

doctrines of syphilization were in vogue, believing himself protected, after having produced a dozen chancroids, he inoculated himself with matter taken from the ulcerated tonsils of a syphilitic friend. This was followed on the eleventh day by a papule (not a pustule, as after the previous inoculations). The papule ulcerated slightly, and in forty-five days a general syphilitic eruption appeared. The doctor now recommenced his inoculations with chancroid matter, and when last heard from was still continuing, then having reached the twenty-seven-hundredth successful chancroid ulcer. Warnery, of Lausanne, under the same "syphilization" delusion, inoculated himself plentifully with chancroids, which took, but produced only local ulcers. Finally, he employed the syphilitic virus once, and an indurated chancre appeared after twenty-three days' incubation, followed by syphilis in due course. Danielsen, a disciple of syphilization, inoculated a man, who had elephantiasis, two hundred and eighty-seven times with chancroid, until he had temporarily exhausted the irritability of the skin, and no more chancroids could be produced by inoculation. In other words, the patient was "syphilized," as it is called. Now, one inoculation was made with true syphilitic virus. An indurated, syphilitic chancre appeared, and in sixty-eight days a general syphilitic eruption followed. Since then very little has been said by its advocates of "syphilization" as a prophylactic.

The course of syphilitic chancre observed by hetero-inoculation is briefly as follows: A chancre is always produced with or without ulceration, a mucous patch never, although certain published observations state the contrary. A strict analysis of these cases proves that they commenced as indurated chancre, and became mucous patches only secondarily after an interval. The first result of hetero-inoculation has often been a pustule, just such a little fester as might appear after the prick of a pin, but this pustule heals entirely in a few days. It is accidental, and in most instances nothing remains to mark the inoculated point except the dried speck of blood. This finally rubs off, and the skin becomes absolutely normal. No change occurs for a period varying from ten to thirty-nine days in the reported cases. Then the first signs of chancre appear, not as in chancroid by a pustule, but as an indurated papule (which, becoming larger, may be called a tubercle), of a dark, vinous-red color, without pain, or perhaps with a little itching. This may remain dry, being covered after a while by a scaly crust, or may, and usually does, ulcerate after a few days, often scabbing secondarily. The epidermis may raise as a pustule before ulceration. The ulcer has sometimes been noted as appearing from the first, but usually at a mean of five days after the papule. It persists for a variable period, several weeks, possibly months, and, getting well, leaves often a pigmented cicatrix behind. The neighboring lymphatic glands indurate, do not suppurate, and general syphilis follows.

This is the course with no appreciable variation, no matter what fluid

is inoculated—chancre secretion, pus from mucous patch, blood, or other discharge.

An apparent exception to the above course exists for vaccinal chancre, where chancre-virus or syphilitic blood is introduced along with vaccine virus. Here the vaccine virus, having a shorter incubation than the syphilitic, develops sooner, and the vesicle runs along regularly, perhaps, at first, but varies from the true type after a time, in that the base indurates and the surface ulcerates; or, perhaps it may scab, the whole resembling a large, scabbed, ecthymatous pustule. Sometimes only the syphilitic virus takes, when, after a longer incubation, the regular papulo-tubercle of syphilitic incubation appears and runs its usual chronic course; or the vaccine vesicle may be imperfect and abortive, the sore soon putting on the appearance of a cutaneous chancre, and general syphilis following in due course.

There is one source of error in regard to vaccinal syphilis; namely, that the vaccinal fever may develop latent, possibly unsuspected, syphilis from which a child is already suffering by inheritance, or previous contagion. Here the vaccination will always be accused of being the cause of the syphilis. The distinction is easy. If vaccination develops latent syphilis, it does so as does the application of a blister or other irritant, and a more or less general eruption comes on quickly, usually starting from the point of irritation, vaccinal or other; whereas, in true vaccinal syphilis, there is first a period of incubation, then a local chancre, then indurated glands, and after a second incubation a general (at once) syphilitic eruption, which does not tend to start from the irritated point. Chancres of inoculation are of course liable to the same complications as chancre naturally acquired.

When the inoculating fluid is rubbed upon a scarified, or a blistered surface, the lesion appears multiple at first, many little papules springing up in the patch, as if many separate points had been simultaneously inoculated, which is indeed the case; these, however, soon coalesce into one mass, forming one lumpy, tubercular chancre-patch. This explains at once how syphilitic chancre may be multiple, several different points having been inoculated at the same or nearly the same time.

