escape of vitreous and hence prefer to extract with capsulotomy in such cases.

(b) Ordinary cases, which appear quite normal but which resist what I consider legitimate pressure by the intra-capsular method. There appears to be great difficulty in rupturing the zonula and the lens does not present at the corneal incision, as it should. In such cases I prefer to re-insert the speculum and extract with capsulotomy rather than court disaster in the shape of a large escape of vitreous, which unfortunately has been my experience in several cases.

Only experience can enable the operator to decide what is the legitimate amount of pressure to be employed, but I am convinced that several individuals would now have better sight, if the operator had not proceeded to use too much force in his endeavour to rupture the zonula. These cases are not of very frequent occurrence, not amounting to more than 2 per cent. or 3 per cent. of ordinary senile cataracts.

(c) Some cases of cataract in those between 35 and 50 years of age. Here again one can only learn by experience, but when I see a case of double cataract in a comparatively young individual with dark hair, I am always prepared for trouble. For in these cases the zonula often proves very resistant to pressure by the intra-capsular method and if pressure is too long persisted in, the zonula breaks as it were with a snap and out comes the lens followed by vitreous. In such cases it is therefore necessary to beware and if there is great difficulty in dislocating the lens, it is better surgery to reinsert the speculum and perform a capsulotomy.

(d) Cataract in glaucoma and glaucomatous cataract.

As regards the former, defined by Smith as cases in which glaucoma has set in during any stage of the normal development of cataract; Smith's treatment in the initial stages would be accepted by most, namely that of performing a large sized iridectomy, provided the cataract is not of the swollen or intumescent variety. But instead of extracting in the capsule as he recommends, 3 months or so later, I think that extraction with capsulotomy is preferable, as in such cases there is a distinct danger of choroidal hæmorrhage, which is probably more likely to occur when the intra-ocular tension is suddenly reduced as in the intra-capsular operation, than when it is more gradually reduced, as in the operation with capsulotomy.

As regards glaucomatous cataract, *i.e.*, cataract which has glaucoma as its cause, it is seldom fit for operation. But there are a few cases in which there is some reaction of the pupil and some perception of light. These are not always hopeless. In such cases, as in those of cataract in glaucoma, a wide iridectomy, followed 3 or 4 months later by extraction with capsulotomy is sometimes attended with success.

And I would add to these cases, those in which the tension is slightly up, for I have no doubt that in such cases, choroidal hæmorrhage does tend to occur. In fact recently at Shikarpore there were cases, which demonstrated the fact. Both patients had double cataract, with no other symptoms of glaucoma except tension rather raised. Both pupils were active and perception of light good. In both cases, both cataracts were extracted, with capsulotomy in one eye and in the capsule in the other. In both eyes in which intra-capsular extraction was performed, choroidal hæmorrhage occurred, while the eyes in which extraction with capsulotomy was done escaped. The cases were decidedly instructive. It is possible that had a preliminary iridectomy been done, followed by extraction a month later, both eyes might have been saved.

(*e*) *Traumatic Cataract.*—In these cases I think capsulotomy is advisable, for I have found a decided tendency to escape of vitreous when such cataracts are extracted in the capsule and now I never attempt to do so. The reason for the tendency for vitreous escape is, I imagine, because the hyaloid membrane has been ruptured by the blow which has caused the cataract.

I have given briefly the above 5 additional contra-indications to the intra-capsular operation, not because I do not believe in that operation, but in the hope that by frankly admitting certain contra-indications, the intra-capsular operation will become more wide-spread than it is at present. For these contra-indications do not amount to 5 per cent. of all cases of senile cataract and for the remaining 95 per cent., I feel no doubt that intra-capsular operation is the operation of choice. But it is more than possible certain operators may have been unsuccessful in some of their intra-capsular work, from ignorance of these contra-indications. I am certainly among that number and have learnt by sad experience the kind of cataract that should be left alone, as far as the intra-capsular operation is concerned.

A Mirror of Hospital Practice.

A CASE OF LARGE OVARIAN CYST.

By C. B. McCONAGHY, M.B.,
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A WOMAN by name Mano, wife of Dalloo, aged about 40, Silawat by caste, from

Narsingarh State, was admitted to the Agency Hospital, Sehore, C.I. on 29th. April 1922.

