buttocks, extremities, and palms and soles, and are frequently found near the mucous outlets, though decidedly less often grouped about the mouth and nose than are other lesions to be described later. They may be few, or developed in a copious exanthem. They may be covered with a thin seborrhœic crust, after the removal of which is exhibited one of the characteristic and almost indescribable color shades peculiar to syphilis, a lucent mixture of red, brown, and purple, suggesting the varnished section of a raw ham. They may be fringed or capped with scanty, dirty-yellowish scales. This eruption rarely occurs in cachectic subjects with a diphtheroid deposit over the papules, covering thus a granulating or superficially ulcerated surface.

Cicatrices seldom follow the involution of the syphiloderm under mercurial treatment. It commonly requires a week or ten days for complete development and, though occurring as an early syphiloderm, may relapse in any stage of the secondary period. Circinate groups, with an unchanged central area of integument, are rather more distinct in relapsing than in early forms of the exanthem. These are readily distinguished from psoriasis by the absence of the abundant nacreous scales of the latter disease, with a history of clearing, not of a primarily cleared centre.

The Large, Flat, Papular Syphiloderm.—This eruption appears in the form of distinctly circumscribed, vivid or purplish-red, flat or slightly globoid papules, discs, "tubercles," or nodosities, from the size of a pea to that of a small coin, many of which distinctly exhibit the quality of color seen in a new copper penny. They may become scaly at the surface or the base, or become granular, moist, and secreting in these situations. They are insensitive, and rarely productive of pruritic sensations. The exanthem may be developed primarily, or be evolved from the macular lesions, or, very conspicuously and commonly, in the exanthematous period of syphilis, with a primary or relapsing and abundant crop of lesions in some special locality—the face (alæ of nose, forehead, mouth), palms, soles, axillæ, buttocks, and extremities. Upon the forehead these lesions may form the so-called corona veneris, glazed papules of coppery hue, arranged often in a line above the brows. They may develop an elevated rim and sunken centre; may ulcerate, especially in cachectic subjects or in localities subject to unusual moisture or irritation. Rarely gyrate and serpiginous lines of these papules are to be seen in special localities, *e.g.*, about the non-bearded lips and chin, or the axilla, where they may form rings. They are to be distinguished from isolated psoriatic patches, circinate in outline, (1) by their dull color, as distinguished from the more vivid hue of psoriasis; (2) by their scanty dirty-hued scales; (3) by the history and concomitant symptoms of syphilis.

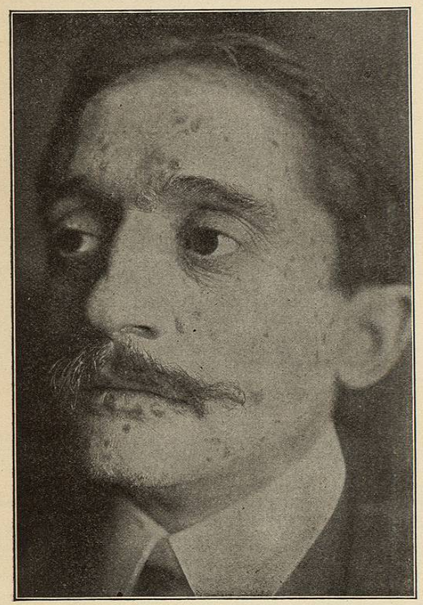


FIG. 4586.—Large Papulo-crustaceous Syphiloderm of the Face.

Syphilitic papules of all types may undergo any one of the following transformations, the features of which may often be recognized at one and the same time in the course of the disease:

1. The evolution of papules may, as a result of hyperplasia or vegetation, proceed to the production of the larger lesions recognized under various titles—warts, papillomata, condylomata, framboesioid verrucæ, etc. In this way isolated or confluent, softish, warty growths, light or deep reddish in color, freely furnishing a secretion, often of nauseous odor, may cover large surfaces of the body or a single region only (scalp, anus, genitalia). These may be crusted from desiccation of the puriform mucus which smears them; in other cases ulceration ensues.

2. The evolution of the papules, as a result of the same processes in special situations, results in the production of broad, flat lesions. These are the results merely of an hypertrophic process occurring where mucous or cutaneous surfaces are in such close apposition that elevation of the lesion is restricted and lateral expansion only is possible. In this way are produced the condyloma, and the pinkish, whitish, and softish lesions known as the mucous patch of the skin, the vegetating mucous patch, *plaque muqueuse*, etc. They are well-defined, slightly raised, flattened discs, from the size of a bean to that of a large coin, their whitish color largely due to the muco-purulent secretion with which they are smeared, and which furnishes the characteristic, disgusting odor of these lesions. Heat, moisture, friction, perspiration, and neglect of the bath are fertile agents in their production in the axillæ, perineum, groins, the inner faces of the thighs, about the vulva, and elsewhere.

