

physical sign, so that when two signs apparently contradict each other we shall know to which of the two should be attached the greater weight. For instance, the hemiplegia in the present case pointed to a right-sided affection, whilst a transitory paralysis of the abducens nerve pointed to a left-sided one. As, however, the latter symptom is often produced indirectly through general intracranial pressure—or, more accurately speaking, through longitudinal stretching of the cerebral axis, as Collier has pointed out,—it was easy to realise that it should be disregarded as a sign of localising value and not allowed to discredit the correct conclusion indicated by the hemiplegia that the lesion was on the right side. In forming such an opinion great care had to be exercised to make certain that the left hemiplegia was of the cerebral type and not of the cerebellar, for in the former case the lesion would be right-sided; in the latter left-sided. It would be out of place here even to enumerate any of the large number of differential points that enable us to distinguish between the two, but I may point out that here again the difficulty of distinguishing between a cerebellar and a thalamic tumour is shown, for a hemiplegia due to thalamic disease resembles that due to cerebellar more closely than does any other cerebral hemiplegia, except possibly the cortical form. Not only may thalamic movements be mistaken for cerebellar ataxy, as has just been mentioned, but, further, the thalamic hemiplegia is apt, like the cerebellar one, to be of a flaccid variety and to be unaccompanied by those changes in the reflexes that we regard as distinctive of interruption of the cerebro-spinal motor paths.

In conclusion we are again reminded of the fact that every case of cerebral tumour, if carefully studied, serves to refresh or expand our knowledge concerning the important question of cerebral localisation.