The kind of capsular opacity indicative of an "over-ripe" cataract, is one corresponding in size and situation to the pupil, of a glistening white colour, its edges marked by striæ or dots. It often has a lustrous satiny look, because probably of the greater presence of cholesterine crystals. There are sometimes smaller opaque spots at a distance from the central spot. I may add in aid of the diagnosis, that when in a dark room artificial light is by a convex lens cast obliquely upon the cataract, the yellow nucleus may be sometimes seen through the fluid to have fallen from the centre to the bottom of the capsule. If the pupil be dilated it may all be seen, but if not dilated, only its upper rim can be discerned. I need remark nothing upon the importance of diagnosticating an "over-ripe" cataract before the operation is performed.

The second case in which capsular opacity gives valuable information, is in the so-called "inflammatory cataract," or one resulting from chronic iridochoroiditis. The nutrition of the lens and therefore its transparency, are impaired by the choroidal disease, and the transformation begins at the surface. Hence capsular opacities appear early. They consist: 1st. In metamorphoses of the intra-capsular epithelium—the cells generated in larger quantities and of irregular shapes; 2nd. Membranes are formed which though transparent singly, yet by their arrangement cause opaque spots and thickening of the capsule; 3rd. Cretaceous deposit occurs in the transformed tissue. Calcification often beginning in the capsule pervades finally the whole lens—and that the capsule may disappear by atrophy. Opacities do not take place so frequently on the posterior capsule as upon the anterior. They consist of deposits of softened lens matter, and also result by extension of the morbid generation of intra-capsular epithelium to the posterior capsule.

The practical clinical distinction between capsular opacities of chronic iridochoroiditis and of partially liquefied cataract, is that the former are scattered all over the front surface of the cataract, while the latter is mainly confined to one large central spot. Both result directly from a similar cause, namely, softening of the surface of the lens, but the causation of the softening is different.

A third variety of capsular cataract without participation of the lens, is noticed after central perforation of the cornea. This happens oftenest in opthalmia neonatorum: by ulceration the cornea is perforated, aqueous humour escapes, the lens comes forward, and the capsule for some time lies against the aperture, exposed to the irritating conjunctival secretions. After a time the opening is closed, the anterior chamber re-established, and the cornea may recover transparency. Upon the capsule will remain a central white dot, sharply defined, and penetrating the lens to a certain depth. The capsule has not been ruptured, but contact with the opening in the cornea has caused transformations of the intra-capsular cells and adjacent lens substance.

Lastly, the capsule often remains as an obstruction to vision, after extraction of cataract. It is often dotted with dense white opacities, or totally opaque. These white spots consist partly of softened lens matter entangled in the folds of the membrane, and partly of new formations by prolification of the intra-capsular epithelium. Sometimes this extraordinary development of cells extends even to the posterior capsule.—*American Medical Times.*

SPERMATORRHŒA SUCCESSFULLY TREATED WITH ACONITE.

In the *Cincinnati Medical and Surgical News* for August, Dr. J. J. Kimberlin has an article upon spermatorrhœa, and gives a case illustrating his treatment. He believes spermatorrhœa to be the result of "an excessive sensibility of all the urino-seminal vessels, especially of the prostatic urethra," and directs his treatment accordingly. The following is his prescription:—

"Two parts of the solid extract of aconite, and one of hemlock, were broken