I had failed to make a complete delivery. Later on some loose lens matter was found forcing apart the lips of the wound and was easily removed, but it had already set up a cyclitis which was followed by sympathetic inflammation of the other eye, necessitating enucleation of the exciting eye. The result was particularly deplorable, as the sight in the remaining eye, upon which I had done a successful extraction the previous year, was considerably impaired. There was additional disappointment, perhaps due to the fact that I had done double cataract extractions on two of his friends with a resulting vision of nearly 20/20 in each eye. Earlier removal of loose lens matter might have prevented the cyclitis, and earlier enucleation would certainly have been better for the sight of the other eye, but this case was at a distance from me and could not be seen as often as I wished.

In case third the nucleus of the lens with the thickened capsule dropped down into the vitreous, the capsule remaining attached above so that it swung as if upon a hinge. Efforts to get hold of it and extract failed, although a properly made wire loop might possibly have been used successfully. The eye was closed and a cool compress of cotton applied for a half hour, in the hope that the anterior chamber would refill and the lens float back into position, as it were. At the end of that time, the aqueous showing no tendency to reform and the cornea remaining depressed or collapsed, the usual dressings were applied. A little vitreous had been lost and its appearance indicated the occurrence of liquefaction. At the end of twenty-four hours the anterior chamber was re-established and the lens had come up into place. It was then a question whether to attempt its immediate removal or leave it to nature (supplementing what nature failed to do in the way of absorption by a secondary operation later on). The success of this course with case first, and the fact that the patient was a nervous invalid, led to the adoption of the latter plan. The corneal wound healed kindly and there was but little iritis, slight adhesions below serving to fix the lens and capsule more firmly in place. The iritis having subsided, we began to consider the question of a secondary operation, when the patient, who had long been an invalid, commenced to decline and soon died from causes having no connection with the eye or operation. It is, therefore, a matter of speculation whether it would have been wiser in this case to have gone down into the vitreous with a wire loop immediately, or attempted the extraction of the lens remnant the day following, in lieu of the conservative course adopted. I hope this phase of the subject will be thoroughly discussed.

The text-books at my command say comparatively little about accidents in operations. deSchweinitz gives the most, but even he does not cover all the points connected with such cases as I have here reported. Of such accidents as the iris falling in front of the knife I have had no experience, nor have I ever lost much vitreous. In one case only have I been compelled to enlarge my corneal incision. The accidents mentioned in this paper have been the worst in my experience, but they have taught me such valuable lessons that I thought it might be more profitable to report them than my successes, hoping that the discussion thus introduced might bring out many points of value to those who feel there is yet something to be learned in this branch of our art.

17 West Ohio Street.

AN INEXPENSIVE 60-LENS OPHTHALMOSCOPE WITHOUT REKOSS-DISC.

Presented to the Section on Ophthalmology at the Forty-ninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898.

BY GEORGE M. GOULD, M.D.
PHILADELPHIA.

It is said that if within five years after graduation an oculist does not devise "A New Ophthalmoscope" his wife and intimate friends begin to make mysterious visits to the best alienists concerning the man's mental condition. I have concluded that it will not do for me to hold out any longer. The little device I show you today is designed to give the working oculist an instrument with double or treble the number of useful lenses in the ordinary ophthalmoscope, without the complicated and bothersome Rekoss-disc, without a handle, that does not need a case, and that is comparatively inexpensive. The lenses are arranged in two sets independent of each other, each set in parallel continuous grooves or channels similar to the Morton instrument in this one respect. Each set of lenses is propelled by a drive-wheel operating a toothed wheel for each of the two sets of lenses, this having a disc on which is the designation of the particular lens at any time before the sight hole. The set of lenses in one end of the ophthalmoscope contains the lenses most used by an emmetropic oculist, and all the rarely-used lenses are in the set at the reverse end. A highly ametropic oculist could have a different set of lenses placed in the most-used end according to his personal needs. The mirror, instead of tilting to either side, is reversible on its axis and thus can be placed at any angle desired for use when patients are in bed or with the light in any direction. The mirror is readily taken out and inserted in either end of the instrument. Side-illumination is excluded by a tube containing the mirror and the body of the instrument. The instrument itself is used as a handle. The arrangement of the lenses is as follows:

At one Extremity (that most used.)		At the other Extremity (that less used.)	
Concave.	Convex.	Concave.	Convex.
. .	. .	8.00	8.00
. .	. .	8.50	8.50
0.50	0.50	9.00	9.00
1.00	1.00	9.50	9.50
1.50	1.50	10.00	10.00
2.00	2.00	10.50	11.00
2.50	2.50	11.00	12.00
3.00	3.00	12.00	14.00
3.50	3.50	13.00	16.00
4.00	4.00	14.00	18 00
4.50	4.50	15.00	20.00
5.00	5.00	16.00	25.00
5.50	5.50	18.00	30.00
6.00	6.00	20.00	. . .
6.50	6.50	25.00	. . .
7.00	7.00	30.00	. . .
7.50	. .	40.00	. . .

The present crude instrument, the first one made, is designed to show its essential principles and methods; the finished instrument will be made of aluminum, and therefore much lighter in weight.

DEMONSTRATION OF AN "AUTOFUNDOSCOPE."

Presented to the Section on Ophthalmology, at the Forty-ninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898.

BY GEORGE M. GOULD, M.D.
PHILADELPHIA, PA.

The little device for which I have dared to coin the