sore throat is handled, making a direct strong application by means of an applicator and a pledget of cotton. Nitrate of silver is best here, used over a small area as strong as 50 p.c. For larger areas 10 or 5 p.c., taking care that there is no excess of the solution to run down over the sound mucosa. I also use freely a 10 p.c. solution of argyrol. Subsequent treatments must be milder and at intervals of from three to seven days. A 1 and a 2 p.c. solution is often valuable in trigonal inflammation (trigonitis).

An admirable effective combination is formed by associating occasional topical treatments with daily injections and distentions.

*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, bringing some utterly rebellious cases entirely within the scope of successful treatment.

There are two kinds of surgery, minor and major.

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