MULTIPLE INOCULATION.—In testing this point it has been found that, where many points were inoculated at the same time, usually all took and appeared simultaneously as chancres. Where the intervals of inoculation were a few days apart, upon the same individual, nearly all took. Puche inoculated twice at twenty-two days' interval; chancre appeared upon both points at the same time. In other cases the second inoculations have appeared to require a longer incubation than the first. Again, inoculations made upon different individuals, with virus derived from the same lesion, have required different periods of incubation for their development.

These apparent exceptions to the fact first noted by Hunter, that

syphilis was not reinoculable upon an already-infected person, are still further borne out by the results of other experiments, such as those of Wallace, who produced an indurated chancre by using chancre-virus upon a man who had reached the eruptive stage of the disease. Wallace, Bidentkap, Sperino, Lee, and others, have performed auto-inoculation soon after the appearance of chancre, in some cases with success, producing a small, ill-defined, indurated chancre, usually with short incubation. Fournier and Puche believe that about two per cent. of auto-inoculations of syphilitic chancre take, presumably when some irritation (inflammatory) of the chancre exists, but the vast majority, especially where the chancre is fully developed, yield only negative results, and in no case does the auto-inoculation of syphilitic chancre produce the pustule and rapidly-advancing characteristic ulcer known as chancroid.

The rule, then, is practically this: reinoculations of syphilitic virus upon patients already syphilitic produce no result. Auto- or hetero-inoculation upon a patient with very young chancre is occasionally successful. A more constantly favorable result might be expected from hetero-inoculation during the late tertiary stage of the disease. At both of these periods the patient is not fully protected, the system not being saturated with the syphilitic poison at first, and the virus being at a minimum toward the end. Between these periods very rarely will reinoculation of any syphilitic virus produce any effect, although an irritative ulceration may be produced in some subjects by the inoculation of any inflammatory pus, and chancroid is inoculable at will in its full vigor on all subjects.

This subject finds an apt and analogous illustration in the results of inoculation with vaccine virus. Any number of such inoculations made at the same time may take fully. Reinoculations practised before the first inoculation has taken or while the vesicle is young, will also yield positive results, but to a less degree. Then, while the protecting power of the virus lasts, the result is invariably negative, or only abortive pustules are produced (false takes). Finally, after a variable period the protection becomes weak or exhausted, and inoculation produces a partial or even perfect result.

Secretions capable of transmitting Syphilis by Inoculation.—This subject has been carefully studied by inoculations, as well as clinically by confrontations, that is, by examination of the individual from whom a given patient acquired his syphilis, and comparing the lesions. The first confrontations of syphilitic chancre were made in 1852, by Bassereau.¹ Later, the confrontations of Diday, Rodet, Fournier, Clerc, Musset, Rollet, were published by Dron.² Fournier³ followed, and numerous other contributions, since made, furnish in all a very full collection from which to draw deductions. The results arrived at have been identical.

¹ "Des Maladies de la Peau symptomatiques de la Syphilis," Paris.

² "Thèse de Paris," 1856.

³ Ricord's "Leçons sur le Chancre," 1858.

Inoculations of healthy subjects with the fluid secreted by syphilitic chancre, mucous patches, any secondary cutaneous, or mucous lesion, yielding a discharge, and of syphilitic blood (Pellizari; Waller, Lindwürm) drawn from a patient with an eruption, taken either from a papule or tubercle, or from the healthy skin between the lesions—all such inoculations yield indurated chancre after a period of incubation, which chancre is succeeded by general syphilis. Whether the blood of syphilis is poisonous in the intermediary periods between the eruptions, when the skin and mucous membranes are sound, is not yet established, but certain observations of vaccinal syphilis would go to prove that it is.

