

is distinguished by being more pronounced in the trunk than in the limbs, and in the lower than in the upper limb, by never affecting the face, by being of a flaccid and not a spastic type, and by being unaccompanied by pain or any other sensory disturbance. Further, there are none of the changes in the reflexes so characteristic of pyramidal affections, such as ankle clonus, heightened activity of the deep reflexes, abolition of the abdominal reflexes, inversion of Mendel's reflex, and the appearance of Babinski's plantar sign and its allies, the "fan" sign, Oppenheim's Schäfer's and Remak's signs. The *hypotonia* that accompanies this paresis is a highly important differential sign. It is shown by the diminished resistance to passive movements, by the flaccid feel of the muscles and the greater mobility of the joints. Special tests by which it can be revealed or estimated are: the extent to which passive hyperextension at the knee is possible (the knee-angle sign), the extent to which the seventh cervical spine descends below the level of the great trochanter when the patient tries to touch his toes without bending his knees, and by a useful test applied most conveniently with the forearm in the following way: If someone is powerfully flexing his forearm against resistance and we suddenly remove this resistance, the forearm will flex to a certain extent and will then recoil. If cerebellar ataxia is present then the forearm will continue to flex even to the maximum possible extent, and there will be no recoil. It is important to remember that the hypotonia of cerebellar disease differs from other forms in not being correlated with absent knee-jerks.

Of the *eye-symptoms* three are of especial importance: nystagmus, sixth nerve weakness, and skew deviation. Cerebellar nystagmus is characterized by being most marked when the patient looks towards the side of the lesion, in this respect differing from nystagmus of labyrinthine origin, by being of a slow and rather coarse kind, and in sometimes being more marked in the homolateral eye. It is practically always lateral in type. The paresis of the sixth nerve is an exceedingly frequent symptom; there is commonly also a dissociated paresis of the opposite internal rectus muscle so that it is weak in lateral movement of the two eyes, though not in convergence. In the latter case there may be a secondary conjugate deviation of the eyes away from the side of the lesion, a symptom of much greater significance than isolated affection of the sixth nerve. There are several kinds of skew devia-