gland is subject to inflammation from injury, friction, or from inflammation of the chancre, and then suppuration may come on. Strumous glands also may degenerate, mat together, and slowly suppurate. When a syphilitic bubo suppurates, its pus is never auto-inoculable. With suppuration, there is of course pain in the affected gland. With "mixed chancre," suppurating bubo is not uncommon, and even virulent bubo may occur. Fournier thinks that pus once formed in a syphilitic bubo is more capable of absorption than in any other form of bubo. Syphilitic bubo bears no relation to the number or size of the chancres. Large buboes often become adherent to the skin. In three hundred and sixty-eight cases of syphilitic bubo, Bassereau saw suppuration in five per cent. Syphilitic bubo is so constant an accompaniment of syphilitic chancre, that practically it may be said to occur invariably. Fournier, in analyzing two hundred and sixty-five cases of syphilitic chancre, found ganglionic induration absent in five. Two of the individuals were very fat, and possibly the ganglia existed, but could not be found. The causes of the absence of induration in the glands are believed to be occasionally phagedena of the chancre (Fournier), the excessive smallness of the lymphatic glands in some fat people (Ricord); finally, in those rare cases where indurated chancre occurs a second time in patients who have had syphilis, the glands may not indurate. Syphilitic, spontaneous bubo (*bubon d'emblée*) does not exist. For diagnosis of syphilitic bubo, *see* DIAGNOSTIC TABLE.

*Treatment.*—The treatment of syphilitic buboes is that of early syphilis, but treatment has indeed little or no effect upon them, as they often persist long after the early cutaneous eruption has disappeared under treatment. Inflammation and strumous complications are to be met appropriately.

(*g.*) SYPHILITIC LYMPHITIS is a specific induration of the lymph-vessels and surrounding cellular tissue. Hard, smooth, and knotty cords are perceptible under the skin of the penis, feeling like the vas deferens, varying from the size of a knitting-needle to that of a goose-quill. They are insensitive to pressure, and the skin over them is not red. Starting in the induration of the chancre, they often do not reach to the root of the penis, but may extend to the ganglia. Sometimes, but rarely, the surrounding induration includes the blood-vessels. There may be one or more of these cords on one or both sides of the penis. Lymphitis, when present, generally precedes adenitis, coming on shortly after the induration of the chancre. It melts away usually during the disappearance of chancrous induration, lasting from three weeks to six months, and more. Rarely inflammation or suppuration may occur, but the pus is never auto-inoculable. If the chancre be mixed, so may be the lymphitis. Rollet states that syphilitic lymphitis occurs in about twenty per cent. of cases. No special treatment is necessary, except what may be required for inflammatory complications.



## CHAPTER IV.

### *SYPHILIS.*

Diagnostic Table of Syphilitic Chancre, Chancroid, Herpes, and Ulcerated Abrasion.—Of Syphilitic Bubo and the Bubo of Chancroid.—Of Syphilitic Lymphitis, and the Lymphitis of Chancroid.—General Syphilis.—Secondary, Tertiary, Malignant, Irregular, and Intermediary Syphilides.—Prognosis of Syphilis.—Duration.—Influence of Gout and Scrofula upon the Course of Syphilis.—The Ten General Characteristics of Syphilides.—Concomitant Symptoms of Secondary Syphilis.—Secondary Incubation, Syphilitic Fever, Alopecia, Indolent Glandular Engorgement, Sore-Throat, Analgesia.

THE following table is intended to serve as a summary of the broad, classical characteristics of syphilitic chancre and chancroid, with their accompanying buboes, as well as for the differential diagnosis of syphilitic chancre, chancroid, herpes, and ulcerated abrasions; of the bubo of chancroid, and that of syphilis; and of the different forms of lymphitis.

