The amount of ataxia present varies somewhat from day to day. There is slight swaying when the patient stands with his heels together and eyes closed.

No further convulsive movements have been noticed, and no paresis. Inequality of the pupils still persists. The right is the larger.

The temperature has been slightly elevated since admission, ranging between 98° and 100°. The pulse has varied between 76 and 120.

The symptoms present in this case point unmistakably to a gross brain lesion, but there were at first no localizing symptoms of sufficient distinctness to warrant a diagnosis of the situation of the lesion. Since the disappearance of the headache, the boy has been able to go about, and it then became manifest that his gait is somewhat ataxic and of a cerebellar type. This symptom together with the absence of the knee jerks, the severe occipital headache, and the early and very intense optic neuritis point on the whole to a cerebellar lesion. The symptoms are, however, of not sufficient weight to justify a physician in advising surgical interference.

There is not sufficient evidence to be gained from his past and family history, and from the onset, nature and course of the symptoms, to enable one to arrive at a conclusion as to the nature of the lesion.

CASE II.

Slow and irregular development of paralysis of the right arm and leg—Paralysis of the left external rectus—Slight weakness of the right external rectus—Paralysis of both motor and sensory branches of the left fifth nerve—Pain sense in the region of the left fifth exaggerated—Temporary impairment of hearing on the left side. (Reported by Dr. McDougall, House Physician.)

P. McM., male, æt 13, school-boy, was admitted to the Royal Victoria Hospital, November 6th, 1897, complaining of weakness of the right arm and leg, and double vision.

One day in July, 1897, when returning home, after playing a game of lacrosse, the patient noticed that the right side of his body was a little weak. The leg on that side easily tired and the toe tended to catch on objects lying in his path. With his right hand he was not able to hold his lacrosse stick as firmly as usual.

A few days later he "began seeing double;" at first but occasionally, but about the time of his admission to the hospital diplopia had become constant, and his friends noted that "his left eye turned inwards."

Within two months from the onset of the trouble, the weakness had developed so that the patient had a very decided "limp" when walk-