ionally these form large cauliflower-like excrescences.

The presence of these condylomata may be the first indication to the midwife that the patient is syphilitic.

The placenta is also the site of syphilitic disease, which may result in the death of the fœtus. In many patients no history of a rash can be elicited, and the first intimation of the existence of the disease is afforded by the birth of a premature or macerated fœtus. The syphilitic placenta is large and pale, and often presents a dull greasy appearance; it sometimes shows yellow or white firm patches.

Tertiary Syphilis.—The symptoms of tertiary syphilis usually appear during the third or fourth year after infection. Under suitable treatment the patient should be cured in the secondary stage, but patients often neglect treatment and fail to persevere with it, with the result that syphilis passes into a chronic condition called tertiary. Almost all he organs of the body are liable to be affected by tertiary syphilis, either with chronic inflammatory changes or with the formation of tumours called gummata.

Bones and joints become chronically inflamed, tumours occur in the brain; degeneration of brain and spinal cord is also of common occurrence, giving rise to various forms of paralysis.

Deafness and blindness as well as disease of the heart and arteries are liable to result from tertiary syphilis.

Various skin diseases are apt to appear during this stage and may be the only sign of the disease.

But there may be no symptoms for several years, during which the patient appears quite well, but the blood gives a positive Wasserman test, a sure indication that the disease is still present.

In the tertiary stage the nurse need have no fear of contagion.

2. In the Child.—Syphilis is the most frequent cause of fœtal death in the later months of pregnancy. The mother may be suffering from the disease at the time of conception, or may contract it during the course of pregnancy, but in either event transmission to the fœtus occurs through the placenta. Usually it leads to the premature expulsion of a macerated premature fœtus. Less commonly the child is born alive showing distinct manifestations of the disease, while in other cases they do not appear until a later period.

The appearance of the syphilitic fœtus varies materially, according as it is born alive or dead. In either instance it is markedly undersized, and the subcutaneous fat is poorly developed or entirely lacking. In the living child the skin usually presents a dry, drawn apearance, and has a peculiar gray'sh hue. It is very brittle and readily cracks at the flexures of the joints. The skin covering the soles of the feet and the palms of the hands is often thickened and glistening, like the hands of a washerwoman. In other cases characteristic vesicles are noted in the same locations.

If intra-uterine death has occurred the skin peels off at the slightest touch.

New Zealand Branch British Red Cross and Order of St. John

Readers will have seen the advertisements in the daily paper for two nurses, one to act as an organising nurse in New Zealand for health work in connection with home nursing classes, lectures and demonstrations, and the other to take the scholarship for nurses in the course of Public Health Training, for which Sister Webster went to Bedford College a year ago. We await with great interest these two appointments. Sister Webster, on completion of her course and before returning to New Zealand to take up the health work for which she has had so complete a training, has been given leave in order to take her midwifery course.