rests his weight chiefly on the leg of the side opposite to the lesion. There is frequently present a considerable degree of lordosis. The gait has two special features. The patient reels as if drunk and tends to stagger and fall over on to the same side as the lesion. Again, in walking towards a given point, he gradually deviates from the appointed direction, describing a path that is curved, with the concavity on the side of the lesion.

The *ataxia* of cerebellar disease is peculiar in being of the dynamic variety, thus differing from the static ataxia of, for instance, tabes or peripheral neuritis. It is, in other words, a dysmetria, being due, not to a lack of precise information from the periphery as in these diseases, but to a defect in the central regulating mechanism of co-ordination. It is, therefore, not dependent on, and indeed is usually unaccompanied by any sensory changes or any diminution in acuity of the "muscle-sense." The ataxia is always more marked in the upper than in the lower limb, and is usually confined to the homolateral side. It is manifested in several ways. During the performance of such an act as pointing to an object, or touching the tip of the nose, irregular inco-ordinate movements appear. Sometimes they have a tremor-like character, but they differ from an intention tremor, such as occurs in insular sclerosis, by not increasing towards the end of the act, and in disappearing as soon as this is completed. Indeed, a limb that is maintaining a fixed attitude, such as being held out straight, is held frequently preternaturally steady, a point to which we shall later refer. The carrying out of a complex movement frequently shows a defect that Babinski has termed "cerebellar asynergy." For instance, if the patient is told to straighten a lower limb that is flexed at both hip and knee joints he will extend first the leg and then the thigh, and not both simultaneously as in the normal. Again, he is unable to carry out any rapidly reciprocating movements, a symptom known as dysdiadochokinesia. Also this occurs on the same side as the lesion, so that, for instance, the patient cannot rotate his hand by the alternate movements of supination and pronation so rapidly on this side as he can on the opposite side, and he will frequently compensate for this incapacity by rotating the arm at the shoulder-joint when he is tested in this way.

A cardinal side of cerebellar disease is *hemi-paresis*. This paresis altogether differs from that produced by cerebral disease, or from that produced by interference with the pyramidal tracts. It