wherein the ultimate result depends more on the *cardiac* than the *renal* involvement.

In tumors, on the other hand, *when once the diagnosis is made*, the case belongs to the surgeon—the physician's only role being to assist in the palliative treatment of inoperable cases. I have said *when once the diagnosis is made* advisedly, because tumors are seldom recognized as such at first, the patient's attention being usually early directed to the *pain* or *hæmaturia* for which he applies to the physician for relief. The latter must therefore be prepared to appreciate the significance of these symptoms, and if unable to arrive at a diagnosis, to avail himself of the assistance of X-ray examination, cystoscopy, ureteral catheterization, ureteral meatoscopy, etc. Even in cases where surgical technique is necessary for diagnosis and where surgical operation offers the only hope for eradication of the disease this preliminary investigation by the physician should not be undervalued, as the results obtained will depend not only on the local lesion, but are often determined by the general condition of the patient, such as the state of the heart, the arteries, the blood, and the renal capacity—factors which the physician's training enables him to more accurately appreciate in their bearing on the particular case. This, it appears to me, is too often lost sight of, to the detriment of the patient.

In tuberculosis the delimitation of territory is still debated though at the present time the trend of opinion is unquestionably in favor of nephrectomy as soon as a diagnosis is made unless precluded by widespread dissemination of the disease or involvement of the other kidney. It is a curious fact that in this disease surgeons often take the more conservative view, while physicians are among the strongest advocates of radical measures. *A priori* one might naturally have looked for better results from general methods, tuberculin, etc., in the management of renal tuberculosis, but both clinical and pathological evidence go to prove that complete eradication apart from nephrectomy is so uncommon and the ultimate results are usually so bad, that one is not justified in counselling reliance upon medical treatment alone. The earlier the condition is recognized and the more localized the lesion the more strictly surgical must the case be considered. Contrary to the teaching of former times more recent investigation in which cystoscopy and ureteral catheterization have been of the greatest value, has shown that *hæmatogeneous infection of one kidney* is the *usual primary condition*, and that the ureters and bladder are secondarily involved. The other kidney in time is likely to be implicated or more general dissemination