

that his task is thereby simplified, and as *early* as possible, so that operation may be undertaken while the patient's general health is yet unimpaired and before the tumour has extended so far as to render hopeless the attempt at removal. Intracranial tumours are sufficiently common to make it necessary to bear them in mind as a possible diagnosis in every case of nervous disease, as is illustrated by the fact that I have myself examined sixteen cases of this nature in the past twelve months only.

In the present paper I do not propose to describe any individual cases, but shall merely offer some general remarks concerning the differential diagnosis between tumours of the cerebellum and those elsewhere in the cranial cavity, paying most attention to the difficulties that are greatest in actual practice. These remarks are mainly based on a study of some twenty cases of cerebellar tumour I have observed in the past few years. Most of them were operated on, several by Sir Victor Horsley.

It will save much repetition if I first give a rapid review of the symptoms that are most characteristic of cerebellar tumour, and then consider the differential points later. I will omit the indirect signs produced by pressure of the growth on neighboring structures. The *general* symptoms of intracranial tumour are usually very pronounced when this is situate in the cerebellum. The headache, which is invariably confined to a sagittal plane, is severe; the optic neuritis is early and rapid in onset and intense in character, and the vomiting and vertigo are frequently very distressing. Besides the general feeling of giddiness and unsteadiness that may occur with any intracranial tumour, we here meet with a special form of vertigo that consists in a peculiar sense of lateral rotation. On closer investigation we find that to the patient both his own body and external objects seem to be turning in the same direction—away from the side of the lesion.

The *attitude* and *gait* shew the following features. The head is held in a position of lateral flexion, the ear on the side of the lesion being approximated to the corresponding shoulder; the head is drawn backwards and is also rotated so that the face looks away from the side of the lesion. These three features make up what is called the cerebellar attitude. When standing the patient is unsteady, though more so subjectively than objectively; the unsteadiness is not appreciably increased on shutting the eyes, so that Romberg's sign is absent. The patient stands with a broad base and