ness or chronicity, coupled with the fact that until recently it has generally been unsuspected, make it liable to be mistaken for a great many diseases. Intestinal lesions are apt to be mistaken for appendicitis or cholecystitis, lung and pleural lesions for empyema, and the chronic superficial lesions for the lesions of tertiary syphilis or tuberculosis. It can hardly be mistaken for either cancer or sarcoma.

The prognosis depends largely upon the site and the acuteness of the lesions. The lesions of the deeper tissues are almost always fatal. Visceral lesions are generally fatal, while superficial lesions are more promising, and indeed some superficial lesions do not seem to be very serious at all. The formation of a calcareous delimiting boundary, which is so common in the lesions of cattle, forming "lumpy jaw," is not observed in the human subject.

Treatment consists in, first, radical extirpation of the diseased tissues, where this is possible; second, curettage, with or without the application of nitrate of silver or iodine compounds in some forms; and third, iodide of potassium internally. If all the grossly diseased tissue is removed, there will be no recurrence. Curettage, while sometimes successful, is not, in my opinion, to be relied upon; and radical extirpation is a much safer procedure where it is possible. The iodide of potassium has seemed to give almost marvellous results in two cases which I have observed, but in other cases it has had no effect whatever.

Having thus briefly outlined the main facts of the disease, I will proceed to give a short resume of my personal experience of actinomycosis, mentioning only the skeleton facts of each case. Since the middle of March, 1900, I have seen nine cases in which the fungus has been demonstrated microscopically. They are as follows:—

Case I.—R. C. McL., aged 22, farmer's son, Oliver's Ferry, Ont., came under observation March 27th, 1900, for what had been diagnosed as a right-sided empyema discharging through a bronchus. Exploratory puncture failed to discover anything in the pleural cavity. On the 23rd of May portions of the 10th and 11th ribs were resected in the mid-axillary line. Adhesion of the lung to the diaphragm was found, communicating with a mass situated in the dome of the liver. This was not considered removable, and drainage was established. A portion of the mass was removed for examination. The patient developed brain symptoms on the 12th of June, and died of cerebral metastasis on the 19th. A post-mortem examination was made by Dr. Adami, who discovered the actinomyces.

This patient had had right-sided pleurisy twelve years before admission to the hospital, but had recovered perfectly, and had remained well until January 1900. The first symptoms of the final illness were pulmon-