness: While visiting in Dutton in July, or early part of August, was ill for a few days from symptoms which the attending physician thought was due to malaria. She recovered from this illness and came to Fingal in August. While visiting her brother there, she was taken very ill, and Dr. Smith, of Fingal, was called to attend her on August 22nd. He found her suffering from a severe chill and severe pain over the right side below the ribs and radiating towards the umbilicus. Temperature, 103.5°; pulse, 120. Tympanitis and vomiting. Dr. Smith re-

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