The patient should be seen with a full bladder, which, except in acute cystitis, is usually feasible. The anterior urethra, back six inches, should be carefully irrigated with some simple, cleansing hot wash by means of a fountain syringe hung seven feet from the floor, and a Jacque catheter, the patient standing. With a little practice this may be readily and effectively done. Two bottles are then used to receive the urine. The first represents the washings of the prostatic urethra, and therefore of the prostate and seminal vesicles, the second the washings of the bladder, and therefore of it, the ureters, and the pelves. A floating or sinking *tripper fäden* or two, with otherwise clear urine. would indicate a granular deep urethra, and in the vast majority of cases endoscopic examination will confirm this, and furnish us the royal means of at once and effectually working a cure.

It is surprising what strong solutions of silver nitrate may be so applied without any other than the wished-for result. I rarely use in such treatment a solution weaker than twenty grains to the ounce, while sixty grains to the ounce is frequently required and well borne, a striking contrast with the objectionable effects so often following one or two-grain solutions of the same salt applied by means of a Keyes or Ultzmann syringe. I use exclusively in such cases the Otis-Klotz urethroscope, which is exceedingly simple of design and easy of application. By a simple trick the straight Klotz tube may be carried clear into the bladder. It should be passed gently as far as it will go, and then, with the thumb against the obturator to prevent its ejection, the flange should be steadily and firmly depressed between the patient's thighs until the distal end will be felt to pass through the cut-off. It should then be steadily pressed onward until the flange has packed the penis up against the symphysis pubis, and then the obturator withdrawn and the Otis lamp coupled on. The bladder being not wholly empty, a stylet armed with a bit of cotton should be used to remove the few drops of urine present, and the examination and subsequent application are but simple matters of detail. I have frequently by such procedure seen into the trigone. Proper care should be taken to limit the application to the deep granular parts. Silver nitrate is usually the agent used. Of late I have seen good results follow the use of Schering's argentamin.

If, as is however frequently the case, the entire volume of urine is cloudy, in the majority of cases the trouble is cystitis, the parts involved being the prostatic sinus and the trigonal region. Finger is the only authority with whom I am familiar who denies the existence of gonorrhœal cystitis. Ignoring here all discussion of all the good that follows the internal administration of anti-blenorrhagics and diluents, I desire to express my conviction that nothing will so speedily and so effectually cure this condition as persistent daily bladder-washing. Of the agents relied on for accomplishing this end I may mention as best, saturated solutions of boric acid, potassium permanganate solutions, two to four grains to the pint, silver nitrate, one-half grain to the ounce, bichloride of mercury, 1 to 20,000 solution, and one-per-cent. trikresol. These are average strengths. The same method used in anterior urethral irrigation is used here, except that the catheter is carried into the bladder. Half a pint is injected and allowed to escape through the catheter, then, the second half-pint being introduced, the catheter is withdrawn and the patient allowed to void it naturally. Sometimes it is well to leave the second half, if mild, in the bladder for an hour or more.

The differential diagnosis between ureteritis and pyelitis is hardly possible. It should here, however, be borne in mind that those portions of the bladder, other than the trigonal region, are rarely, if ever, involved, and also that the location of the urethral orifices and the character of their epithelial lining both favor gonorrhœal extension. Unless speedily cured by internal medication it is probably only a question of time when gonorrhœal inflammation of the ureters will extend to the pelves. Topical treatment of the ureters in the female has recently been successfully accomplished by Dr. Howard A. Kelly, and also in the male with the aid of the cytoscope by Dr. James Brown, of Baltimore, and Nitze and Casper, of Germany. This procedure, however, so far as the male urethra is concerned, can hardly be considered practicable for other than exploratory purposes. In the instances wherein it has so far been attempted, the object has been to determine the condition of the kidney to be left in a contemplated nephrectomy.

Many a sufferer from pyelitis has had his healthy bladder washed for months, and not a few have submitted to cystotomies for the cure by rest and drainage of a cystitis that did not exist. The modern revival of suprapubic cystotomy has much increased the frequency of this blunder due to faulty diagnosis. If it has accomplished no benefit for the patient, it has at least taught the surgeon a valuable lesson in diagnostic art.

There are several symptomatic features that are common to both pyelitis and seminal vesiculitis. Of these, two are prominent; first the obstinacy with which they persist after the most thorough topical treatment of prostate and bladder, and, second, their intermittent character, that is, their proneness to improve again and again to a point of apparent cure only to relapse in a day or two to their old state of pronounced pyuria. Fortunately these features eventually narrow down our diagnostic work to these two diseases, and equally is it a matter of gratulation that the differentiation is a comparatively easy task. Of course there are other conditions, such as tuberculosis, neoplas-