3. Papules may scale at apex or base, and the scaling become so significant a part of the process that the papular character of the lesion is almost disguised. In this way is produced the papulo-squamous syphiloderm. The scales are commonly scanty, desiccated, dirty gray in color, often attached, occasionally freely shed from the surface. Beneath them may be seen elevated papules having the so-called copper color, with the smooth, glazed surface of such lesions, or dull-red maculæ. Rarely the surface granulates.

PALMAR AND PLANTAR SYPHILODERMATA.—Syphilitic papules of the palmar and plantar surfaces are peculiar: (1) Because of the unusual thickness of the epidermis of the region affected; (2) because of the intermittent friction, contact, and exposure to which the organs are subjected. They may be early or late, transitory or peculiarly obstinate, and recurrent lesions. Careful inspection of the palms of the majority of patients exhibiting a copious macular exanthem will result in the detection of a few pea-sized discolored blotches in this region, which often are covered with a thin, slightly adherent scale. In greater approximation to the type of the average cutaneous papule, firm, circumscribed, dull-reddish, and distinctly elevated lesions, from the size of a large pinhead to that of a pea, are often seen in the same

region. A variation from this type produces the dirty-whitish, corneous, epidermal masses embedded in the palms and soles like foreign bodies, and almost as readily separable. These are arrested forms of complete evolution of the syphilitic papule in the palms and soles. When progressing, unmodified by treatment, they become depressed and poorly defined in outline, coalesce so as to form circumscribed patches, from the size of a coin to that of an egg or larger, with newly developed outlying lesions. The next features are unquestionably impressed upon the patch by the traumatism and stretching of the infiltrated skin. Scaling follows, centrally and at the periphery; fissures form in the lines of the furrows; ulcers develop, centrally situated, circular, oval, or stellate in outline. A purplish-floored ulcer is often seen here, its contour suggesting the fracture of a pane of glass. Recurrent and abortive attempts at reproduction of the palmar and plantar epithelium result in the formation of strata of ragged-edged epidermis, which irregularly fringe the deep losses of tissue. The entire palm or sole may be involved, and the process gradually sweep up to the wrist, instep, or ankle, and over the digits, affecting also the nails. The dorsal surfaces are occasionally involved, but always by extension from the palms or soles. Psoriasis limited to the palms and soles is of exceedingly rare occurrence; the specific lesions of this region are far more common, and are often accompanied by other unmistakable signs of syphilis with a history of infection. Squamous eczema is at times limited to the palms and soles, but, in the vast majority of all cases, affects the entire region, including the palmar faces of the digits, and is accompanied by itching. (See Plate LIV.)

THE PUSTULAR SYPHILODERM.—Pustules occur as early and late manifestations of syphilis, being, however, less frequently observed than the lesions just described. The purulent content may be sterile or contain the common pyogenic micro-organisms. The lesions are of the size of a pinhead to that of a bean, transitory or persistent, with mild or grave symptoms, and may originate as macules or papules, be isolated or grouped, scanty or abundant, and result in crusting, ulceration, and cicatrization. "Papulo-pustular," "pustulo-crustaceous," and similar terms are employed to indicate these mixed forms. Authors have also employed the phrases "acne-form," "variola-form," "impetigo-form," "ecthyma-form," etc., to designate the several varieties of the pustular syphilodermata. These terms are here purposely omitted, for the reason that the several diseases whose names are selected for comparative purposes are represented by lesions widely varying in the different stages of each disease, and exhibiting different features in different individuals. The phrases "syphilitic psoriasis," "syphilitic eczema," etc., are similarly discarded, as tending to contribute to the same confusion.

The Small, Acuminate, Pustular Syphilodermata.—The lesions of this class are of the size of a pinhead and larger, vivid or dull red, roundish, rapidly or slowly formed, and superficially seated, isolated, or wellnigh confluent pustules, which may be copiously developed in a general exanthem with syphilitic fever, or, more commonly, recognized in clusters about the regions where the pilo-sebaceous follicles are large and abundant. They may begin as macules or papules. The apex of each becomes yellowish-green as the pus forms, which may desiccate into minute crusts or may cover underlying ulcers of similar size. They assume at times circinate outlines. They are often seen on the scalp, face, neck, and trunk; rather less frequently on the extremities. Involution is often followed by rather persistent pigmentation; more rarely by minute atrophic scars.

