power, and the following was accepted as normal. Abduction 5° to 8°, adduction 25° to 50°, sursumduction 2° to 3°.

This standard is not absolute, and is chiefly useful for purposes of comparison. In every case where there is binocular vision, the range of fusion may be temporarily increased in any direction by systematic exercise of the muscles. I have seldom known this apparent increase in power to be long maintained after the exercises had been discontinued.

Equal exercise of all the muscles will sometimes develop a preponderating power in a sense that did not exist before. This fact, when it occurs, is more significant than the original latent tendency. An habitual abduction of 5° and adduction of 25° (in the absence of hyperphoria) could hardly be regarded as abnormal, but an abduction of 5° with an adduction of 60° or more, and esophoria of more than 2° or 3° would probably be sufficient justification for operative interference.

When there is binocular vision with a latent tendency in any direction, and a considerable relative excess of power in the muscles acting in that direction, the fault may safely be corrected by operation—tendon relaxation or tendon shortening. Relief from headaches, asthenopia, and neurasthenic symptoms often follows such operations; they are, therefore, not only justifiable, but positively indicated under such circumstances in the absence of refractive error, or where the refraction has been corrected without affording relief. A careful investigation of every case of muscular anomaly during a number of years in private practice has furnished from a material of 8,000 patients 110 cases that seemed suitable for operative interference, *i.e.*, about 1·4 per cent.; they may be classified as follows :—