is drilled in the shade a one millimeter opening, so that by elevating the handle, which is to one side, a convenient light is had for making muscle tests.

The back is so arranged that it may be hung on the wall when not in use.

This holder seems to combine in compact form all near tests and being held thruout by the patient, the operator has both hands free.

A MAGNETIZED KNIFE TO EXTRACT SMALL MAGNETIC FOREIGN BODIES FROM THE ANTERIOR CHAMBER.

JAMES M. PATTON, M.D.

OMAHA, NEBRASKA.

In extracting small magnetic foreign bodies from the interior of the eye by the corneal route, I remember on one occasion having difficulty due to the foreign body's becoming pinched in the iris angle as a result of a slight loss of aqueous on making the corneal incision. It has been our custom to use the inner pole or ring magnet of Mellinger as well as our giant magnet. The patient is able to lie comfortably on the operating table with the ring arranged in such a way that the injured eye is as near its center as possible. The soft iron "electrode" becomes strongly magnetized on approaching the center of the ring and the traction on the foreign body can be controlled to a nicety. This is most important in teasing a small foreign body around the pupillary margin of the iris into the anterior chamber. The tips of the "electrodes" can be of various shapes and sizes, either relatively large, which gives stronger traction, or small and delicate for use in the lips of small incisions.

Recently, while attempting to extract a small foreign body from back of the iris, I had drawn it around the pupillary margin into the anterior chamber and, as is our custom, prepared to make my corneal incision without removing the ring from the patient's head. My assistant failed to turn off the current when I made my incision and I was much gratified to

see the foreign body move quickly to the point of the knife and remain in that position after the knife was removed, apparently adhering to the lips of the wound. It was then easily removed with the "electrode" of the inner pole magnet. I have tried this repeatedly with very satisfactory results. It is possible to remove the foreign body in this way with practically no loss of aqueous.

When using the giant magnet, a Graefe knife can be magnetized by placing it in contact with the tip of the magnet for a few minutes. It is then sufficiently magnetized to attract the foreign body, altho not so strongly as when used in conjunction with the inner pole magnet.

BILATERAL DISLOCATION OF CRYSTALLINE LENS, REMOVAL.

W. G. PUTNAM, B.A., M.B., C.M.

YARMOUTH, N. S.

F. L., 48. Fisherman, small farmer. A large fat man, weight 275 pounds. Has consulted me several times previously for failing sight. Family history: Father blind for years, result of chronic glaucoma. One sister blind from same cause, her physician not recognizing the trouble. One brother living in the U. S. A. blind presumably from same cause.

Refraction record:

Sept. 3, 1905. R. 5/200 with—13.00=20/120. L. 9/200 with—9.00=20/200.
Aug. 1, 1906. R. same. L. 7/200. with—9.00=20/200.

On June 19, 1909, he came to see me, saying that his glasses had quite gone back on him. He had noticed this directly after a severe fall backwards, which had almost rendered him unconscious. Examination showed dislocation of both lenses, the right upward, the left downward, with moderate dilation of pupils.

On the morning of July 4, 1909, he came to my house to tell me that his wife had noticed something strange in his left eye two days before. I found the left lens in the anterior chamber. We had no hospital at that time, so I

advised him to go to Boston, Mass., the next day, the earliest possible, for treatment. Next morning he began his work as usual, but very soon was taken with an intense pain in his left eye and seen by his regular physician, who found him nearly crazed by pain, pulse 36, temperature 98.6° , and the eyeball very hard. He was given morphin sulphat, gr. $1/4$, hypodermically and when I saw him at his home in the country, two hours later, the pain was much easier and pulse was 56. I found the eyeball very hard $T+3$ at least, the lens pushed forward close against the cornea, its periphery covered by the iris which was "ballooned" forward. Under cocain, in about half an hour, the iris dropped back and the margin of the lens was free, so I decided to attempt removal of the lens. I made a good upward section, practically at or just behind the corneoscleral junction and at once there was some escape of watery vitreous as was to be expected. I tried in various ways to remove the lens by pressure, loop spoon, hook, but every effort brought more vitreous. I finally got a hook engaged and thought the lens was coming, but it slipped off and dropped back into the vitreous. In view of the very acute glaucoma present, and influenced in part by the family history, I did a wide iridectomy, bandaged the eye and gave a gloomy prognosis. However, apart from some pain, everything went on nicely, and a month later a traumatic cataract was to be seen. Later on this began to be absorbed and there being no nucleus, complete

absorption resulted by March 10, 1910. $V.+7.00=20/70$. On Sept. 14, 1911, he came to see me again, this time the right lens was in the anterior chamber, having been noticed the previous evening by his wife. Next morning, thru a section similar to the one made in the left eye, I was able to remove the lens, with only a trifling loss of vitreous. The after history was uneventful.

Vision Oct. 31, 1912. $R.+8.00=20/30$. $L.+6.00=20/40$.

I have seen the patient many times since. In June, 1917, vision was the same, and I often see him driving around, and he says there is no apparent change. August, 1920, Dr. S. W. Prowse, F.A.C.S., of Winnipeg, saw the patient and can vouch for results as given.

April 8, 1921, the man was found dead in a field near his home. I knew he was suffering from some cardiac lesion, but, of course, was not looking for his death so soon.

The points of interest to the writer were: 1 family history, 2 progressive myopia under observation years before the accident, 3 partial dislocation of both lenses, due to indirect violence, 4 further dislocation into anterior chamber, with interval of over two years, 5 operative result. There are certain features in the case I do not quite understand. What became of the lens capsule? Did I remove the lens in its capsule? This case was seen before we had a hospital here and both operations were done at the home of the patient some miles in the country.