ilitic nodes of the internal organs, being protected from contact with the outer air, rarely, if ever, terminate in ulcerative destruction: they generally tend to fatty involution, absorption, and cicatrization. Specific deposits of the outer skin, the mucous membranes—as, for example, of the nasal and oral bones, on the other hand, are all noted for their pronounced tendency to rapid ulceration or gangrenous destruction.

The explanation of this peculiar difference in the behavior of indurations or tumours essentially identical in morbid character, is to be found in the fact that the poor nutrition and low vitality of the cellular elements composing a primary or secondary syphilitic node, exposed to pyogenic infection by contact with the outer air, offers very favorable conditions for the rapid development and destructive multiplication of germs that are notoriously deleterious even to healthy tissues exposed to them. Pus-generating cocci deposited on the excoriated surface of a syphilitic focus, as, for instance, a primary induration of the prepuce, or a gummy swelling of the nasal bones, will, by their multiplication, lead to massive invasion and rapid ulcerative destruction of the densely infiltrated and poorly nourished node.

Syphilitic ulcers of every kind present a combination of syphilitic and of pyogenic infection.

If we succeed by appropriate systemic treatment in preventing the extension of the central softening of a syphilitic node to the surface, ulcerative changes also will thus be prevented. For example: The timely administration of large doses of iodide of potash may prevent necrosis of the nasal bones, which are the seat of a growing gummy swelling. Their dense infiltration pertains to syphilis; their necrosis, however, is caused by the invasion of pyogenic germs. But we possess another means for preventing ulcerative destruction of syphilitic deposits located in the outer skin. They are more exposed to pyogenic infection, but they are also more accessible to local remedies.

The aseptic protection of the surface of the primary induration offers an easy remedy for preventing the formation of the primary ulcer or chancre.

True, that the prevention of the ulcerative destruction of a primary induration of the prepuce will not prevent the systemic development of syphilis; but it will, nevertheless, constitute a valuable service rendered to the patient, who will be spared all the suffering, annoyance, and danger connected with the development of the primary ulcer.

If a patient, exhibiting a recent primary induration of the penis, presents himself for treatment before the appearance of the pustular excoriation, or before the epidermal film of the formed pustule is broken, and if the surgeon thoroughly cleanses and disinfects the affected parts, afterwards carefully enveloping the penis in an aseptic dry dressing, ulceration of the indurated node—that is, the development of a primary ulcer—can be effectually prevented.

The node will lose its epidermidal covering, but the aseptic dressing will exclude pyogenic infection, and the course of development and involution of the syphilitic deposit will be as though it were subcutaneous. A small quantity of lymph will exude from the excoriated surface, will be imbibed by the aseptic dressing, and will exsiccate,—thus forming a hermetic seal and protection to the diseased tissues.

Fatty disintegration of the infiltrated tissues will be followed by the formation of new epidermis, and when, after three or four weeks, the dressings come off, a cicatrized though still somewhat indurated portion of skin will be exposed to view.

Specific rash, and other manifestations of systemic infection, will appear in due course of time; but the incalculable extension of the ulceration to adjoining non-infiltrated parts of the skin, and the formation of suppurative buboes and other complications, will be obviated. The following case may serve as an illustration:—

Case H. B., aged 25, presented himself Jan. 2nd, 1887, with a hard, elevated node, the size of a nickel, occupying the dorsum penis, and another smaller induration near the frenulum. Suspicious cohabitation had been indulged in for some time until within a few days of the visit. Bilateral indolent inguinal lymphadenitis was noted, and the presence of specific infection was assumed. The patient was kept under daily observation, and was directed not to