Surgical Treatment of Cystitis.—It is in the surgical treatment of cystitis that the greatest difference is found between our practice and that of our immediate predecessors, of even a decade ago. And it is here that I have some fresh additions to make, in the description of methods which have brought some utterly rebellious cases entirely within the scope of successful treatment.

There are two kinds of vesical surgery, minor and major.

Minor cystic surgery consists in the use of a sharp or serrated curette, or a wire brush, or a bunch of fine wire needles. I expected great help from these instruments when I began to use them, but I must confess to disappointment in the issue. The tissue removed is of value in differentiating a tubercular bladder, but I cannot see that the recovery is hastened, while harm may be done, as Sampson has shown, if the ureteral orifices are injured, by favoring an ascending infection.

Major Surgery.—When I receive a case of intense vesical inflammation, where all local treatments, even the mildest, are impossible on account of the pain produced, I, without loss of time, resort to major surgery, and propose, at the outset, to put the bladder at rest by making the Parker-Emmet incision, in order to secure good continuous drainage. I do this in a few seconds, often by putting the patient in the knee-chest posture and letting air into the bladder through the urethra; then lifting up the perineum the anterior vaginal wall is exposed and lifted a little on a pair of curved artery forceps, introduced through the urethra and slightly opened. A knife is plunged through the septum at this point, and the opening enlarged fore and aft until it is at least an inch long. I wipe out the bladder thoroughly with dry gauze, and sew the vesical mucosa to the vaginal at about six points, to prevent too rapid closure of the wound. All this takes about the same time to do as it does to describe the operation.

Such an opening ought to be left, as a rule, for from three to six months. The bladder and vagina should be irrigated every day either *per ureithram,* if not too sensitive, or *per vaginam.* A continuous daily hot water bath, as recommended by Hunner, leaving the patient immersed for hours, is a most valuable adjuvant in the worst cases. In due time the bladder will be found to have cleared up, perhaps wholly, when the fistula is closed, and the patient discharged. On the other hand, many cases clear up only to a certain point and go no further, and of these I wish to speak somewhat particularly, for this is that large residual group of our worst cases of cystitis, generally looked upon as hopeless.

Let me briefly outline the treatment of such a case. In the