that seen on previous admission. All manifestations of uremia and acidosis disappeared under treatment. The acute exacerbation of the nephritis subsided but the chronic nephritis persisted.

C. Uremia with progressive renal insufficiency, as exemplified by—

Collins, a young negro, twenty years of age, admitted to the hospital for chronic nephritis. On admission the renal function was fair. Functional studies were made at weekly intervals. Each examination revealed a slightly greater reduction of renal insufficiency. The patient showed a step ladder descent into absolute renal function and died a typical death in uremia. The proximity of uremia was known to us long before any clinical manifestations appeared.

D. Chronic stationary uremia.

A man was re-admitted about one year after his discharge from the hospital with a zero phthalein output. Nausea and vomiting were present from time to time throughout this entire year. The patient died on second admission with an exacerbation of his chronic uremia.

5. According to the predominance of functional or organic changes, it is extremely important to recognize whether the case is one in which the uremia is due to organic or functional changes. The development of uremia in a case of marked chronic interstitial nephritis offers little in a permanent way as a result of treatment, whereas in an identical clinical picture encountered in back-pressure kidney such as seen in cases of enlarged prostate the prognosis may be good. This is familiar to the surgeon but not as a rule to the internist. I have known of several instances where the internist and surgeon have differed as to prognosis. Following the use of