The secretions of other pathological lesions, not syphilitic, will not produce syphilis unless some of the patient's blood be inoculated at the same time. Gonorrhœa, acquired from a syphilitic patient having at the time only gonorrhœa, reproduces itself as gonorrhœa, and not as syphilis. The same is true of chancroid, even by inoculation, if no syphilitic blood be inoculated along with the pus. Certain confrontations and inoculations of mixed chancre go to prove that from such a sore may be derived either simple chancroid or mixed poisonous chancre. Diday inoculated pus from a pustule of acne produced upon a patient "in full syphilis," by the administration of iodide of potassium. The result was negative. The same is true of the vaccine virus. Pure vaccine virus, taken from a syphilitic patient before there is any pus in the vesicle, will produce vaccinia only, if no blood is inoculated. This is well shown in some of the vaccino-syphilitic epidemics, where many children were vaccinated at the same sitting, from the same child, the virus being taken from arm to arm. Often, in such cases, the result has been that those first vaccinated developed vaccinia only and no syphilis; others a little later, when the virus was giving out, developed vaccinia, followed by indurated chancre on the same spot, usually before the vaccine pustule got well; finally, those last vaccinated developed only an abortive vaccine vesicle or none at all, while indurated chancre appeared after incubation upon the vaccinated spot, and general syphilis followed. All the controversy on vaccinal syphilis cannot be reproduced here. Suffice it to say, syphilis can be communicated by vaccination, but only where blood has become mingled with the vaccine lymph, or where a true chancre lies hidden under the vaccine vesicle and mingles its discharge with the vaccine lymph. If pure lymph be taken early, neither does chancre follow at the vaccinated point, nor syphilis afterward; but, since a little blood may readily be mixed with the lymph, and not be perceived, no amount of caution is too great, and in no case should vaccine lymph, derived from an individual even remotely suspected of being syphilitic, be employed. If not the lymph, much less should the vaccine scab be used, as it necessarily contains, besides vaccine lymph, both pus and blood, and a portion of the solid tissue of the skin of the individual from whom it was taken. Inoculation has failed to produce positive results from ulcers of the

late tertiary period of syphilis. Diday¹ inoculated sixteen times with blood from patients suffering from tertiary syphilis (nodes), always with negative results. The fact that patients with tertiary syphilis may occasionally acquire a chancre and the earlier eruptions anew, and the other undoubted fact that such patients may procreate healthy offspring, render it still more certain that late tertiary syphilis is no longer either communicable or transmissible. Bumstead² mentions one case of probable transmission of syphilis by inoculation from blood in the tertiary stage. The victim was a surgeon of Ohio, who reports that he inoculated an abrasion on his finger while operating upon a case of syphilitic necrosis of the skull. Chancre and general syphilis followed in due course. As for transmission, on the other hand, patients who have positive tertiary symptoms undoubtedly procreate diseased children sometimes, just as they as certainly often produce healthy ones. Hence, tertiary syphilis may be said to be generally, but not always, free from the dangers of transmission and of communicability. The older the disease, the less apt it is to be transmitted. The male loses the power of transmission seemingly before the female.

None of the physiological secretions or excretions can produce syphilis by inoculation. Mucus from the mouth or vagina may be inoculable, if any syphilitic lesion (chancre, mucous patch) exist upon the membrane from which the fluid is collected, otherwise the result is invariably negative. The same has been proved by experiment to be the case with tears, sweat, urine, semen, milk. Milk from a syphilitic woman is neither inoculable experimentally, nor does it give the disease to the child who drinks it. Apparent infections by milk, without any recorded primary lesion (Melchior Robert, Lane, Parker, Mahon, Bell, and others), are set off by other carefully-observed cases, where children suckled by a syphilitic nurse have escaped disease, even where the nurse had a specific lesion of the nipple (Dugés, Ricord, Cullevier, Nonat, Vernot, and others). Where the nurse has a syphilitic lesion of the nipple, the child surely becomes poisoned, if it have a fissure or other abrasion of the lips through which the poison can be absorbed; but in such case syphilis in the child is always preceded by chancre of the lips or mouth.

Semen, although not inoculable, is believed sometimes to contain the germ of the poison, infect the ovule, through it the child, and through the child the mother.

METHODS OF TRANSMISSION OF SYPHILIS.—Syphilis always commences as a chancre, with two exceptions:

1. Inherited syphilis. If the father be syphilitic and the mother healthy, the child seems sometimes to escape infection, probably because at the moment of impregnation the virus in the father, either from the effect of treatment or from a natural lull in the disease, was not in a

¹ *Gazette Médicale*, 1849.

