

Melchior examined 36 cases of cystitis (17 women) and found			
<i>B. coli communis</i>	25—17	pure	cultures.
<i>Streptococcus pyogenes</i>	5—3	“	“
<i>Proteus Hauser</i>	4—1	“	“
<i>B. Tuberculosis</i>	3—2	“	“
<i>Diplococ. ured liquef.</i>	3—2	“	“
<i>Staphyloc.</i> “ “ <i>Lundstrom</i>	3—1	“	“
<i>Streptobac. anthracoides</i>	3	“	“
<i>Gonococcus Neisser</i>	1	“	“
<i>Typhus b.</i>	1	“	“

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

The most important group opened up by a bacteriological study of the urine, is the tubercular cases, which as a rule call for 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 to a few well-defined patches; it is rarely universal.

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

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

The divisions into acute and chronic, separate the cases according to duration and intensity of symptoms.

DIAGNOSIS.

A diagnosis of cystitis may be made when pus is found in the urine, in association with an inflamed area in the bladder; this latter may be inferred by symptoms such as pain and frequent urination, or by a direct visual examination of the interior of the bladder.

I must bear in mind that my remarks may fall into the hands of some very busy practitioners who may find it hard to get time to use