The Large, Acuminate, Pustular Syphiloderm.—Yellowish-brown, conical pustules, of the size of a pea and larger, may develop slowly from the small lesions just described, or rapidly from maculo-papules. They are usually superficial in situation, become crusted at the apex, and, after the formation of the crust, may be depressed centrally. Ulcers frequently form as the result of this process, the healing of which may leave small cicatrices. They form over the scalp, face, neck, shoulders, and extremities; and are usually the expression of either a graver form of syphilis or of a syphilis less judiciously managed than the lesions previously described.

The Small, Flat, Pustular Syphiloderm.—This is a relatively frequent manifestation of syphilis, beginning by the development of circumscribed macules or maculo-papules, which rapidly form flat, roundish pustules, the size of a pinhead and larger, superficial in situation. They are usually grouped, isolated, and at first not confluent; but their reddish and purplish areolæ become fused, and the whole is soon covered with a flattened, dirty-yellowish, and greenish crust, which commonly surpasses the limits of the patch. On the removal of the latter, a violaceous surface is seen, granulating, puriform, occasionally superficially eroded, possibly ulcerated. These lesions are often seen in and about the scalp, and about the lips, chin, beard, and trunk. In persons of weak constitution, and not properly treated, the face will occasionally be found almost completely covered by an irregularly crusted mask, formed in the manner described above, the pustulo-crustaceous lesions occasionally spreading in a serpiginous course, or forming the familiar rings, or segments of rings, seen in the grouped syphilodermata.

The Large, Flat Pustular Syphiloderm.—Pustules, the size of a bean and larger, deeply seated, or projected from the surface, may represent any of the forms described above, proceeding to full evolution, usually in cachectic subjects. They represent, also, the later periods of the so-called secondary stage of syphilis. Often they have dark red, deep, infiltrated bases with violaceous areolæ; and the pus finally desiccates into thick, bulky, greenish, or blackish crusts, firmly adherent to the edges of a foul-based, hemorrhagic, or pus-filled chamber beneath; or, after bursting, they leave open, sharply cut ulcers, with blood or pus freely formed from an exposed, eroded, sloughing surface. The ulcerative phase, with its crust, is indeed often the conspicuous feature of the process, the deep-seated pustular lesion which ushered in the mischief being thus speedily metamorphosed. These ulcers may be few or numerous, superficial or deep; and may be in outline circular, oval, semicircular, dumb-bell-shaped, etc. Their cicatrization commonly results in a typical syphilitic cicatrix.

RUPIA.—This term was at one time employed as the name of a distinct disease. It has long since lost any applicability to non-syphilitic disorders. Every rupia should to-day be recognized as syphilitic. Indeed, according to modern usage, the name merely describe certain peculiarities in the syphilitic crust. The explanation of its former temporary and unmerited elevation to the dignity of a disease supposed to have a separate entity is to be found in the fact that occasionally a patient will be extensively covered with rupioid crusts, who exhibits scarcely another symptom of syphilis.

The crusts thus named may be few and small, or large and generalized. First appear macules, then pustules, the contents of which desiccate into crusts of greenish, brownish, and blackish shades, covering and nicely fitted over underlying ulcers. The ulcer slowly spreads at the periphery, and its purulent and hemorrhagic secretions add by desiccation to the bulk of the crust. The additions are made beneath and laterally to the under surface and edges of the closely adjusted crust, which hence becomes a conical, stratified shell, usually with a slightly concave inferior surface, the whole often compared to an oyster shell. Each succeeding stratum of incrustation, from the conical apex of the crust to its base, represents, therefore, a somewhat larger ulcer and a somewhat more abundant secretion. There may be an outlying violaceous areola. The indolently spreading ulcers beneath correspond in size to the shells which cap them. They may be superficial or deep, but usually have a foul, purulent, or hemorrhagic floor, and punched-out edges. Grave as is the condition of the patient who is extensively covered with the largest-sized rupioid lesions, the best of results

may be anticipated under proper hygienic management and energetic treatment.

The Vesicular Syphiloderm.—Vesicles are rarely the results of the syphilitic process in the skin. They usually point to an exudation more acute in type than that recognized in the indolently traversed cycle of syphilis. Occasionally miliary papules exhibit a vesicular apex containing a droplet of serum. Circinate and other groups of vesicles are described by French writers as of occurrence in this disease. Two explanations of the so-called vesicular lesions are at hand: first, the development of eczema, herpes, etc., in infected persons—phenomena not rarely observed by an expert; second, the occurrence of vesicular lesions provoked by extensively applied or internally ingested medicaments employed for the relief of the systemic disorder.

