

some acquaintance with the use of the ophthalmoscope is of great value in the diagnosis of ocular lesions, and in investigating the subject one should be certain that there are no alterations in the interior of the eye to account for the visual disturbances. It is not fitting that I should point out the value of ophthalmoscopic examinations to the trained neurologist; I do not very well see how he can dispense with them. Should he be unable to examine the fundus of the eye with the mirror he should, in all events, seek a report upon the condition of the fundus at the hands of some confrère expert in ophthalmic work. As is the case with other organs of the body, there are absolutely no tissue alterations to be found in any part of the eye, due to the presence of hysteria. A negative report upon the fundus condition is therefore, a *sine qua non* in examining a suspected hysterope.

#### ANOMALIES OF ACCOMMODATION.

Taking one age with another, the commonest ophthalmic sign of hysteria is a defect in the focusing power of the eye—anomalies of accommodation. For various reasons these conditions have been called *hysteria*, *insufficiency of accommodation*, *ciliary paresis*, *paralysis*, *painful accommodation*, *nervous astigmatism*, *opia*, etc. The patient complains of the usual symptoms of asthenopia—pain in the eyes and forehead when attempting to read or do any other near work, blurring of print, photophobia, frequent winking, etc. These cases are rarely permanently relieved by glasses or by an exclusive local treatment of the eye. If there is a defect in the range of accommodation, the so-called paresis of accommodation is nearly always in the form of a true hysteric contracture of the ciliary muscle—the motor power by which the eye is focused for various distances. The nearest point at which the eye can accommodate itself for the distinct seeing of small objects varies with the age of the individual. As you are well aware, this point is very close to the eye in childhood, remote from it in