20 per cent. of all cases, and in most women, there is no history of a sore.

It is well known that a mixed infection may occur, so that the appearance of a soft sore or a gonorrhea does not preclude the possibility of the spirochete having gained entrance at the same time. It is remarkable how frequently we find evidences of syphilis in patients who give only a history of gonorrhea. Soon after the appearance of the sore the nearest lymph glands become infected, and next the organisms gain entrance to the blood stream, and are distributed to all the organs and tissues, producing the general symptoms and symmetrical lesions characteristic of the septicemic stage of the disease. After a time the organisms disappear from the circulation and are deposited in different parts, where they may afterwards give rise to the *asymmetrical* lesions—the nodes, gummata, or vascular manifestations of the so-called tertiary stage. Recent investigations have shown that the central nervous system is invaded at a much earlier period of the disease than was formerly believed to be the case, though so far as symptoms are concerned the infection of the nervous system may remain latent for years. P. Ravaut (*Ann. d. Med.*, Paris, 1914) says that there is a *preclinical* involvement of the nervous system in 65 per cent. of cases in the secondary stage of syphilis. The discovery of the spirochete in tabes and general paralysis has proved that these lesions are due directly to the spirochete, so that the term *parasyphilitic* must disappear from the medical vocabulary.

The failure to recognize secondary syphilis is frequently due to an imperfect practical acquaintance with other skin diseases, from which it must be differentiated, but a *generalized eruption without itching,* and *associated with enlargement and hardness of the lymph nodes, especially the epitrochlears, sore throat, falling of the hair,* etc., is very characteristic. An experienced observer will often detect a slight enlargement and increased consistency of these nodes after all other signs of the infection have disappeared. This is important clinically.

It is well known that a high fever, with chills and other febrile symptoms, may be present during the secondary period. In the two cases of accidental infection in physicians, before referred to, the patients mistook these symptoms for an attack of la grippe. Typhoid fever and miliary tuberculosis are also at times erroneously diagnosed as the cause of the trouble.

It is not, however, the primary infection nor the secondary manifestations that are most frequently overlooked or wrongly