The Bullous Syphiloderm.—Discrete, roundish bullæ, from the size of a pea to that of a small egg, appear simultaneously or in crops upon the syphilitic skin, in consequence of a more or less circumscribed elevation of some portion of the epidermis by accumulation of a clear lactescent serum, pus, or blood. The contents usually desiccate into bulky, adhesive, stratified, greenish or dark-colored crusts, which may cover granular, eroded, or ulcerative surfaces. Often they are surrounded by a violaceous halo. The ulcer, after removal of the crust, may spread in depth or area, or cicatrize; this according to the vigor of the patient and the treatment pursued. Lesions of this sort are rather more often recognized upon the extremities than elsewhere, in consequence of the greater distance of the latter from the centres of circulation. They are more often encountered in late

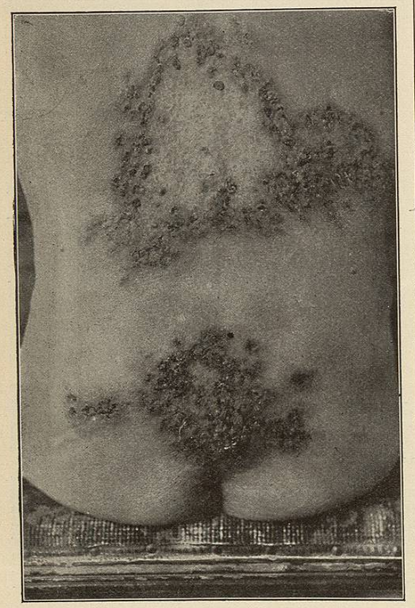


Fig. 4587.—Serpiginous Tuberculo-ulcerative Lesions of the Skin of the Back.

periods of the disease, and in cachectic subjects. They are for these reasons most often seen in the tender skin of the infant who is the victim of hereditary syphilis.

It should not be forgotten, when making a diagnosis of the bullous syphiloderm, that the iodide of potassium, in exceptional cases, is capable of producing such lesions in typical aspect when administered to the syphilitic as well as to the non-infected patient. American observers chiefly have called attention to this important fact, among them Drs. O'Reilly, Graham, Morrow, and the author.

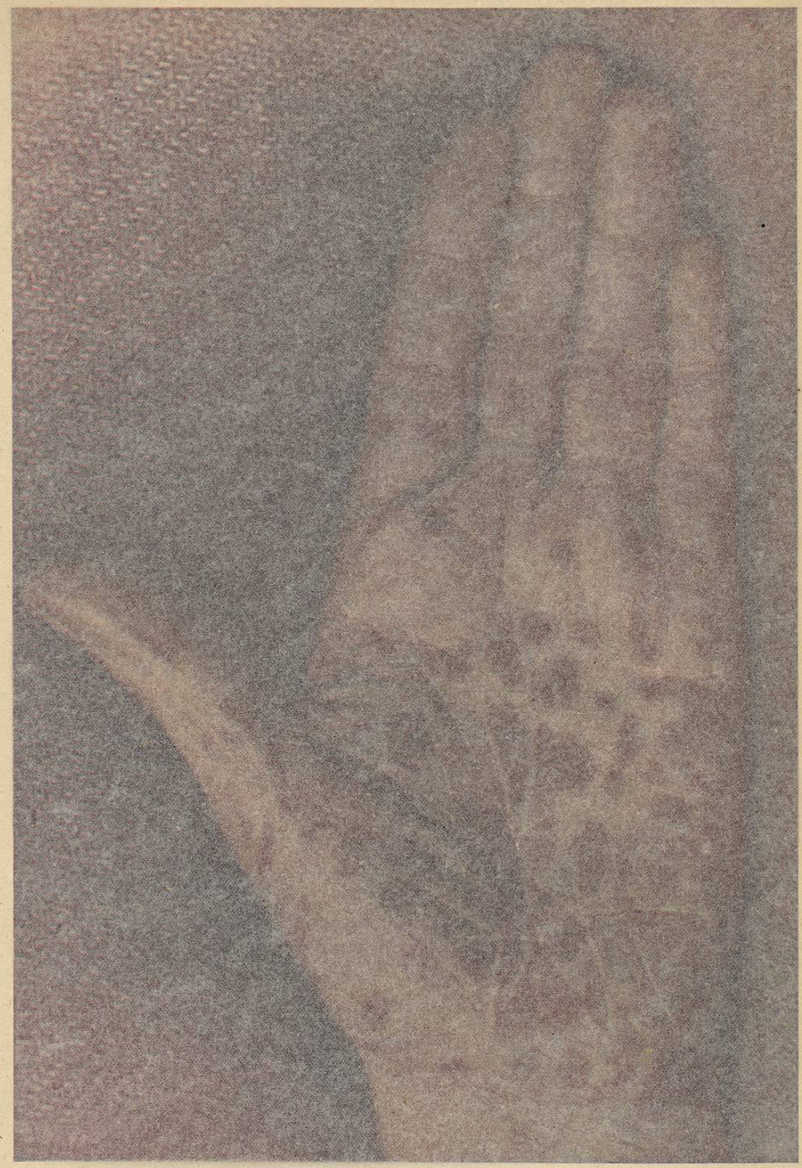
The Tubercular Syphiloderm.—Hyperplastic evolution of the papule, besides producing the aberrations from type already described, may also result in the formation of definitely circumscribed, deeply-seated, single or multiple, bright-reddish or livid, solid, cutaneous or more commonly subcutaneous, lesions, from the size of a pea to that of a small egg, known as tubercles. These are usually late syphilitic symptoms, which, in consequence of difference of involution, are divided into two classes.—the resolutive and the ulcerative.