Condition on admission.—The patient was very weak and emaciated and had an enormously distended abdomen.

She measured 31 inches round the chest and 60 inches round the abdomen just below the umbilicus. The swelling on palpation appeared to consist of two oval smooth masses containing fluid and united in the middle line. There was no fever, nor much pain. Dyspnœa, loss of appetite and great inconvenience from the size and weight of the swelling were the chief complaints.

Latterly she had become very much weaker and emaciated. Heart sounds normal but weak—Pulse 60 regular but weak—Respiration 18. No albumen was found in the urine.

History of the Swelling.—18 months ago the woman was in good health and having missed 2 periods she suspected a pregnancy. There was a slight swelling in the lower part of the abdomen but no further signs except the amenorrhœa. This swelling gradually increased and she still thought it a pregnancy in spite of experiencing no fœtal movements. After 9 months as the swelling was still growing she consulted some women friends who also considered it a pregnancy. When the swelling had existed for 14 months and nothing had happened she went to the hospital at Narsingarh and was advised to go to Sehore for treatment. She returned home and waited for a further 3 months and finally came to the Agency Hospital.

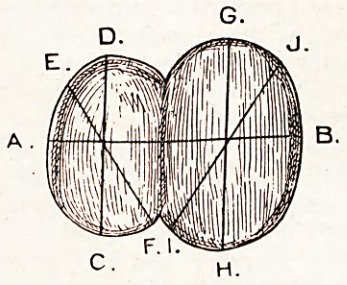
The family history is good. She has had 4 children, 3 of whom have died from small pox and the last aged 6 is alive and well. Gives no history of ever suffering from venereal disease. Her husband also is in good health and never had venereal.

An ovarian cystic tumour was suspected and operation was advised—but was absolutely refused. The hospital nurse examined the woman and reported that the uterus was apparently normal. There was no discharge.

On 1st May the husband was very anxious that some fluid should be removed by tapping as she was suffering very much from dyspnœa. This was done and 11 gallons of brownish coloured fluid were drawn off slowly, this gave great relief. Operation was again advised but resolutely refused. The woman died on the night of 4th. May and her husband consented to a post-mortem. She never had any fever or much pain while in hospital—took very little nourishment and the dyspnœa and discomfort of the tumour were the chief symptoms she experienced. No drugs gave her any relief.

Post-mortem.—This was performed at 8 a.m. on 5th May by Sub-Assistant Surgeon Rao Sahib Narain Canoji Rao. On opening the abdomen an enormous mass was found consisting of two oval tumours united together in the middle line and filling up most of the abdominal cavity. The larger cyst was to the left.

The tumour was freed from all adhesions and removed, it weighed 84 pounds.



Measurements of Tumour.

A B.	was 48	inches,	largest circumference of tumour.
C D.	„ 34	„	smaller half.
E F.	„ 30	„	do
G H.	„ 43	„	larger half.
I J.	„ 35	„	do

The larger cyst contained a thick brown muddy coloured fluid while the smaller one clear yellow fluid. Between these two main cysts there was a collection of smaller cysts some containing clear fluid, and others clear fluid and caseous masses of degenerated ovarian tissue. No pus was found in any of the cysts.

The uterus was examined and appeared quite healthy and normal in size. The liver was rather small and contracted, spleen normal in size, stomach and intestines appeared healthy. The mesenteric glands were slightly enlarged.

There were no signs of any peritonitis. The abdomen measured 30 inches in circumference after the tumour had been removed.

This case of ovarian tumour is the largest yet seen in this Agency Hospital. It was a great pity that no operation was permitted as the woman's life might have been saved by its removal at an earlier period.

POST-MORTEM EXAMINATION IN CEREBRAL MALARIA.

A New and Simple Method of Demonstrating Parasites in the Capillaries of the Brain.

By R. N. RAJA, L.R.C.P. (Edin.), L.F.P.S. (Glas.), late Captain, I.M.S. (T. C.),

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A piece of brain tissue from the cerebrum or cerebellum is pressed between two slides and the material thus obtained is transferred to a clean slide and spread out with the edge of