in the tissues. This does not correspond satisfactorily with the diagrams given by Kanthack and Hewlett, or with the appearances seen in our case. Instead of a peripheral zone of clubbed rays, the diagram shows fine broken filaments, some of which radiate outward for a long distance between the cells of the mycetoma tubercle. Yet Vincent gives the usual clinical history and symptoms, and his description of the appearance of the grains obtained from the discharge out of the sinuses is fairly well in accord with what we have noted in our specimens. It is possible, therefore, that Vincent has figured an atypical and far advanced mass rather than one that is typical.

To sum up, the descriptions given by various observers are so contradictory that the time is not yet ripe to make a positive statement as to the nature of the fungus of this disease; nor, unfortunately, do we make matters clearer by our case, with its microscopical characters in general confirming the view that it is allied to actinomyces, and nevertheless, in our specimen, the certain presence of segmentations of the filaments.

Lastly a few words require to be said upon the clinical history of the disease. As with actinomycosis, so here, local injury, such as the prick of a thorn, is the common history given of the origin of the disease.[2] Bocarro found the pad of areolar tissue along the bases of the toes to be the favorite initial seat of the lesions, and, as the names given imply, the foot is the organ in general affected. Its prevalence in connection with the foot is evidently due to the habit of walking barefooted. On this continent barefootedness is the exception; in India among the rural population it is the rule. It is interesting to note that the disease in the case here reported began in the age of barefootedness, namely, before the fourteenth year, and that the first pathognomonic development was upon the pad of the toes. Nevertheless other regions besides the feet may be primarily affected. Thus of Bocarro's hundred cases in the Province of Scinde,[2] three were upon the hand, one over the shoulder-blade, one in the region of the sacro-iliac joint. As to the age of incidence, the same authority gives the period between the twentieth and fortieth years as being that of most frequent development; but on referring to his table, the greatest number per decennium is found between the tenth and twentieth years.

In general the disease has a very chronic course; cases have been recorded of twenty-six and even thirty years' duration; the usual