The *resolutive tubercular syphilide* is characterized by slow evolution without marked subjective symptoms, disappearance after absorption of the plastic infiltration commonly involving the entire thickness of the derma, and the production, without previous ulceration, of an indelible scar. The lesions begin as superficial, reddish, and roundish gummatous nodules, the size of a pinhead, which, as they attain the larger dimensions named above, become flatter, smoother, more lustrous, and more deeply tinted. They are largely facial or cervical in situation, but may also spread over the trunk and extremities. They are often free from scales, except when seated upon the palms or soles, in which situations they may be covered with thick corneous plates beyond the borders of which can be recognized a violaceous halo. These lesions may be generally disseminated, or grouped in distinctly circumscribed patches, either circular in outline or exhibiting some modification of the latter (*e.g.*, the reniform, horseshoe-shaped figure, etc.). The former are the earlier; the latter the later, of occurrence.

When facial in situation, the tubercles may spread in a fan-shaped area over the forehead, or extend over the bridge of the nose to the cheeks, assuming the figure of a butterfly. The thinned, atrophic centre and elevated rim of the patch may then be significant.

An exaggerated grade of confluence and proliferation of these tubercles results in the hypertrophic, leontiasic, or vegetative syphiloderm. In these instances the nose, the chin, the ear, or some other part presents an enormous increase in bulk, with definitely distinguished lobules separated by furrows, the picture presented strongly resembling the elephantiasic condition. Again, a voluminous verrucous growth may spring from some portion of the scalp, and even in the end encroach upon a large part of that region, the warty mass freely projecting comb-like masses from the surface, smeared often with a puriform and offensive secretion (framboesia syphilitica, papilloma syphilitica, etc.).

The *ulcerative tubercular* (*tuberculo-ulcerative*) *syphiloderm* is a somewhat later manifestation of the disease, or one which, developing as it does rarely within a few months after the evolution of the chancre, occurs in neglected, untreated, cachectic, or so-called "galloping," cases. Here also the lesions appear upon the face, trunk, and extremities, with the general characteristics already described, but more commonly in definite groups. Instead of undergoing, however, the atrophic changes observed in the resolutive form, a portion, rarely all, of the tubercles forming the patch, soften or become covered with a greenish or blackish crust from desiccation of the ichorous or sanguinolent liquid furnished by the breaking down of the gumma, beneath which an ulcer forms somewhat larger in size than the lesions from which it sprang. In this way the face may display over the chin, forehead, or cheeks a dense tumefaction composed of a group of closely agglomerated, livid papules, ulcers, and crusts, the size of a pea, or a distinctly outlined ring of such lesions disintegrating at the periphery and surrounding an atrophic, cicatricial, or even ulcerated central area. Gangrene and phagedena very rarely complicate these destructive processes. The ulcers which form are



Erythematous Syphilide of Palm of Hand.

(From the Collection of Photographs of Skin Diseases belonging to Dr. John A. Fordyce, of New York.)

may be anticipated under proper hygienic management and energetic treatment.

THE VESICULAR SYPHILODERM.—Vesicles are rarely the results of the syphilitic process in the skin. They usually point to an exudation more acute in type than that recognized in the indolently traversed cycle of syphilis. Occasionally miliary papules exhibit a vesicular apex containing a droplet of serum. Circinate and other groups of vesicles are described by French writers as of occurrence in this disease. Two explanations of the so-called vesicular lesions are at hand: first, the development of eczema, herpes, etc., in infected persons—phenomena not rarely observed by an expert; second, the occurrence of vesicular lesions provoked by extensively applied or internally ingested medicaments employed for the relief of the systemic disorder.

