of the interstitial nephritis has been divided mainly between two schools: the one considers it the outcome of a low grade but progressive inflammation, while the other believes it the result of a primary circulatory disturbance with a secondary atrophy and replacement fibrosis. Unfortunately the issue has been somewhat confused by the further introduction of the terms primary and secondary interstitial nephritis. Each group claims that their explanation is adequate for the so-called genuine contracted kidney. We would do well to drop such irrelevant terms and leave the application of a new nomenclature to him who clearly indicates the pathological sequence of events concerned in chronic interstitial nephritis.

Gull and Sutton considered the relationship of the arteries to the diseases of the kidneys as a peculiarly intimate one in which the arterial processes preceded and determined the interstitial nephritis. No agreement was reached by subsequent workers of the actual nature of the arterial disease, some viewing it as an endarteritis (Thoma), others as an hypertrophy (Johnson, Ewald, Friedmann), while the subsequent work by Prym and Jores drew attention to the arterial lesion as a true arteriosclerosis. Jores, furthermore, contended that the associated arterial changes in other organs, as was described by many, was also an arteriosclerotic process. The differentiation of this process rested upon the finding of deep arterial degenerations associated with a splitting of the internal elastic layer. As Jores, however, observed, arteriosclerosis may occur in the arteries of other organs in the absence of sclerosis of the renal vessels.

While the above authors were contending the dependence of chronic nephritis upon disease of the bloodvessels, Ziegler maintained the differentiation of types of chronic nephritis into groups associated or unassociated with arteriosclerosis. Those kidney lesions resulting from arteriosclerosis he believed to be individual and of a purely degenerative character, and designated them the arteriosclerotic kidney.

Both Jores and his pupils repeatedly remarked that chronic interstitial nephritis is a disease most frequently encountered in advanced life, a period when arteriosclerosis is also most prevalent. Nevertheless, they remark upon the finding of occasional cases in which they have been able to demonstrate advanced renal sclerosis unaccompanied by arteriosclerosis within the kidney. This agrees with the finding of Orth, who believes that in chronic interstitial nephritis the vascular changes are not essential because their variety does not correspond with the extent of the lesions. Roth described a number of cases in which renal sclerosis was advanced, but in which the arteries did not show the type of sclerosis defined by Jores as arteriosclerosis. He did, however, find that the arteries were affected by a connective-tissue thickening of the intima with