² Referring to *Medical Times and Gazette*, August, 1861.

state of activity,¹ or because he had advanced too far into the tertiary stage to be able to transmit it.² Fathers with tertiary syphilis certainly, as a rule, where the mother is sound, procreate healthy children, as far as syphilis is concerned. Where the mother and father are both diseased in the earlier stages, the child is invariably syphilitic. Where the mother alone has syphilis (except in the later tertiary form), the child is also always infected, unless the mother is under treatment.³ Ricord and Baerensprung believe that the child is rarely if ever infected, if the mother acquire her disease after the seventh month of pregnancy.⁴

2. Where a mother becomes poisoned by carrying a syphilitic child in her uterus, the germ of the poison having been communicated to the child through the spermatozoon of the father, the mother having no chancre. That this method of infection occurs is doubted by some high authorities.⁵

Chancre is produced wherever upon the human body the syphilitic

¹ Hippolyte Mireur has collated the evidence on the subject under discussion in an admirable essay, "Sur l'Hérédité de la Syphilis," Paris, 1867. He leans toward the belief that, if the mother escape, a syphilitic father cannot produce a syphilitic child. He gives the following case (page 26): About a year after contracting chancre, followed by well-marked secondary symptoms, which had disappeared entirely under treatment, M. C— married. Ten months afterward his wife was delivered of a vigorous, healthy child, "the image of his father," who remained perfectly well up to the age of two years. At this date a little indolent erosion appeared upon the lip of the father. The latter paid no attention to it, but continued to fondle and kiss his child. After a time there appeared upon the lip of the child a livid, indurated excoriation, one centimetre in diameter, accompanied by indolent bubo under the jaw. After a time, in spite of treatment, the child developed a characteristic syphilitic roseola and mucous patches at the anus.

² Mireur (page 91) relates the case of a syphilitic mother and father, where the disease ran its course without specific treatment. After two miscarriages and a still-birth at term, the fourth and fifth children were born alive, but developed syphilitic eruptions shortly and died. The sixth and seventh children were born healthy and continued well, notwithstanding the fact that both father and mother had subsequently "gummy tubercles and ulcers scattered abundantly over the extremities," for which they finally placed themselves under specific treatment.

³ In Thurman's case (*Journ. de Méd. et de Chir.*, Toulouse, October, 1851), two syphilitics were married. Both had been treated, apparently recovered, and never afterward, while under observation, manifested any symptoms of syphilis. Seven children were born, became covered with a syphilitic eruption, and died. Pregnant for the eighth time, the mother was brought under the influence of mercury. The child was born healthy, and grew up sound. Pregnant for the ninth time, the treatment of the mother was repeated, a healthy child resulted, who remained well. Pregnant for the tenth time, treatment was neglected. A child was born, seemingly well at first, who developed a syphilitic eruption, and died after six months. In her eleventh pregnancy the mother again took mercury. A healthy child was born, who remained well.

⁴ In Chaballier's case (*Journ. de Méd. de Lyon*, May, 1864), Madame X—, at the end of the seventh month of pregnancy, had intercourse with her husband, who had been traveling for five months. Thirty-eight days afterward (during the ninth month of pregnancy) Chaballier found three indurated chancres on the vulva. The child was born at term, seemingly healthy, and was immediately given to a healthy wet-nurse. One month after confinement the mother left her child to join her husband on his travels. At the end of six weeks Chaballier was called to see the infant. He found it covered with a papulo-vesicular eruption, with intense coryza, and mucous patches on the scrotum and in the mouth. At the same date the mother, while traveling, developed mucous patches at the vulva and anus. The child died.

⁵ Sturgis, of New York, "Hereditary Syphilis" (*New York Medical Journal*, July, 1871), has again collated the evidence, endeavoring to show that syphilis in the child depends solely on syphilis in the mother, syphilis in the father being a matter of no importance, so long as the mother does not become directly diseased by him.

virus contained in the secretion of chancre, in blood, or any secondary syphilitic lesion, is brought within reach of the absorbents, by being placed upon a surface deprived of epithelium. That it may make for itself a way through the tender epithelium of mucous membrane, if left long enough in contact with it, as does the poison of chancroid, has not been proved, but, from certain cases, seems highly probable. It cannot get in through the epithelium of the skin without an abrasion of the latter.

The methods of contagion are immediate and mediate. The latter method is much more common for syphilis than for chancroid, owing to the numerous lesions of all parts of the body capable of secreting the poison, their long duration, and apparent insignificance. Hence syphilis is very often transmitted by means other than sexual contact. Surgeons and accoucheurs get chancre of the fingers by inoculating abraded spots in the exercise of their professional duties. Chancre is not infrequently transmitted in kissing, a little mucous patch in the mouth of one party poisoning any fissure on the lips of the other with which it may come into contact. Both of these methods are immediate.

CASE XLVI.—A young gentleman brought his sweetheart to be treated for a hard, excoriated, globular lump upon her lip, which failed to get well under the assiduous care of a homœopathic physician during many weeks. The lump was as large as a cherry, and very hard, as were also the sub-maxillary glands of the same side. The surface of the lump was excoriated, bleeding, tending to scab. It got well promptly under the internal administration of mercury. The young gentleman had mucous patches in his mouth. The couple were married, and the young lady subsequently aborted.

