or seemed to be an obstruction you would cut down onto it, and these patients got well if you removed the tumor. Such cases were accidental. We started seven years ago taking up these cases of tuberculosis of the kidney and subjecting them to cystoscopic examination. Dr. Millett has done a good deal of good work with the cystoscope. This is the result. He has found that 85 per cent. of the cases of tuberculosis of the kidney are still confined to one kidney.

When the second kidney becomes involved, the disease works much more rapidly than in the first. The patient is generally in good condition. He still has great powers of recuperation.

The patients come in and say that they have some trouble with their bladder. They have to get up often to micturate in the night. The urine looks dirty. If you tell him to bring you some he may say "I got this the day before yesterday;" or, if you happen to leave the bottle on your stand, it continues to look dirty instead of settling. It is dirty urine. Most any other kind would tend to settle. Now perhaps you get a history that he passes some blood, then this frequent micturition. You question and find usually that he has more pain on one side than the other, and in 85 cases out of 100 the disease is still in one kidney, because when the other kidney becomes infected he goes to pieces so fast he cannot get to anybody. You put in the cystoscope and you notice that the vicinity of one ureter has papules, while the other side is perhaps clear. Having made your diagnosis, having ascertained that the other side is clear, you will read the history. While in one kidney there will be nothing microscopic, around the other kidney there is hardly a section that will not show that there is tuberculosis. What shall we do about the ureter? We have had six or seven of these cases, and we have simply put in six or seven m. of pure carbolic acid and tied it off. It can be compared to an elastic tube. Either fill it with pure carbolic acid, 10 or 15 m., or take it out. You take the kidney out from the back, and leave it hang down back. Loosen it down as far as you can. Turn the patient back as far as you can. Make a little incision. If you find the ureter. If you cannot find it, have someone assist you. Get hold of the ureter and strip; now keep pulling and stripping; keep pulling back and the entire ureter will come out. When you get down to this point, use a catgut suture, and put two stitches in the bladder and sew it up like a hole made with a knife. Don't take out half of the ureter. I don't know of any more pernicious practice. They say, "Well, I did not take out all of the ureter; I left as much as I could." If you are going to leave the ureter, leave it where it is. If it don't heal up, don't leave it where it will spue its contents into the pelvis. I have seen these cases come in with fistulas in all the surrounding parts, simply from