

ing the lips of the incision together. Another instance of impaired union is seen in Fig 3. The globe, it is true, is not weakened to the same extent as in the last case where union has practically had to be maintained by a conjunctival flap and some granulation tissue. The outer half of the globe is held together by definite fibrous tissue, as well as by a good conjunctival flap, although a distinct element of weakness must result from the non-union of the lower half of the wound due to an included anterior lens capsule. An infiltration of the new connective tissue elements about the wound, the presence of leucocytes in large quantities about the innermost part of the incision in the neighborhood of Descemet's membrane, as well as on the anterior surface of the lens capsule within the chamber, would point to an inflammatory reaction for which the included capsule should be held responsible.

I am ready to admit that there are certain cases where other procedures might be followed more safely; cases of a very friable zonular ligament, as well as those where a cataract has complicated myopia, might perhaps be better treated with the cystotome, the fibres and capsule being subsequently removed by the very careful use of an irrigator. Yet all must agree that the employment of an irrigator is attended with its own dangers as far as loss of vitreous is concerned.

The objection is held by some that by employing forceps additional pressure has to be exerted upon the lens, and that possible rupture of the suspensory ligament and dislocation of the cataractous lens into the vitreous may result. This, however, need not of necessity follow. In order to obtain a grip of the capsule very little extra pressure need be exerted upon the lens than when the point of the cystotome punctures the capsule; quite naturally if roughness is resorted to, or if the eye is not able to be kept under control, accidents will happen with one instrument as with the other.

The pattern most commonly seen resembles in many respects an ordinary iris forceps, with the tips curved slightly upwards, the main point of difference being that the small, sharp teeth are directed downwards, as well as inwards, instead of inwards only as is the case of the iris forceps. A pair of forceps which I have found most useful and which I have employed a number of times at the Royal Victoria Hospital with satisfactory results was made for me by Messrs. Wulffing-Luer, of Paris. The handle is approximately 8 cm. long, tapering to a slender tip, where an extension arm of about 8mm. is welded at an angle of 120° to each blade. These tips are curved concavely below and conform with the underlying convex surface of the lens. The tiny, sharp teeth are directed downwards and inwards and interlock at the distal ends of the tips.