Children acquire chancre of the lips from nursing-women with mucous patches of the nipple, and, on the other hand, healthy nurses get chancre of the nipple by suckling children with inherited syphilis, who have mucous patches of the lips. In this way nurses have been accused of giving syphilis to their nurslings, when the truth was, that they (the nurses) received the disease from the children. Colles's law, that a child with mucous patches of the mouth cannot produce ulceration of the nipple, if it sucks its mother, depends simply upon the fact that its mother already has syphilis before the child is born, and consequently cannot get a new chancre of the nipple.

Many interesting examples of mediate contagion have been recorded. Puche speaks of a gentleman with a long prepuce, who, after marriage, encountered an old mistress, with whom he had intercourse. Returning home shortly, without having washed, he repeated sexual intercourse with his wife, depositing the virus from his prepuce in her vagina. He escaped, but, in due course, she developed chancre and general syphilis.

A similar authentic instance is related of a woman who proved unfaithful. Her husband, embracing her shortly afterward, relieved her of the poison left in her vagina by her lover, himself developed chancre, while she escaped.

Smokers of a pipe sometimes get chancre of the lips, the virus being

deposited upon the mouth-piece of the pipe by some previous smoker, who had mucous patches of the lip.

CASE XLVII.—An old, gray-headed man came into the hospital with an extensive indurated ulcer upon his upper lip. This, it was found, he had acquired by smoking the pipe of a friend, who had mucous patches. General syphilis of a severe type succeeded.

Glass-blowers get syphilis in the same manner, as they work in sets of three at the same tube, passing it from mouth to mouth. Syphilis sometimes runs through a whole family, from the use of the same spoons or cups, passed from one mouth to another. Washer-women become infected in cracks of the fingers through the virus contained upon soiled clothes. Wet cups¹ once started an endemo-epidemic of syphilis. Transplanting teeth has proved another source of mediate contagion, catheterization of the Eustachian tube has done the same, as has also the operation of circumcision, with instruments which were infected with syphilitic virus, and, in the religious rite, possibly though not probably, the act of sucking the wound.² Vaccination is a familiar instance of mediate contagion. In all such cases chancre precedes the development of general syphilis.

DURATION OF SYPHILITIC CHANCRE.—The duration of syphilitic chancre is from two weeks to several months. In about fifty per cent. of the cases a general syphilitic eruption appears before the chancre has cicatrized. A chancre once healed occasionally reindurates and reulcerates.

NUMBER.—Syphilitic chancre is most often unique, because commonly only one point is inoculated. It may be multiple to any extent, according to the number of points deprived of epithelium and capable of absorption, which are primarily exposed to infection.³ When multiple, however, it is usually so from the first and not consecutively, like chancroid, because its secretion is not auto-inoculable.

SIZE.—Syphilitic chancre may occasionally reach a large size, as large as a quarter or half dollar. This is, however, exceedingly rare; commonly it does not grow to the size of a nickel penny; it is often as small as a split pea and sometimes smaller. In size and general appearance it compares unfavorably with its more formidable-looking rival, chancroid.

SITUATION.—Syphilitic chancre occurs indifferently on all points of the body. No regions are exempt from it, or even less liable, as is the case with chancroid. Syphilitic chancres of the head, face, and breast, are not very uncommon. They reach their full size and development. Indeed, chancre of the lip is particularly prominent, large, hard (spher-

¹ Rollet, p. 620.

² R. W. Taylor has written an excellent essay on this subject (*N. Y. Med. Jour.*, December, 1873).

³ During the past year a gentleman under the authors' care acquired syphilis through multiple points of contagion, and had eight simultaneous chancres, all of about four weeks' incubation.

ical), and chronic in its course. The genitals, of course, furnish the favorite seat, but simply because they are most often exposed. The favorite position on the penis seems to be the mucous layer of the prepuce, often just behind the corona glandis. Urethral chancre is not very uncommon. A well-marked case is reported in the *American Journal of Syphilography and Dermatology*,¹ of a patient who was treated for gonorrhœa, his symptoms being creamy discharge from urethra, with pain on urination. After a while he developed a general syphilitic eruption, and enlarged, indolent, painless ganglia were felt in the groins. An endoscopic tube was now introduced, and detected on the roof of the urethra, one and a quarter inch from the meatus, the chancre, as a slight oval ulceration, not yet healed. There was no lumpiness around the urethra, no painful spot on erection, no blood in the urethral discharge, but undoubtedly the case was one of urethral chancre; for gonorrhœa does not produce ulceration of the urethra. The endoscopic tube introduced long afterward disclosed a faint whitened cicatrix, marking the position of the old ulcer on the roof the canal. These appearances were verified by several gentlemen. Another (unpublished) case has been observed by the authors during the past year. Chancre of the skin around the genitals and anus is not very uncommon.

