

the increase of general intracranial pressure that is so great in these cases may give rise to false localising signs that are frequently on the opposite side to the lesion. As is well known, the paralysis of the sixth nerve is particularly unreliable in this respect, and I have several times seen it occur on the opposite side to the tumour. The signs on which one can most rely to determine the side of the lesion are as follows: The ataxia, hypotonia and cerebellar paresis are invariably most marked on, and often confined to, the side of the tumour. The movements of the nystagmus are slower and have a wider range in the direction of the lesion than in the opposite direction. The homolateral arm is held extended more steadily than the contralateral one. Lastly, when the patient is rotated in a chair and the movement is suddenly stopped, the sense of subjective rotation is less intense and the succeeding eye deviation and nystagmus are less marked when the chair has been rotated towards the affected side than towards the other. Here, however, as elsewhere in localisation diagnoses, care should be taken not to lay excessive stress on any single symptom, but to attach different standards of value to the different symptoms and then to make a diagnosis on the general clinical picture present.