REMARKS ON CATARACT EXTRACTION.
WITH A TABLE OF TWENTY CASES.
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THE operations for cataract rank amongst the most important and the most interesting of all the operations in ophthalmic surgery, and upon their successful issue will depend in a great measure the reputation of anyone who aspires to the position of an ophthalmic surgeon. There is no class of cases in the whole range of surgery which has such a telling effect upon the non-professional public as

successful operations for cataract; to the operator it gives a feeling of satisfaction which few operations can afford. Although these remarks apply generally to all cases of cataract, they are particularly applicable to cases of senile cataract, and upon this operation I will say a few words.
Though a young ophthalmic surgeon, still I maintain a decided preference for the old operation of flap extraction. No other is so simple, requires so little manipulation, and none other, unless perhaps it is Liebreich's new operation, fulfils the conditions which are as imperative in ophthalmic as in any other form of surgery—namely, of *doing what you have to do with as little injury as possible to parts themselves, and as little disturbance as possible to surrounding organs.* It

Cases of Senile Cataract.

No.	Age.	Sex.	Nature of operation.	Results to Vision.	REMARKS.
1	70	F.	Flap extrac- tion	Vision perfect	I operated on both eyes at one sitting. The result was perfect at the time. A week after she struck the left eye, and a prolapse occurred. It was destroyed with caustic gradually, and did not interfere with the good results.
2	"	"	Ditto	Ditto	
3	80	M.	Ditto	Central pupil; vision perfect	Cataract remarkably hard and dense.
4	70	M.	Ditto	Central movable pu- pil; vision good	
5	60	F.	Ditto	Vision good; pupil circular & movable	A case of double cataract operated upon at one sitting. Recovery was very rapid.
6	"	"	Ditto	Pupil slightly irre- gular; vision good	
7	75	M.	Ditto	Central movable pu- pil; vision perfect	This old gentleman was a watchmaker by profession, and was able to continue his work after the operation.
8	40	M.	Ditto	Central pupil; vision perfect	This patient was young for a senile cataract. There was no history of injury, and the left eye was not cataractous. He wished an operation.
9	70	M.	Ditto	Vision perfect; cen- tral pupil	This man had been an old sailor; and, living on the coast after the operation, he could see ships at a great distance.
10	75	F.	Ditto	Central pupil; vision perfect	This lady had been blind for more than fifteen years, and yet the sensibility of the retina remained unimpaired. The cataract in the right eye had undergone cretaceous degeneration.
11	60	F.	Flap extr.; iridectomy	Vision good	At the time of the operation prolapse of the iris occurred. It was snipped off; and this was followed by a slight loss of vitreous. The cataract sunk out of sight, but was removed by Taylor's loop.
12	60	F.	Flap extrac- tion	Loss of vision	This patient was of an intensely restless and irritable disposition. Although the operation was perfect, iritis set in on the third day and spread to the choroid, and ultimately destroyed sight.
13	63	M.	Ditto	Central pupil; vision perfect	A healthy man. He made a rapid recovery. Iridectomy was per- formed in consequence of prolapse at the time of the operation. This patient was blind with the other eye from an old injury.
14	63	M.	Flap extr.; iridectomy	Central pupil; vision perfect	
15	68	F.	Flap extrac- tion	Slightly irregular pupil; vision good	

Cases of Traumatic Cataract.

No.	Age.	Sex.	Nature of operation.	Results to Vision.	Remarks.
1	18	M.	Suction ope- ration.	Vision perfect; cen- tral pupil	A blow from a piece of metal had ruptured the lens capsule without wounding the globe. The lens matter filled the anterior chamber.
2	24	M.	Ditto	Central pupil; vision not quite perfect	This injury was precisely similar to the preceding one.
3	20	M.	Ditto	Central pupil; vision good	This, again, was an injury similar to the above two cases; all three were under treatment at the same time. Some capsule partially obstructed the pupil in this case, but does not interfere with vision.
4	60	M.	Ditto	Vision perceptive of large objects	Was struck by a stone three weeks before admission. Lens matter filling anterior chamber. Capsule still obstructs vision. A future operation necessary.
5	30	M.	Ditto	Vision good; central pupil	Eye struck by piece of wood ten days ago. Lens opaque and swollen, but intact. No doubt small rupture of capsule.

seems to me that many ophthalmic surgeons waste their time in attempting to devise the most extraordinary and complicated means for extraction of the lens; they have become the victims of the same kind of feelings which prompt men to cross the Atlantic in an open boat, when they could do so with far greater safety in a Cunard steamer. But those under the influence of ophthalmic daring are far more dangerous than the subjects of maritime rashness, for having performed a few operations with success, they would endeavour to persuade all others to follow the same dangerous route.
The chief objections which have been urged against flap extraction, and which have caused some of the most eminent oculists to abandon the operation, are, liability to sup-

puration of the flap, tendency to prolapse of the iris, and the great loss of vitreous which sometimes occurs. These points of late years have been dwelt upon with such vehemence and weight in most works on ophthalmic surgery as virtually to put a veto upon the operation which I think it scarcely deserves. Out of close upon one hundred flap extractions, I have never seen a case of suppuration of the cornea, and I feel confident that this condition is no fault of the operation, but of the individual upon whom the operation is performed, and shows a debilitated state of the system which can easily be remedied by a few weeks or months of fresh air and good feeding, together with attention to other hygienic rules. It is the fashion now, and has been for many years, for all classes to resort to London for the performance of cataract extraction, and I believe firmly that in this circumstance alone we may find the cause of suppuration of the flap which occurs so frequently after this operation in metropolitan practice. Few persons bear changes of climate and external conditions so badly as aged persons, and what chance they may gain by increased skill in going to London they lose by being drawn from the quiet and repose of their own homes.