| *Syphilitic Chancre.* | *Chancroid.* | *Herpes.* | *Ulcerated (Balanitic or other) Abrasion.* |
|---|---|---|---|
| 1. *Nature.* — Always a constitutional affection. | 1. Always a local disease. | 1. Sometimes a local disease, sometimes a neurosis. | 1. Always local. |
| 2. *Cause.*—Sexual intercourse with a patient suffering from syphilitic chancre, or some secondary syphilitic lesion of or near the genitals, vaccination with syphilitic blood, accidental or designed inoculation of any vehicle containing the syphilitic virus, upon an abrasion of any portion of any tegumentary expansion. | 2. Sexual intercourse with a patient suffering from chancroid of or near the genitals; accidental or designed inoculation with the secretion of chancroid, or that of virulent bubo. | 2. Mechanical irritation, friction, as in sexual intercourse; chemical irritation, as of acrid discharges. As a sequence of cold, fever, or as an essential neurosis. | 2. All of the causes mentioned for herpes, except the last three. — |
| 3. *Situation.* — Usually upon or near the genitals, not very infrequent on the head, hands, or nipple. | 3. Very rarely encountered except on or around the genitals. | 3. Of very frequent occurrence upon the genitals. | 3. Same. |
| 4. *Incubation.* — Constant, not less | 4. None after absorption of the poi- | 4. None. | 4. None. |

| *Syphilitic Chancre.* | *Chancroid.* | *Herpes.* | *Ulcerated (Balanitic or other) Abrasion.* |
|---|---|---|---|
| than ten days, usually three weeks. | son. Ulcer usually fully formed on the second or third day; very rarely commences later than the seventh. | | |
| 5. *Commencement.*—Begins as an erosion or a papule, and remains an erosion or ulcerates. | 5. Begins as a pustule or ulcer, and invariably remains as an ulcer. | 5. Begins as a group of vesicles, rarely as a single vesicle, and remains as an ulcer. | 5. Begins as an abrasion or fissure, and remains as an ulceration. |
| 6. *Number.*—Usually unique or simultaneously multiple; never multiple by successive auto-inoculation; never confluent. | 6. Usually multiple, both simultaneously and by successive auto-inoculation; often confluent. | 6. Generally multiple, simultaneously and by successive crops of vesicles; sometimes confluent. | 6. Generally multiple and confluent |
| 7. *Physiognomy.* (*a.*) Shape: round, oval, or symmetrically irregular. | 7. (*a.*) Shape: round, oval, or unsymmetrically irregular, with border described by segments of large circles. | 7. Shape: irregularly rounded, with borders described by segments of small circles left by the different vesicles. | 7. Irregular, of any shape, otherwise resembling superficial chancroid ulcer. |
| (*b.*) Lesion is habitually flat, capped by erosion or superficial ulceration; or scooped out; or deep, funnel-shaped ulcer, with sloping edges. Sometimes the papule is dry and scaly. | (*b.*) Always true ulcer, excavated, hollowed out. | (*b.*) Ulcer usually superficial; sometimes in solitary herpes there is but one vesicle, and the ulcer is absolutely circular (Fournier); in this case there are no neighboring patches of vesicles to clear up diagnosis. The base and general physiognomy of herpetic ulceration are, in other respects, similar to those of chancroid, but of less virulent aspect. | |
| (*c.*) Edges: sloping and adherent, sometimes prominently elevated. | (*c.*) Edges: sharply-cut, abrupt, often undermined. | | |
| (*d.*) Bottom: smooth, shining. | (*d.*) Bottom: uneven, warty, irregular, without lustre. | | |
| (*e.*) Color: sombre, darkish red, gray, | (*e.*) Color: yellow, tawny, false- | | |



| *Syphilitic Chancre.* | *Chancroid.* | *Herpes.* | *Ulcerated (Balanitic or other) Abrasion.* |
|---|---|---|---|
| or black, lesion sometimes livid and scaly, occasionally scabbed. | membranous - looking, sometimes bright. | | |
| (*f.*) Secretion: slight, sero-sanguinolent, unless irritation provokes inflammation and a supply of pus. | (*f.*) Secretion: abundant and purulent. | | |
| 8. *History.*—Not found on patients who have had syphilis previously. | 8. Found indifferently upon all. | 8. Found by preference upon patients with long prepuce and tender balano-preputial mucous membrane, often showing marked tendency to return monthly, fortnightly, or at irregular intervals after lack of cleanliness, a carouse, or unusual sexual intercourse. | 8. Found indifferently upon all on the action of efficient causes. Most common on patients with long, tight prepuce, who are not cleanly in their habits. |
| 9. *Inoculability.*—Not auto-inoculable without great difficulty, unless irritated, and secreting thick pus. | 9. Readily auto-inoculable, producing characteristic chancroid ulcer by the third day. | 9. Sometimes auto-inoculable with great difficulty, when secreting thick pus, producing abortive pustule, not characteristic chancroid ulcer. | 9. Same. |
| 10. *Course.*—Slowly progressive, cicatrization slow. | 10. Rapidly progressive, cicatrization slow. | 10. Does not usually tend to get much larger than the size at which it started; limitation and cicatrization rapid. | 10. Same. |
| 11. *Sensibility.*—Rarely painful. | 11. Often painful. | 11. Stinging heat at commencement. | 11. Usually painful. |
| 12. *Induration.*—constant, parchment-like, and very faint, or cartilaginous and extensive, terminating abruptly, not shading off into parts around, almost insensitive to pressure, movable upon parts beneath the skin, and not adherent to the | 12. Absent in type-cases. An induration may be caused by irritants or by inflammation. It is boggy, not elastic, sensitive to pressure, shades off into surrounding tissues, is adherent to parts around, disappears promptly on healing | 12. Inflammatory induration, capable of being produced by the same causes as in chancroid, and behaving in a precisely similar manner. | 12. Same. |

