

from the upper lid, is most in vogue both in Paris and London. Surgeons no longer seek "the maximum of linearity" insisted on by Von Graefé, and have transferred the incision from the sclerotic to confine it altogether to the corneal region. Though cosmetically not so perfect as the simple extraction (without iridectomy), if we look only to practical results, it is found to give the greater number of cures. What we are taught to seek in every modern extraction, are cleanliness of the wound, perfect adaptation of the flap, a corneal incision large enough to allow easy escape of the lens, and thorough evacuation of cortical matter. This is facilitated by the iridectomy, which lessens the danger of glaucomatous complications, and should always be insisted on in cases where the eye to be operated upon is hard to the touch. The use of antiseptic precautions in cataract extraction I have usually seen confined to a preliminary disinfection of hands, instruments and the ocular surface itself. Boracic and salicylic acids in combination, form the solution which De Wecker employs. He discards altogether the use of sponges in eye surgery, using absorbent, antiseptic cotton instead, which may be thrown aside as it is used. I have seen only one oculist operate under the spray; it is not used at Moorfields.

Amongst interesting eye operations, I have seen Mr. MacNamara extract the whole lens in its capsule at the Westminster Ophthalmic Hospital; and, whilst serving in the Indian Medical Department, he had, he tells me, many opportunities of performing the operation, with success, upon natives. The dangers of the operation, from the unavoidable loss of vitreous, are such that it has not become a favorite with specialists. To extract by this method, a broad keratome and a scoop are all that are required. The pupil should be first fully dilated with atropine. A broad incision is made with the keratome at the sclero-corneal border. Through this a scoop or cataract spoon is passed forward into the anterior chamber, till it rests on the margin of the lens. Rupturing by downward pressure the ciliary attachment of the capsule, the scoop is passed transversely behind the lens and withdraws it entire from the eye, enclosed in its capsule. The after results, when the operation succeeds, are very brilliant.

The use of Eserine in eye surgery should not be passed over without remark. This drug, sulphate

of eseria, the alkaloid of the Calabar bean, empirically introduced to the profession by Lagureur, has been found most useful in cases of acute and hæmorrhagic glaucoma, through its well-known effect in diminishing the calibre of blood-vessels, and diminishing secretion. In some cases it does away with any necessity for operation. In sclerotomy it is instilled before and after the operation; in cataract extractions it is usefully employed, to restore the iris to the proper position and prevent it becoming fixed in the angles of the wound. One or two drops suffice to produce myosis. Its action is not so permanent as that of its antagonist, (atropine). It is useful also in ulcers of the cornea.

Of all the apparently hopeless cases we meet with in eye practice, none seem more beyond our skill than cases of detached retina. Such detachments may be due to injury, myopic changes, increased fluidity of vitreous, or may be mechanically produced by effusion of fluid between the choroid and retinal coats. These detachments are easily recognized by the ophthalmoscope, and their extent may be mapped out with the perimeter. It is in the cases where the detachment has been mechanically brought about by effusion, that means have been taken for its relief.

Mackenzie, I believe, first recommended puncturing the sclerotic below the seat of detachment. Bowman followed, advising laceration of the detached retina, with two needles, as in the operation for secondary cataract, to allow the escape of the effused fluid into the vitreous. De Wecker endeavored to draw it off with a trocar and canula, and subsequently attempted to form a permanent drain, by inserting a gold wire through the sclerotic and allowing it to remain for some time in the eye. Finding none of these plans successful, he had returned to the simple puncture till lately, when I have seen him substitute the galvano-cautery needle for the knife, and with this puncture the sclerotic at the point of the detachment.

The operation is done thus: The patient being prepared as for cataract extraction, the operator seizes the conjunctiva and subconjunctival tissues with the forceps, near the inferior border of the cornea, and draws the globe forcibly upwards and inwards as far as it will go. A point is then selected free from vessels, and the needle heated to a white heat, is plunged between the external and inferior recti (or should the seat of detachment