In the days when it was thought a peculiarly dangerous thing to touch or wound the iris, and when this structure, like the peritoneum, was invested with a mysterious dread, prolapse of the iris in flap extraction was supposed to be fraught with great danger. In the present day this accident is deemed of far less consequence, for we know that the prolapsed part may be excised without danger or detriment to the result of the operation; and I think this should always be done, without any attempt being made to reduce the protrusion. Prolapse occurring after the operation I have rarely met with, and in every case could attribute it to some careless act on the part of the patient or attendants.

Escape of vitreous is a thing which, I am happy to say, has rarely happened to me, and certainly it is not more frequent in the flap than in any other method of cataract extraction. When a very fluid state of vitreous exists, some of it will almost invariably escape, whatever the mode of operation adopted. In flap extraction no doubt more will escape than in those forms of operation where the flap is small; but then, within certain limits, I think the escape of vitreous bears no relation to the results of the case, and I have frequently seen large escapes attended with little lowering of the visual power. Whilst I am quite ready to believe that the various forms of linear extraction may be attended with better results than flap extraction in the debilitated and fragile constitutions met with in our London hospitals, I feel quite convinced that the latter operation is the best adapted for our well-fed, healthy agricultural and mining population. Nor with such a simple and beautiful, I might almost say natural, operation to resort to, can I fully comprehend how persons can adopt conscientiously such a complicated and, to my mind, indefensible operation as Mr. Taylor's last, and which seems to me a veritable ophthalmic *tour de force*. Two knives are required to make the corneal section. The iris is incised at its periphery, and the lens is extruded through the artificial opening in it. Every step is performed with difficulty and attended with danger, and when the operation is completed a double pupil is left. Nor are the arguments Mr. Taylor uses in favour of the operation strictly logical. We are told that the peripheral section of the iris avoids its being bruised and stretched. As though any rational being could believe that seizing the iris with a forceps, which must necessarily crush its delicate structure, puncturing it, and subsequently completing its section with a pair of scissors, can be attended with less danger than the slight stretching of the naturally extensible and readily dilating pupil. If such a person does exist, we may soon expect to hear it seriously proposed that all women in future should be delivered by abdominal section, to avoid stretching the os uteri and vaginal walls. No doubt this latter operation would frequently be attended with success in young and healthy women, and if anyone were to commence to put it in practice he would soon obtain a few successful cases to bear testimony to its being a very great improvement on the old method of delivery.

Having in my last paper made a few general remarks upon the plan of treatment I generally adopt, I will say a few words upon the cases in the table. There are in all twenty cases, fifteen of senile and five of traumatic cataract. The former are all the cases of senile cataract I have

operated upon during the current year. The latter are selected from a large number, and are added to illustrate the beneficial results of the suction operation when the lens capsule has been ruptured by a blow upon the eye without any external wound. In all these five cases this accident happened, and, curiously enough, three of the cases were under my care at the same time.

The senile cataracts were all successful, with one exception, and this exception illustrated well what I said at the commencement of my paper concerning persons coming from a distance. This patient was a highly nervous and excitable person. The operation was most successfully completed, but nevertheless, owing, as she said, to not being in her own bed and from the noises of the town, she could obtain no sleep; opiates did not relieve her. On the third day suppurative iritis set in, and the eye was eventually completely lost.

In two cases prolapse of iris occurred during the operation, and the portions were removed. In one of these, after the iridectomy was performed, some vitreous escaped, and the lens in its capsule sunk out of sight. I succeeded, by means of Taylor's loop, in extracting it without difficulty or danger, and the patient made a good recovery.

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ON THE FILLET, OR LOOP, AS AN OBSTETRIC INSTRUMENT.

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THERE is a fashion in all things, and our art is no exception to the rule. Each year sees the introduction of new instruments, or the modification of old ones. Many of these changes represent real progress and improvement; others merely the fashion and fancy of the day, soon to be again, in their turn, replaced and superseded.

The fillet, or loop, the instrument whose modification and reintroduction I wish to advocate, is one of great antiquity, but whose merits and utility are at present very imperfectly recognised. It has, in fact, fallen almost into disuse, and is dismissed in our text-books either as unworthy of notice altogether, or in a few half contemptuous lines, as an obsolete and nearly useless relic of the earliest infancy of obstetrics.

Its advantages, however, as an obstetric aid, are, I think, very obvious and well marked. We may find in it a means of successfully meeting many of those minor difficulties in labour which occasion so much loss of time to the practitioner and distress and pain to the patient. The cases in which it is most applicable are those in which the head presents, but is delayed, often for many hours, at or near the outlet of the pelvis, by uterine inertia, or by rigidity or small relative capacity of the vagina and vulval orifice. These are the cases which, according to our present rules of practice, must either be terminated by forceps, or consigned to the tedious and dangerous resources of time and patience.

Now, the fillet possesses several advantages over the forceps as a remedial agent under such circumstances.

1. It is light and portable; may be carried easily in the breast pocket as a companion in all cases of labour.
2. It may be applied without chloroform or other aid, and in most cases without the patient being aware that instruments (the bugbear of parturient females) are being employed at all.
3. The space which it occupies in the pelvis is much less than that taken up by the forceps.
4. When once applied it will remain in position, without further trouble or readjustment, so that traction may be resumed at any moment when desirable.

A brief sketch of the most common conditions in which the use of the fillet is indicated will be here sufficient. A consideration of its mode of action, and of the mechanism of delivery, will suggest many others.

In simple cases, where slight additional expulsive force is alone required, mere gentle traction on the head—the