

And in 22 cases of chronic cystitis, Dr. Brown found—

<i>B. coli communis</i>	11 times
<i>Staphyloc. pyogenes aureus</i>	3 times
“ “ <i>albus</i>	2 times
<i>B. coli communis</i> (with tub. bac.)	1 time
Unidentified (possibly a variety of <i>B. coli</i>)	1 time
<i>Pyuria sterile</i>	2 times
A <i>staphyloc. albus</i> (which, decomposed in urea, was pyogenic, but either did not liquefy gelatine or did so extremely slowly)	2 times

There were also six cases of tuberculous cystitis.

Compare these findings with those of Melchior, and you will find the similarity is in some respects a striking one. (Fr. VIII., 291.)

Melchior examined 36 cases of cystitis (17 women) and found—

<i>B. coli communis</i>	25—17	pure cultures.
<i>Streptococ. pyogenes</i>	5—3	“
<i>Proteus Hauser</i>	4—1	“
<i>B. tuberculosis</i>	3—2	“
<i>Diplococ. ureæ liquef.</i>	3—2	“
<i>Staphyloc. “ “ Lundstrom</i>	3—1	“
<i>Streptobac. anthracoides</i>	3	“
<i>Gonococ. Neisser</i>	1	“
<i>B. typhus</i>	1	“

The great importance to be attached to a study of the etiology of cystitis is the discovery of several factors easily within our control, notably the traumata. By recognizing this fact we can do much, in many instances, to prevent a cystitis.

The most important group opened up by bacteriological study of the urine is that of the tubercular cases, which, as a rule, call for the more aggressive plans of treatment.

I will pass over the pathology, simply noting two important facts which bear powerfully on the treatment of cystitis.

First, that the disease is sometimes purely superficial, being seated only in the mucosa, while at other times it extends deep down, even into the muscularis.

Second, the disease is often localized in a few well-defined patches; it is rarely universal.

The following clinical forms may be recognized, apart from the determination of the infecting organism or organisms:

1. Catarrhal, involving the superficial mucosa.
2. Desquamative.
3. Ulcerative.
4. Granular.
5. Papillary.
6. Bullous edema.