would bring out a good many interesting facts which I cannot discuss now; for instance, among those cured there were two of esophoria with normal refraction in which the chief complaint was persistent vertigo, both entirely relieved by tenotomy of the internal recti; in neither of these, however, was there anything approaching epileptiform phenomena.

The clinical investigation of functional muscular anomalies can only be undertaken at the expense of enormous loss of time and the exercise of unbounded patience on the part of the surgeon; hard conditions, it is true, but not too hard for him who delights in his profession and feels the joy of overcoming difficulties that have baffled others.

If the results I have now placed on record are reliable, and I believe they are, being the outcome of many years' patient observation and steady work, free, I hope, from partiality of any sort, then it follows that whoever ignores the injurious effects of muscular faults in ophthalmic practice, fails to accord at least 1 per cent. of his patients the benefit which a proper application of his knowledge should bestow.

I have purposely abstained from any discussion of the theoretical aspects of faulty muscular equilibrium, for the reason that I could not on the present occasion do justice to this part of the subject, and from a clinical standpoint it matters not what the cause of physical distress may be so long as the means employed for its relief are efficient.

In reply to some points raised in the discussion which followed the paper, Mr. Buller said: Mr. President, first as to the point raised by Dr. Stevens—want of uniformity in standard of measurement. I claim that it is impossible to establish a definite standard for all cases, and say that a man must come up to that standard or he is abnormal. I think that Dr. Stevens supports me in this contention,