THE BULLOUS SYPHILODERM.—Discrete, roundish bullæ, from the size of a pea to that of a small egg, appear simultaneously or in crops upon the syphilitic skin, in consequence of a more or less circumscribed elevation of some portion of the epidermis by accumulation of a clear lactescent serum, pus, or blood. The contents usually desiccate into bulky, adhesive, stratified, greenish or dark-colored crusts, which may cover granular, eroded, or ulcerative surfaces. Often they are surrounded by a violaceous halo. The ulcer, after removal of the crust, may spread in depth or area, or cicatrize; this according to the vigor of the patient and the treatment pursued. Lesions of this sort are rather more often recognized upon the extremities than elsewhere, in consequence of the greater distance of the latter from the centre of circulation. They are more often encountered in late

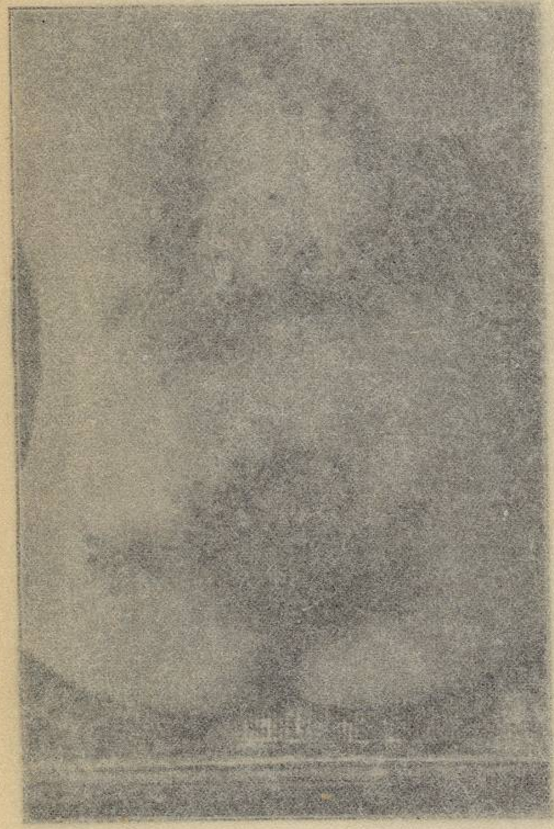


FIG. 4[illegible].—Serpiginous Tuberculo-ulcerative Lesions of the Skin of the Back.

periods of the disease, and in cachectic subjects. They are for these reasons most often seen in the [illegible] of the infant who is the victim of hereditary syphilis.

It should not be forgotten, when making a diagnosis of the bullous syphiloderm, that the iodide of potassium, in exceptional cases, is capable of producing such lesions in typical aspect when administered to the syphilitic as well as to the non-infected patient. American observers chiefly have called attention to this important fact, among them Drs. O'Reilly, Graham, Morrow, and the author.

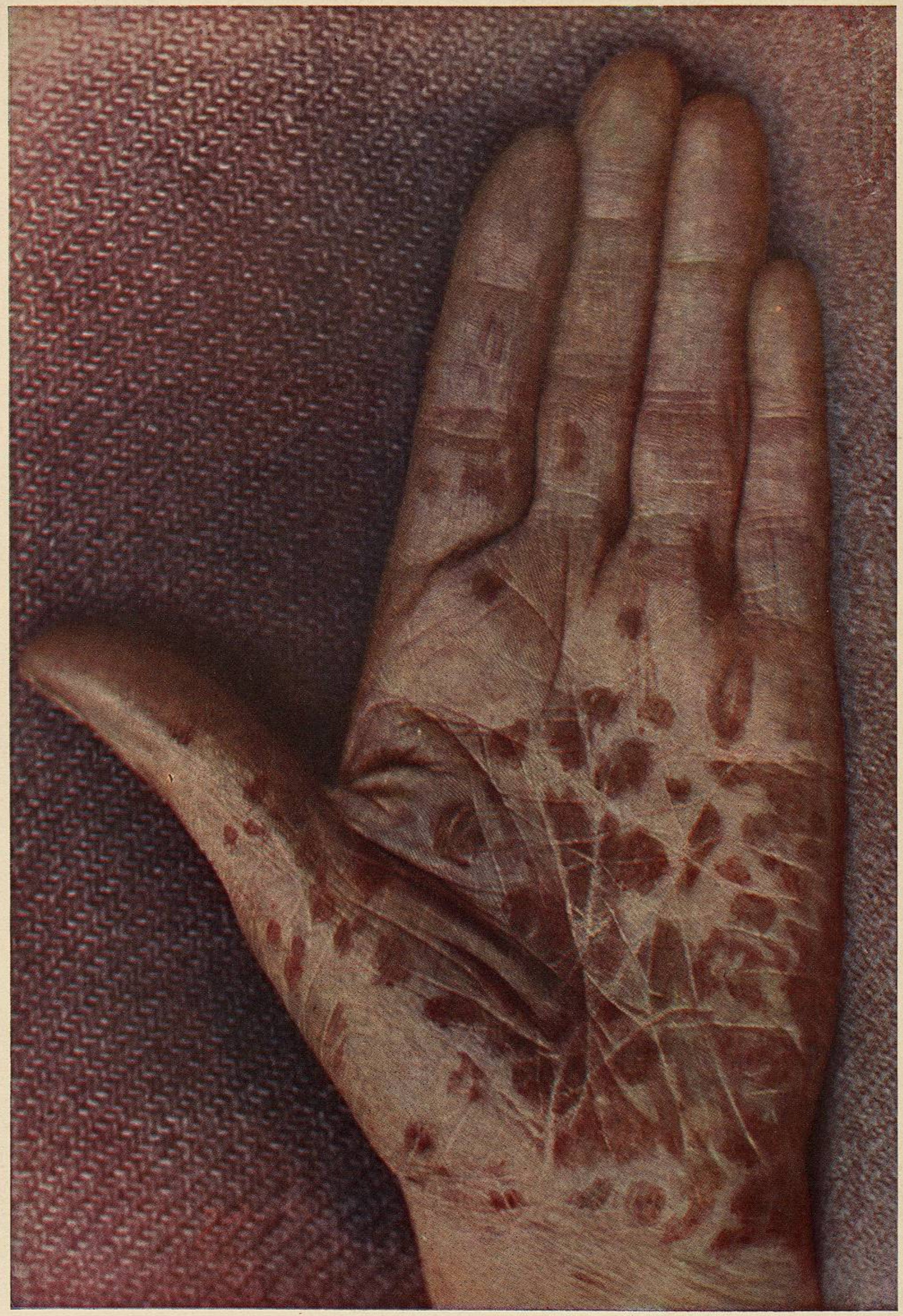
THE TUBERCULAR SYPHILODERM.—Hyperplastic evolution of the papule, besides producing the aberrations from type already described, may also result in the formation of definitely circumscribed, deeply-seated, single or multiple, bright-reddish or livid, solid, cutaneous or more commonly subcutaneous, lesions, from the size of a pea to that of a small egg, known as tubercles. These are usually late syphilitic symptoms, which, in consequence of difference of involution, are divided into two classes—the resolutive and the ulcerative.

