themselves as a normal element of the disease, but only as late and secondary complications; while in the other cases where I have spoken of the existence of central nerve irritation, the occurrence of some such lesions may be looked on as almost a certainty. I have now myself under observation a case of considerable interest in its bearing on this point—that of a man of advanced age who has for many years been suffering from paralysis agitans. He is subject to periodical exacerbations, or one might almost term them acute attacks of the disease, and the curious point in his case is that at the times when these exacerbations occur an erythematous eruption is found simultaneously to make its appearance on both legs, which gradually dies out again as the severity of his other symptoms abates. Were the case truly one of paralysis we should not expect to find any such accompanying lesion.

From these considerations we may, I think, feel justified in saying that the relative value of the two forms of tremor as a pathological symptom is this:—That when the trembling is constant the case is to be regarded as one of irritation of the nerve centres (though the exact nature of this irritation still remains to be determined), while in those cases where the tremor is intermittent and excited chiefly by attempts at voluntary motion, we have to deal with instances of real paralysis, due in all probability to nerve mischief deep-seated, and, so far as our present knowledge extends, irremediable. Both classes of case present very much of interest, and a wide field for research and study, not only to the pathologist, but also to the physician; and, while regretting the very small amount of real knowledge of the subject of which the profession can at present boast, we must hope that, with the daily advance of science, we may soon obtain clearer and more definite information for our future guidance.

ART. VII.—*Symmetrical Corectopia with Dislocation of the Lens.*

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THE occurrence of this congenital anomaly is, in my experience, very rare. Of necessity my field for observation is comparatively limited in a provincial town; but, if not uncommon, I should have been sure to have seen, in many thousands of ophthalmic cases, or met in general practice, a second case of the nature here depicted,

which I have not. This has tempted me to place it on record, though I am aware that from time to time many analogous cases of eccentric pupil have been noticed, and may be found referred to in reports and ophthalmic works.

Family history.—Father and mother healthy; sight good; father addicted to drink. Eldest son in the army; sight perfect. Second son a shoemaker; sight perfect. Two younger children; in one there is extreme near sight, in the other the vision is excellent.

T. S., age eighteen. Congenital luxation of left lens outwards, lying half across the pupil; congenital luxation of right lens upwards. In both eyes the iris is tremulous. $V. = \frac{1}{60}$; with -2 sph., $V. =$ little less than $\frac{1}{3}$.

Brother, age twenty. Pupils as represented in drawing (Fig. 1).

Fig. 1.

$V. = \frac{1}{3}$; hardly improved by spherical concaves; both acted perfectly to atropia and eserine; periphery of the lens crossed the pupil at about $\frac{1}{3}$ from the outer margin, when dilated with atropia. From this I judged that the lens lay nearly, if not quite central in the eye. There is a well-marked "crescent" in either fundus.

Fig. 2.

The other drawing (Fig. 2) is of a little girl, age thirteen. Extremely hypermetropic; when about seven years of age I gave her convex glasses. I then lost sight of her, and she only again came to hospital ten days since. I dilated the pupil (with liq. gelsemiæ) to demonstrate the displaced lenses to some students, when this drawing was made; both lenses are displaced upwards and fixed; there is no tremulousness of the iris.