blinded in war. It is unfortunate that no account of St. Dunstan's Hostel has been included.

ERNEST THOMSON.

CORRESPONDENCE

Atropin in Cataract Extraction

To the Editor of THE BRITISH JOURNAL OF OPHTHALMOLOGY

SIR,—In the course of reading the proofs of the December number of the BRITISH JOURNAL OF OPHTHALMOLOGY, I was interested in Mr. Fisher's advocacy of the use of atropin in cataract extraction. But surely, Sir, this is nothing new. It was done habitually by some of the best-known Continental operators, notably by Axenfeld, and by Hess, of Munich. I have seen both these surgeons operate with the atropin-dilated pupil. The following is a transcript of my notes taken at the time:—(1) "Extraction of cataract in a young adult by Axenfeld. Axenfeld has the pupil dilated either with homatropin an hour before, or with scopolamin two days before operation. (2) Hess. Extraction of senile cataract. The pupil has been dilated with atropin, one drop of 1 per cent. the night before and one drop on the morning of operation. The pupil is therefore fully dilated." The operative details were also given in my articles on Continental clinics, *Ophthalmoscope*, 1912. It is true that Fisher uses the atropin when the patient is on the table, and that more of the alkaloid may thus enter the eye, but the principle seems exactly the same as that employed in 1911 by the two surgeons named. Hess was at that time in Würzburg.

Yours etc.,

ERNEST THOMSON.

To the Editor of THE BRITISH JOURNAL OF OPHTHALMOLOGY

SIR,

I think Mr. Fisher's note on cataract extraction in this month's issue of your Journal should not pass unnoticed.

There appears to be little that is new under the sun, and it may interest Mr. Fisher to hear that Lieut.-Col. Drake-Brockman told me at the International Ophthalmological Congress at Lucerne, some few years ago, that he systematically dilated the pupil before cataract extraction, that I myself do the same thing, and that Mr. Stanford Morton has for many years dropped a solution of atropin into the eye immediately after extraction: probably many others use it before or after in the same way.

Col. Drake-Brockman was wont to lacerate the capsule with a needle as a first step in extraction, and for this purpose a dilated pupil was necessary ; moreover, he considered the section was easier with a dilated pupil and that the iris was not so liable to fall over the edge of the knife.

Mr. Stanford Morton applies the mydriatic immediately after the operation to get rapid and full dilatation of the pupil and to check any tendency to iritis, and to lessen the risk of prolapse of the iris.

I apply a mydriatic the night before or the morning of the operation, and, as I practically now always aim at performing a simple extraction, I do it chiefly for three reasons :

(a) The iris is more out of the way and less likely to fall over the edge of the knife.

(b) The escape of the lens through a dilated pupil—or one that has been quite recently dilated—is facilitated.

(c) I consider the pupil, which remains usually considerably dilated, is less likely to be followed by prolapse of the iris and by inflammation thereof.

Some years ago, I was in the habit of using eserine immediately after the extraction to keep the pupil contracted and lessen the risk of iris prolapse, but I have for some time come to the conclusion that a contracted pupil is more likely to cause prolapse than the opposite, and for this reason : take a recent simple cataract extraction, let the iris go back nicely into position and let the wound *slowly* leak—failing to heal—for several days ; the iris does not prolapse. Let that wound heal weakly and retain the aqueous and let the pupil be contracted, a sudden effort or squeeze on the part of the patient bursts open the wound more or less and the aqueous in the posterior chamber will carry the iris with a rush into the wound, whereas, if the pupil was dilated, there would be very little posterior chamber and the fluid would flow in *front* of the iris and out through the wound with much less risk of causing prolapse.

Mr. Fisher's practice is undoubtedly a good one, but, to my mind, his practice is better than his theory. He says, page 751, "obviously, when the atropine solution is dropped into the conjunctival sac and the section immediately proceeded with, the alkaloid in considerable strength must make its way into contact with the iris, etc. etc."

But, Sir, is this so ? In the cases I operate on, the section is attended by an escape of aqueous, which, presumably, rather tends to wash away any fluid in the conjunctival sac than aid and abet its getting into contact with the iris.

Isn't it more likely that the absorbing power is greatly increased by the full exposure of the absorbing surface after the introduction of the speculum, especially preceded by the action of cocaine and adrenalin instilled for several minutes before ?

One more point in Mr. Fisher's note I would fain allude to, and I could write pages on it; he says he quite rarely performs a simple extraction: what joy he misses!

I hope some day he will join the band of simple extractors, amongst them, in the past such masters as Charles Bell Taylor—*facile princeps* as an operator—and Charles Bader, and, amongst the present, Charles Higgins, Richardson Cross and—not least—Stanford Morton, *cum multis aliis*.

What more beautiful result than a perfect simple extraction! "*Ars est celare artem*," as Bell Taylor used to put it.

Apart from the cosmetic gain, look at the advantages of simple extraction:

- (1) Scarcely any pain during and much less after the operation.
- (2) Fewer instruments introduced into the eye.
- (3) Much less bleeding.
- (4) Much less risk of prolapse of vitreous.
- (5) Practically no risk of capsule being drawn up into the wound months after the operation with secondary glaucoma resulting.
- (6) When needling capsule, a more limited opening suffices in the pupillary area, with less risk of vitreous coming forward and blocking the filtration area, and so causing increased tension—often so difficult to treat.

(7) If anything, the vision is rather better after simple extraction and there is less spherical aberration and less complaint of glare. *Per contra*, the chief disadvantages of simple extraction are:

(i) The bugbear of iris prolapse: well, if it happens, it can be snipped off, but it doesn't often happen, certainly not sufficiently often to counterbalance the advantages; moreover, the combined operation is not entirely free from the risk of prolapse.

(ii) A difficulty in getting rid of soft cortex. This is readily overcome by washing out the anterior chamber with warm sterilized saline solution, only this must be most carefully prepared. I personally weigh the saline and attend to the disinfection of the undine and tube and also—a very important point—to the temperature of the solution used. I get it ready myself before the extraction, but only use it when necessary, not systematically.

Finally, Sir, how few really good operators one sees! As in a shooting field one sees a lot of fair shots, but seldom a really good one, so with ophthalmic operations.

Ought we to be satisfied with mediocrity in anything? Ought we not to go on striving and struggling to improve and eventually to "rise on our dead selves to higher things."?

Yours, etc.,

S. JOHNSON TAYLOR.

NORWICH.

December 14, 1917,