| *Syphilitic Chancre.* | *Chancroid.* | *Herpes.* | *Ulcerated (Balanitic or other) abrasion.* |
|---|---|---|---|
| latter. Induration may disappear in a few days, usually outlasts the sore, and may remain for years in the cicatrix. | of the sore, or before that time. | | |
| 13. *Transmission to Animals.* — Not transmissible. | 13. Transmissible with difficulty. | 13. Not transmissible. | 13. Not transmissible. |
| 14. *Phagedena.*— May occur rarely. | 14. Much more common. | 14. Very rare, if at all possible. | 14. Same. |
| 15. *Bubo.* — Syphilitic bubo constant. | 15. In about two-thirds of cases glands are unaffected, in the other third inflammatory or virulent bubo occurs. | 15. Glands are very rarely involved. Inflammatory bubo may occur, virulent bubo is impossible. | 15. Same. |
| 16. *Lymphitis.*— Syphilitic lymphitis possible. | 16. Inflammatory or virulent lymphitis possible. | 16. Inflammatory lymphitis alone possible. | 16. Same. |
| 17. *Prognosis.* — For local consequences good, but syphilis follows. | 17. For local consequences more serious; no after-effect. | 17. Good in all respects. | 17. Same. |
| 18. *Treatment.*— Local treatment but slightly effective. | 18. Local treatment curative. | 18. Same. | 18. Same. |

| *Syphilitic Bubo.* | *Bubo of Chancroid.* |
|---|---|
| 1. *Nature.*—It is a specific affection, with peculiar characteristics. | 1. It may be simple (inflammatory) such as might attend any inflammatory lesion, or virulent. |
| 2. *Frequency.*—It is a constant symptom attending syphilitic chancre. | 2. It is a complication occurring about once in three cases. |
| 3. *Number of Glands involved.* — In those regions where multiple glands are found, it is generally poly-ganglionic; these may be unilateral or bilateral in the groin, rarely matted together into one large mass, but, when so, the latter retains the characters of indolence, etc. | 3. Usually consists of a single gland in any region of the body. In the groin it may be bilateral. It is never a group of small, movable glands. |
| 4. *Date of Appearance.* — It develops during the first or second week of syphilitic chancre. | 4. There is no fixed period of appearance. |
| 5. *Size.*—The glands are usually only slightly enlarged. | 5. The gland is greatly enlarged. |
| 6. *Induration.*—The glands are specifically indurated, feeling like cartilage or wood. | 6. No hardness except inflammatory. |
| 7 *Evidence of Inflammation.* — None; | 7. Every appearance of inflammation. |



