Senile cataract was formerly often treated by *couching* or *reclination*, that is, the lens was dislocated from its fossa backwards and downwards into the vitreous by means of a flat slightly curved needle passed through the sclera, behind the iris and against the face of the lens. This procedure is now virtually obsolete, and was discarded, although easy of execution, because the hard lens, in its new position, acted as a foreign body in a large percentage of cases, and excited irritation and inflammation which issued in complete blindness. In the modern operations the cataractous lens is removed from the eye, or "extracted," as you have already seen. Until recently "flap" extraction (fig. A.) was largely performed, the distinctive features of which are the use of a broad triangular knife; an incision dividing nearly one-half of the corneal margin either above or below from the sclera; and the evacuation or extrusion of the lens through the pupil without an iridectomy.

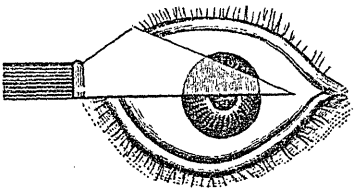

FIGURE A.

Now-a-days, some modification of the so-called "modified linear" operation, (fig B.) devised by the late celebrated Von Græfe, is generally done, its characteristics being, the use of a narrow or linear knife; iridectomy; and a somewhat curvilinear incision across the summit of the cornea.

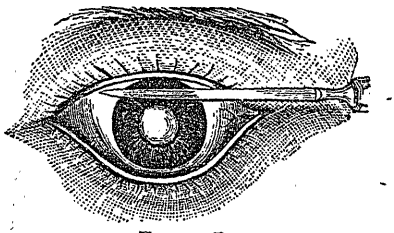

FIGURE B.

You have seen various cases in illustration of the latter method. The patient lying on his back in bed, with the lids separated by a stop-spring speculum, and the eye steadied by fixation forceps grasping the conjunctiva a little below the cornea, the knife, with its point directed towards the centre of the eye, is passed through the sclero-corneal junction a little below the top of the cornea into the anterior chamber at its upper and outer part; its handle being then depressed it is pushed quickly in front of the iris and made to emerge at a point horizontally opposite that of entrance (counter-puncture). The forceps being then laid aside, and the cutting edge of the knife directed upwards and forwards, the section is carefully finished so that its centre lies just within the corneal tissue, the patient being at the same time encouraged to avoid straining. The delicate iris forceps are then passed through the cut, a small fold of iris seized near the pupillary edge, withdrawn and snipped off. The speculum is then removed, the patient being warned not to squeeze the eye. The upper lid being then raised, the patient looking downwards, the cystitome or pricker is passed into the anterior chamber and its point drawn lightly over the capsule along the margins of the pupil. Careful pressure is then made against the lower part of the cornea with a small india-rubber spoon or curette; and the lower edge of the lens being thus pushed back the upper tilts forward and engages in the wound, from which the lens emerges, the cornea being gently stroked upwards to favour the escape of any cortical matter. The pupil being clear enough to enable the patient to count fingers at two feet, and the lips of the cut being freed from any debris, straps of rubber and silk plaster are applied to the lids of both eyes, and then a light bandage, if it is thought desirable; or, preferably, the eyes are covered by a fold or two of dark silk, which is fastened to the forehead. Great care has to be taken during the operation to avoid compression of the globe by the operator or by contraction of the orbicularis, so as to prevent rupture of the hyaloid capsule and escape of the vitreous humour. Generally the patient is kept quietly in bed for forty-eight hours, using a feeding-cup and bed-pan p.r.n. The day after the operation the straps are gently washed off and a drop or two of sol. atropiæ sulph. grs. iv. ad ʒj. applied; and this is done daily for about a fortnight, straps or a bandage being used for a week, and afterwards a shade for a while.