in the mother has been developed in the susceptible tissues of the child, and we have here an interesting example of the variability in the manifestations of the disease dependent upon the reactive powers of the tissues.

Were any further word necessary in support of this contention it would be found in the significant way in which the liver is affected in congenital syphilis. Extensive specific lesions of the liver in the acquired disease are relatively uncommon. They are the most common of all lesions in the congenital affection. As Chiari has pointed out, out of 144 cases of congenital syphilis examined by him, the liver was diseased (and that extensively) in 123 cases or nearly nine-tenths. Were the ovum infected it would be difficult to explain why the liver should thus be especially singled out. When we remember that this organ is the first to receive the blood coming by the umbilical vein, then if the infection originates from the placenta hepatic implication is the natural sequence.

The essential difference between such congenital, or ante-natal, and 'acquired,' or post-natal syphilis is, that in the former the virus passes immediately into the blood and so becomes disseminated through the organism, in the latter, the dissemination is delayed. The second stage of acquired syphilis, is the first stage of the congenital disease.

Again, although as a pathologist not in practice, I have not met with and am little likely to come across the condition, continuing the analogy between tuberculosis and syphilis[1] we must, I hold, admit the inherent probability of Kaposi's statement that it is possible to have a primary cutaneous syphilitic lesion, a true specific indurated chancre, not followed by any secondary effects. And further it is well established that women who have borne syphilised children and have themselves shown not a sign of primary or secondary manifestations may, years after, present unmistakable tertiary lesions.[2]

Up to this point, therefore, it may be laid down :

(1) That from analogy, as from clinical history and absence of any indications of the same, in sundry cases there may be an absence of the primary cutaneous or epithelial manifestations of syphilis.

(2) That individuals may fail to present either primary or secondary symptoms that are recognisable, and yet eventually develope definite tertiary lesions of the disease.

(3) That where the subject is relatively insusceptible, it is possible

[1] Every pathologist knows, many from personal experience, how frequent among those performing autopsies are cases of strictly localised cutaneous tubercles not followed by extension. Such primary cutaneous tuberculosis is characterised by its tendency to remain localised.

[2] Vide Finger, Arch. f. Dermat. u. Syph. 1890, p. 331.