| *Syphilitic Bubo.* | *Bubo of Chancroid.* |
|---|---|
| the glands are freely movable among the tissue. The skin is neither adherent nor red, nor is there any pain. The most prominent feature of the swelling is its indolence. | The gland becomes fixed (peri-adenitis), the skin adherent, the part feels hot, there is pain, the skin reddens, the prominent features are those of inflammation. |
| 8. *Termination* always in resolution, except in occasional cases, where, from simple inflammation or strumous degeneration, suppuration ensues. | 8. Termination occasionally by resolution, usually by suppuration. Virulent bubo invariably snppurates, and becomes an open chancroid ulcer. |
| 9. *Auto-Inoculability.*—In cases of suppuration the pus is not auto-inoculable. The abscess does not become a chancre, or a chancroid ulcer. It does not extend, and never becomes phagedenic. | 9. When the bubo is inflammatory, the pus is not auto-inoculable; where it is virulent, the pus is invariably readily auto-inoculable. Such an abscess becomes a true chancroid, and may extend or become phagedenic. |
| 10. *Natural duration* is a few weeks or months. | 10. Natural duration is a few weeks, or many months, as a chancroid; possibly years, if it becomes phagedenic. |
| 11. *Prognosis* good as far as local results are concerned, but the patient invariably has syphilis. | 11. Prognosis good for inflammatory, less so for virulent bubo, especially if it becomes phagedenic. In neither case does syphilis follow. |
| 12. *Local treatment* ineffective, except for complications, general treatment of doubtful efficacy, but sometimes serviceable. | 12. Local treatment useful and necessary to avert suppuration, cure chancroid left by virulent bubo, and lessen complications. Mercury harmful. Anti-syphilitic treatment absolutely useless. |

| *Syphilitic Lymphitis.* | *Lymphitis of Chancroid.* |
|---|---|
| 1. Occurs only in case of syphilis, and has peculiar characters. | 1. Exists as simple inflammatory lymphitis, or in virulent form; the former liable to complicate any inflammatory affection, the latter found only with chancroid. |
| 2. Feels hard, like the vas deferens, of the size of a knitting-needle, or of a goose-quill; no pain, on erection, or on handling. | 2. Some inflammatory hardness. Pain on erection, and on handling. |
| 3. Skin uncolored. | 3. Skin red over inflamed vessel. |
| 4. Termination by gradual resolution. Very rarely there is suppuration; but, in such cases, the pus discharged is not auto-inoculable. | 4. Termination by resolution or suppuration. Virulent lymphitis invariably suppurates, in which case the pus discharged is auto-inoculable, and the openings become chancroids. |
| 5. Treatment unnecessary, and of little effect, except in case of inflammatory complication. | 5. Local treatment advisable to quiet pain, avert suppuration, or limit extent and severity of chancroids left behind by the suppuration of virulent lymphitis. |

## GENERAL SYPHILIS.

Usage has adopted the name "primary syphilis" for the syphilitic chancre, and its accompanying adenitis and lymphitis. These manifes-

tations, although the expression of constitutional poisoning, are never themselves general, but always strictly local. A chancre never does nor can appear elsewhere than at that point through which the poison first entered the body. Hence inherited syphilis has no primary stage, but is general from the start. The adenitis constituting syphilitic bubo invariably affects the gland or glands in direct communication with the lymphatic trunks coming from the chancre; the other lymphatic glands of the body, which may become indolently enlarged, do so only after the second period of incubation. The latter do not belong to the primary period, but form a part of general syphilis. And so of the lymphitis of primary syphilis, it affects only those vessels passing between the chancre and the syphilitic bubo.

Hence, primary syphilis, so far as its manifestations go, is purely local. Not so with general syphilis. There is no organ or tissue of the body through which it may not manifest its presence by symptoms, or upon which it may not exercise its power. The lymphatic glands all over the body may suffer, some habitually more than others. The skin from crown to sole, the nails, the hair (the teeth in inherited disease), and the mucous membranes, especially around the natural orifices, have their peculiar affections, due to syphilis. The eye and the testicle do not escape, and each and every viscus is liable to be invaded, as are all the tissues, connective, fibrous, muscular, cartilage, bone, brain, nerve, and vessel. Not only this, but the all-embracing arms of general syphilis include the functions as well, any of which may be disordered by it and each and all of the special senses may be perverted or destroyed—including the sexual appetite. The symptoms of all the forms of local, special, or general paralysis of motion or sensation, may be occasioned by syphilis. Finally, the intellect may succumb. Acute and chronic mania, dementia, lunacy, idiocy, all the above, and many more, form a category of symptoms comprehended under the one term general syphilis.

General syphilis has been arbitrarily divided into a secondary and tertiary stage. For convenience of description and treatment, such a division is a good one, and will be retained in this treatise.

*Secondary syphilis* includes all the earlier affections of the tegumentary expansions, cutaneous and mucous, and many of the lighter affections of the eye, testicle, and other glands, with some of the varieties of nervous syphilis.