The *resolutive tubercular syphilide* is characterized by slow evolution without marked subjective symptoms, disappearance after absorption of the plastic infiltration, commonly involving the entire thickness of the corium, and the production, without previous ulceration, of an indelible scar. The lesions begin as superficial, reddish, and roundish gummatous nodules, the size of a [illegible], which, as they attain the larger dimensions named above, become flatter, smoother, more lustrous, and more deeply [illegible]. They are largely facial or cervical in situation, but may also spread over the trunk and extremities. They are often free from scales, except when seated upon the palms or soles, in which situations they may be covered with thick corneous plates beyond the borders of which can be recognized a violaceous halo. These lesions may be generally disseminated, or grouped in [illegible] patches, either circular or [illegible] [illegible]

[illegible]

An exaggerated grade of [illegible] and proliferation of these tubercles results in the [illegible] syphilides. In these instances the nose, [illegible] the ear, or some other part [illegible] as enormous [illegible] in bulk, with [illegible] furrows, the [illegible] elephantiasic condition. Again, a [illegible] growth may spring from some portion of the [illegible] and even in the end [illegible] the warty mass [illegible] from the surface, [illegible] offensive secretion ([illegible] syphilitica, etc.).

The [illegible] (*tuberculo-ulcerative*) syphilide is a [illegible] manifestation of the disease, one which [illegible] as it does rarely within a few [illegible] of the chancre, occurs in [illegible] or so-called "galloping," [illegible] appear upon the face, trunk, and [illegible] general characteristics already [illegible] in definite groups. In [illegible] the atrophic changes [illegible] a portion, rarely all, of the [illegible] soften or become covered [illegible] crust from desiccation of the [illegible] liquid furnished by the [illegible] beneath which an ulcer forms [illegible] the lesions from which it [illegible] may display over the [illegible] composed of a [illegible] papules, ulcers, and [illegible] a distinctly outlined ring [illegible] the periphery and surround[illegible] or even ulcerated centre. [illegible] very rarely complicate [illegible] processes. The ulcers which form are



ERYTHEMATOUS SYPHILIDE OF PALM OF HAND.

(From the Collection of Photographs of Skin Diseases belonging to Dr. John A. Fordyce, of New York.)

of a typical syphilitic aspect, with pultaceous floor, steep, "clean-cut" edges, ichorous secretion, and serpiginous tendencies.

