tion of the eyes. The commonest is the Magendie type, in which the homolateral eye looks downwards and inwards and the contralateral eye outwards and slightly upwards. It is usually a temporary phenomenon and, therefore, has carefully to be watched for.

The general characteristics of cerebellar tumours are further worth remembering, namely, the tendency of the symptoms to progress in definitely marked-off steps, and the continual variation in the activity of the deep reflexes.

If I were asked to place the above-mentioned signs in order of their diagnostic value I should do so as follows: First ataxia, then the characteristic vertigo, the hypotonia, paresis, nystagmus and skew deviation. With this clinical picture in mind we may next consider some of the problems of differential diagnosis that most frequently arise.

Of *superatentorial* tumours those that give rise to the greatest difficulty in this respect are tumours of the frontal lobe, of the optic thalamus, and of the corpora quadrigemina. It is uncommon for a cerebellar tumour to be confounded with one in the parietal, temporal or occipital lobe. It can be thought to be situate in the *Rolandic area* only if the observer mistakes for an attack of *petit mal* one of the giddy spells that occur in cerebellar disease, and which sometimes gravely impair consciousness. In cerebellar attacks, however, there are never any local twitchings, as there are in the Jacksonian attacks; even in the true cerebellar fit there is no clonic stage, only a tonic condition of the muscles that lasts for a variable time. The subsequent paralyses are also of a totally different kind in the two affections.

A *parietal* tumour may occasionally be a source of embarrassment in diagnoses. It gives rise to a lack of dexterity in the limbs, which, however, is due to an astereognosis, or sometimes to sensory asymbole, and so is quite different from cerebellar ataxia. When the tumour extends far back in the parietal lobe it may produce conjugate deviation of the eyes, but in such a case there will probably be present a contralateral homonymous hemianopsia or else a mind-blindness for objects, together with evidence of visual aphasia.

Frontal tumours give rise to many symptoms resembling those of cerebellar tumours. In both cases there may be present nystagmus, conjugate deviation of the eyes, speech disturbance, unilateral tremor of the limbs, and even the so-called cerebellar attitude of