*Tertiary syphilis* follows secondary, and consists of the later and the ulcerative skin-affections, the deeper lesions of connective tissue, muscle, bone, cartilage, and of the internal organs (visceral syphilis), with the deeper and more serious lesions of the eye, testicle, brain, and all morbid conditions occasioned by what is known as gummy deposit.

The line between secondary and tertiary syphilis is not always well marked, and, although in typical cases the lesions become progressively



deeper, commencing as mere efflorescences in the secondary stage, and gradually increasing in severity to the most extensive ulcerations, and destructions of bone and cartilage in the tertiary, yet some of the symptoms, naturally belonging to the secondary group, as the mucous patch and scaly eruptions, frequently crop out in the tertiary stage, while more rarely nodes come on with early syphilis, and occasionally most extensive ulcerative or other tertiary (gummy) lesions appear within the first few months after chancre, perhaps all the lighter secondary eruptions having been omitted.

This latter form, where tertiary symptoms come on in place of the secondary, is called "malignant syphilis." The former variety is known as "irregular syphilis."

Inherited and nervous syphilis will be described separately.

Certain of the eruptions which occur late in the secondary stage, and early in the tertiary, have been grouped by Hardy[1] under the title of "intermediary syphilides." The distinction drawn between secondary, intermediary, and tertiary syphilitic symptoms, is useful as a guide to treatment. Mercury as a rule is advantageous in proportion to the nearness of the symptoms, for which it is given, to the primary lesion (chancre), while iodine is nearly a specific for the later manifestations. The intermediary symptoms require both medicines combined.

Secondary syphilis lasts often a year, sometimes two, or more.

Tertiary syphilis (except as malignant) does not commence till after the expiration of at least one year from the appearance of chancre. It may never show itself, or may appear after a period of health of many years, often five or ten, sometimes as late as fifty-two (Fournier). There can be no absolute certainty about the dates of syphilis, or about what symptoms will appear. The whole secondary stage may be skipped under treatment, some late tertiary ulceration alone evidencing the fact that the patient had general poisoning at all.

Case XLVIII.—In the fall of 1872 a robust-looking patient presented himself in a state of mental distraction, about an ulcer on his glans penis, not auto-inoculable, which had been pronounced lupus by his physicians, and for which extirpation, by a cutting operation, had been proposed. The ulcer was as large as a half-dime, eaten out deeply, with abrupt edges, hard base, etc., inguinal glands unaffected—in short, a typical tertiary ulcer. The patient was married, and had had a healthy child. His wife also was healthy. The ulcer had commenced as a hard spot, which fissured and ulcerated without much pain. The patient had not been untrue to his wife. The ulcer had existed for eight months, gradually increasing in size. Ulceration had been arrested once by caustic applications, but the cicatrix had shortly reopened. When told that the sore was syphilitic, the patient, on the authority of his physicians, laughed at the idea. He said that he had had chancre eleven years before, without suppurating bubo; that this chancre had been pronounced syphilitic by a reliable surgeon, and that he had taken mercury in pills for a while. He was an intelligent patient, and a close observer, and he declared positively that he had never had any eruption, or any symptom due to syphilis after his chancre, so far as he was aware. He stated, in further corroboration of his view, that during the sum-

[1] "Maladies de la Peau," Paris.

mer (a few months previously), after the ulceration had existed for some time on his penis, he had had an attack of iritis. For this he had consulted an oculist, who, learning that he had once had a chancre, gave him mercury and iodide of potassium, the latter in gr. vijss doses, *until it upset his stomach*, so that he was obliged to fall to a lower dose, and, as he triumphantly asserted, although the eye got well after a while, yet the ulcer advanced steadily, "I taking as much iodide of potassium as the stomach would bear. Why, then, should not the ulcer have improved had it been syphilitic?" It was mainly on this account that the patient's former physicians had concluded that this ulcer must be lupus, since it could not be syphilitic, and evidently was no cancer.

The patient was answered that his ulcer was syphilitic, and had not gotten well, while his eye was under treatment, because he had not taken a large enough dose of the iodide of potassium. Local treatment was at once suspended, the patient was put upon a diet of rice-and-milk, with ten-grain doses of subnitrate of bismuth four times daily. No medicine was used except a saturated solution of iodide of potassium in water, āā ʒj. Of this he took drop-doses at first, and ran it up by drops, largely diluting it before it was taken into the stomach, and using it only after meals. No change in the ulcer occurred until gtt.-xv doses were reached. Improvement was rapid at gtt.-xix doses; at gtt.-xx, the stomach rebelled, and the dose was reduced to gtt. xv, and then advanced to gtt.-xvii.