Mixed forms of commingled resolutive and ulcerative tubercles are not of rare occurrence. The following are

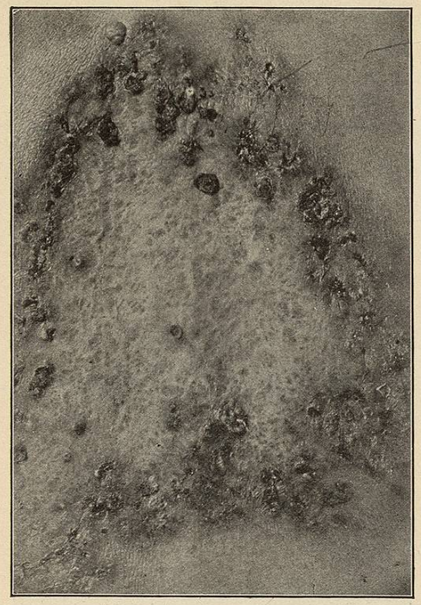


FIG. 4588.—Enlarged Portrait of Group of Lesions shown in Fig. 4587; showing Peripheral Extension by Multiple Circumscribed Ulcers.

common clinical pictures: A patient, from five to ten years after infection, has the forehead, nose, and cheeks fully covered with numerous, firm, smooth, shining nodules, the size of a pea, vivid and dull red in hue, occupying an infiltrated integument of the same general color. Some of the tubercles are slightly crust-capped, others are irregularly excavated as if wasting at such points. Between them are distinctly defined, atrophic, non-pigmented depressions from the size of a large pinhead to that of a pea resembling youngish scars. These are spread with some regularity between young and mature tubercles even at the scalp border and among the hairs over the tip of the nose and well over the cheeks. Uneven and verrucous patches may indeed occupy distant portions of the scalp where hairs have fallen from an atrophic area. Sometimes they undergo colloid degeneration. Attention is particularly directed to this complexus of nodules, crusts, atrophic discs, minute ulcers, and scanty pustules when occurring in this region, as it is a feature very rarely seen in any other disease than syphilis.

In most of these cases the changes wrought in the course of time after the employment of an appropriate therapy are marvellous. The violaceous tint disappears; the scars, if any have resulted, are transformed into thin superficial uncolored or dead-whitish inconspicuous blemishes; the natural fat of the panniculus adiposus is restored; and, even in middle life, after the fullest grade of evolution described above has been reached in the face of a woman, a fair degree of comeliness is restored.

Lupus vulgaris is distinguished from this condition by its onset at an earlier period of life, its far narrower limitations, its greater asymmetry, its profounder and more disfiguring scars, and its much more indolent career. The tubercles of lepra producing the characteristic leontiasic aspect of the face are far more chronic in evolution, more deeply pigmented and "varnished," less often ulcerated, crusted, and commingled with scars. The pearly, milium-like nodules of epithelioma are quite unlike the tinted tubercles of syphilis, are never so numerous, and the smooth-glazed, bright red, and scantily secreting floor of the epitheliomatous (rodent) ulcer never suggests the foul excavations of syphilis. Psoriasis is always scaly, never ulcerative in type, never crusted nor pustular. The most difficult cases for differential diagnosis are those of hypertrophic acne of the nose, with gaping orifices of sebaceous ducts whence comedo plugs may have been expressed, interspersed between dull-reddish acne papules. Here the history of the case, the absence of scalp-lesions, the stricter limitation of the patch to the tip and alæ of the nose, the absence of a distinct ulcer, and the conspicuously smaller size of the scar-like depressions, usually furnish a clew to the distinction sought to be established.

The blastomycotic patch is almost invariably distinguished by its characteristic encircling border or wall, on the sound side of the integument sloping gradually to the level beneath, studded with exceedingly minute pin-

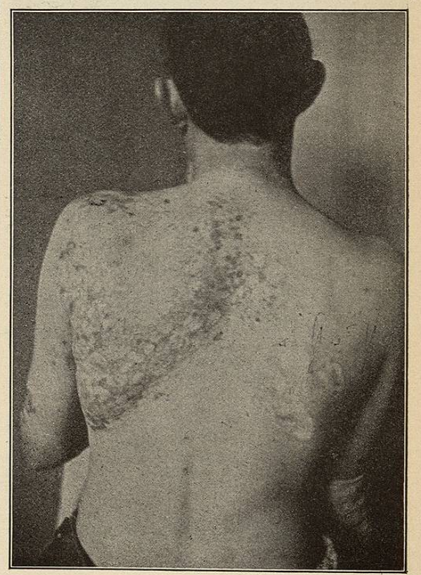


FIG. 4589.—Tubercular Syphiloderm of the Shoulders, showing Scars and Pigmentation.

point-sized abscesses, in the contents of which can readily be distinguished the double-contoured organism with its lucent lenticular space within.

THE GUMMATOUS SYPHILODERM.—Single and multiple, isolated or massed nodules, from the size of a pea to that of an egg, or larger, originating simultaneously, but