

point to malignancy. Complete immobility of the eye means general invasion of all structures, and indicates malignity.

In slowly growing tumors, which are generally benign, we have difficulty in diagnosing them from the periosteal thickening I have already mentioned, and also from chronic localized phlegmon.

If the tumor be *vascular* in nature, the exophthalmos can generally be reduced temporarily; excitement, crying, etc., can increase it; and, lastly, we may watch the effect of compression of the carotid on it. A pulsation and bruit can be observed in some of these tumors, but we must not forget these are also present in malignant tumors. Of the vascular tumors, I have only seen a congenital nævus, at the back of the eye, and it became partly visible on rotating the eye far outward. The most common tumor of the cellular tissue is sarcoma, and the diagnosis at best is conjectural. In an old note-book I find the following, copied from Berlin of Heidelberg: "If the tumor be solid, surface nodulated, does not fluctuate or pulsate, but is not stone hard, not connected with brain, nor proceeds from walls of orbit, eyeball, nerve, muscles or lachrymal gland or neighboring cavities, then it is almost certainly sarcoma of orbit."

Tumors of the optic nerve may or may not be malignant; here the blindness and atrophy of the disc as seen by the ophthalmoscope precede other symptoms; later we get the projection of the eye directly forward.

This exophthalmos directly forward we get with other diseases, such as Grave's disease, and paralytic proptosis, etc.; but in Grave's disease, etc., there is the lack of blindness, and the exophthalmos is generally bilateral.

Lastly, cysts of the orbit are not uncommon. Dermoid cysts being congenital, then there are hydatid and extravasation cysts. Encephalocele I have already referred to.