In six weeks the ulcer was cicatrized, thus establishing the diagnosis.

This case illustrates at once so many important points necessary to be considered in connection with syphilis, that it has been reported at length.

*Syphilides.*—The most conspicuous symptoms of general syphilis affect the skin, and are known as syphilides, or syphilo-dermata. The prominent primary lesion characterizing the cutaneous affection gives it its name, and in syphilis most of the confusing epithets of dermatology may be dispensed with. Thus, if a papule be the prominent lesion, or a vesicle, or a pustule, the affection is not necessarily called a lichen, or eczema or impetigo, but a "papular," "vesicular," or "pustular syphilide," as the case may be; adding "general," or "in groups," according to the physical distribution of the lesion. Ulcerated syphilides, again, are spoken of as superficial or deep, serpiginous or perforating, making the nomenclature of syphilis exceedingly simple, since the words themselves describe the affection.

*Prognosis.*—As to the character of the general syphilis, which is to follow upon a given chancre, the peculiarities of the individual have more to do with it than any thing else, excepting of course judicious treatment. Certain authors have advanced that phagedenic syphilitic chancre is followed by severe syphilis. The condition of the patient, allowing him to have phagedena, it is fair to presume, is also such as will cause him to suffer severely from his syphilis; but it does not necessarily follow, for the cause of the phagedena might have been a local one or one only acting temporarily, and then the succeeding general syphilis might be mild. Nor indeed does Diday's idea prove trustworthy, that the length of incubation of the chancre, or the length of secondary incubation, portends the character of the general syphilis which is to follow. There is undoubtedly a measure of truth in this, for, if the quantity or quality of the poison absorbed, or the state of the individual, be such as to allow the first local and general manifestations of the disease to be long delayed, it is reasonable to suppose that the whole course of the malady will be mild. The same natural inference may be made with some reason in connection with the mildness or severity of the chancre. But neither of these rules is reliable. Not infrequently we see cases of protracted, severe, obstinate disease attending a chancre of very long incubation. And the syphilide following the chancre which never ulcerates is sometimes more intractable than the same eruption following a large, excavated, ulcerated, primary lesion. Syphilis acquired from a mild case may be severe or mild. The following three cases will tend to demonstrate the fact that individual peculiarity has more to do with the form of syphilis than any thing else:



In 1865, in the cutaneous wards of St. Louis Hospital, under Prof. Hardy's care, were two cases, man and wife. The man had severe malignant syphilis, with large gummy deposits in his skin; some of them ulcerating; all occurring within a few months after chancre. This man had poisoned his wife while he yet carried his chancre. She had a very mild papulo-erythematous syphilide, bearing none of the characters of malignancy. The woman, from whom the man acquired his disease, was sought out and found. She also was a simple case of ordinary mild syphilis. The poison in these three cases was identical, handed directly from one to the other, but the results were so widely different that it would have been hard to convince a layman of their identity of origin. What the idiosyncrasy is which makes syphilis bad in one case and light in another cannot be affirmed. Scrofulous and strongly lymphatic individuals, although a little more prone to suffer from severe suppurative and ulcerative lesions than others, are by no means the only ones who have severe attacks. The most obstinate and long-enduring cases are frequently found in connection with the gouty diathesis, the predominant eruptions in such cases being scaly and tubercular, and nervous syphilis being not uncommon.

Perhaps the best light that can be thrown upon the question of prognosis may be derived, not from the time of appearance, but from the character of the first eruption of the secondary period. If this eruption be scanty and purely erythematous (roseola), or even papular, the case will probably be much more mild than if the earliest eruption were vesicular, or, still worse, pustular, especially if complicated early by iritis. Finally, if extensive tubercular eruptions and ulcerations appear in place of the usual secondary symptoms, the case is one of malignant syphilis, and the prognosis becomes grave. There is no just foundation for the opinion which has been advanced, that syphilis acquired from a secondary lesion runs a more severe course than if it were acquired from contact with a chancre. As far as the virulence of the poison is concerned, the converse of the above proposition would theoretically appear