FORM OF SYPHILITIC CHANCRE.—Syphilitic chancre appears after an incubation of not less than ten days, usually not till the end of three weeks, as a reddened spot, which quickly excoriates; or as an elevated solid papule, which excoriates or ulcerates. It may take any one of four forms, in the following order of frequency:

- (1.) Erosion;
- (2.) Ulceration;
- (3.) Deep ulceration, funnel shaped (Hunterian chancre);
- (4.) Indurated papule, which remains dry.

(1.) *Erosion*.—This form is believed to include two-thirds of all syphilitic chancres. Bassereau put it at three-quarters. Its favorite seat is mucous membrane. It is very common inside the prepuce. It is oval or a little irregular in shape, with a polished, raw-looking surface of a vinous-red, sometimes very dark from extravasation of blood or from pigmentation, or of a more subdued gray color; occasionally there is a central adherent pultaceous membrane (Clere), but usually the only discharge is a sanious serum, and that scanty; no pus being visible whatever. This is indeed an erosion, and not an ulcer. The induration of this form is most often parchment-like, as if the erosion reposed upon a thin sheet of parchment slipped beneath it. The induration is sometimes central, occasionally annular. These erosions are flat. Sometimes an erosion may cap an enormous induration as large as a marble, as on the lip, and not be attended by an appreciable discharge of pus. The surface of these elevated, indurated erosions sometimes granulates, becoming

¹ 1871, page 37—Keyes.

papular. Large flat erosions may occupy the skin, but they usually scab.

(2.) *Ulceration*.—Superficial ulceration with slanting edges is found with parchment, but more commonly with the split-pea, induration. The ulcer may be quite superficial if the induration stand out prominently, or the induration itself may be excavated, when the ulcer will be deep. The base is often grayish, discharging a slight amount of sero-purulent fluid.

(3.) *Hunterian Chancre*.—This form is less common than either of the above, but is actually an advanced condition of the last variety. The induration is often extensive, far overreaching the edges of the ulcer, which latter seems to have eaten down into it. The induration is the specific, cartilaginous, elastic, woody induration of syphilis. The ulcer has sloping, adherent edges, never undermined, not the abrupt borders of chancroid, and the funnel-shaped appearance of the ulceration is not found in any other variety of sore. The shape is rounded or oval. The discharge is similar to that of the last-described ulcer.

(4.) *Indurated papule which does not ulcerate* is found sometimes on the skin after inoculation, natural or artificial, and occasionally on the penis, even on the mucous layer of the prepuce in patients whose prepuce is loose, short, and dry. These indurated tubercles would undoubtedly excoriate or ulcerate if kept moist, and in fact the elevated excoriated chancre often remains for weeks as an induration before the surface erosion appears. Indurated papules of the skin, which do not erode or ulcerate, scale off after a time, or become covered with a scaly crust. The color of these papules is a dark vinous-red.

Under any of the above forms may uncomplicated syphilitic chancre appear. The course is about the same in all. They rarely heal within two weeks, and often last for months. There is rarely more than one of them, and, if two or more coexist, they are usually of the same type. The induration, which generally may be found from the first, occasionally does not appear until after some days. It may disappear within a fortnight, but usually outlasts the sore, remaining behind in the cicatrix. Chancre uninflamed and unirritated is painless.

The symptoms of urethral chancre, which cannot be seen, are usually a discharge coming on long after suspicious connection, generally thin, often bloody, a painful spot along the urethra during erection, and a lumpiness felt through the skin; but all these signs are sometimes lacking, except the discharge, and even this may be quite creamy. The endoscopic tube may be used in certain cases, making an absolute diagnosis of ulcer, and the condition of the inguinal glands goes largely to clear up its nature. Urethral chancre is more often situated just within the meatus, and may be seen by separating the lips of the latter.

COURSE OF CHANCRE.—Syphilitic chancre progresses slowly, reaching its height in a few days or weeks, and then, with or without a