UROTROPIN IN THE TREATMENT OF CYSTITIS.

Kelly (*Therapist*), realizing that cystitis is due to the invasion of the bladder by micro-organisms, says that the first indication for treatment is to render the urine antiseptic. For this purpose he has tried, with a certain amount of success, salol, ammonium benzoate, guaiacol, resorcin, benzonaphthol, sodium salicylate, creasote and other preparations. They are all helpful in making the urine antiseptic, but no one of them has given him the complete satisfaction which he has had from the use of urotropin, a non-toxic and non-irritating derivative of formic aldehyd. It is formed by the action of four molecules of ammonia on six molecules of formaldehyd, and was first introduced to the profession by Nicolair in 1895, who asserted that it possessed the power of dissolving uric-acid concretions, and also that, taken *per ora*, it prevented the development of bacteria in the urine. In cases of phosphaturia and cystitis its action is almost a specific one. It appears in the urine as early as fifteen minutes after its administration, and its presence can be recognized twelve hours later after a dose of 7½ grains. It is soluble in 1.2 parts of water at 68° F., and the reaction of its solution is faintly alkaline.

If the condition of the patient is a very bad one large doses of the drug should be given, as much as 20 grains twice a day; and if the urine is strongly alkaline, a little dilute mineral acid should also be given until the reaction is improved. Kelly gave these remedies to a man aged thirty-five years, who had suffered for a long time with cystitis. Nine days from the beginning of the treatment the urine became clear and slightly acid, and in fourteen days it was free from pus. This was the first time in fifteen years that he had passed clear urine. The dose of the urotropin was gradually diminished, and discontinued altogether in a couple of months. There was no return of the trouble.—*Med. News; St. Louis Med. and Surg. Journal.*

SYPHILITIC SCARS.

Geo. Henry Fox points out (*New York Medical Journal*, April 8) that these secondary lesions remain as a permanent record of the disease for diagnostic reference. While there is nothing absolutely characteristic in a single, small, rounded, smooth, white, depressed cicatrix—the number of these, their location and peculiar, grouped or semicircular arrangement "often proclaim their origin beyond all shadow of a doubt." When a group of these is situated upon the upper