usually productive of great good. The measure above all others to be adopted is prophylaxis; and this includes the proper care of the primarily injured eye, as well at the time of the injury as later on; and this of course involves the question of enucleation. This is an important problem, and there are many points to be carefully considered before a conclusion is reached. It may be stated as a cardinal point, however, that an eye so seriously injured in the ciliary region as to preclude the possibility of retention of sight should be promptly removed; for such an eye is not only a useless organ, but is a source of constant menace to its fellow.

(20) *Diseases of the Eye from Syphilis.*—Syphilis is a prolific source of eye disease, and may cause almost any form of it. The *inherited* form of syphilis, through defective development or inflammation of the several parts of the eye during intra-uterine life, may cause blindness. And abnormalities in the osseous development of the orbit or of the skull may, through pressure upon the visual tract, cause optic neuritis or atrophy and blindness. Diffuse (parenchymatous) keratitis—a disease of early life—is also occasionally productive of blindness. Either the *inherited* or the *acquired* form of syphilis may cause blindness through kerato-iritis, iritis, irido-cyclitis, irido-choroiditis, choroiditis, retino-choroiditis, and optic neuritis or atrophy. In tertiary syphilis, gummata—affecting by preference the sclera or the ciliary body—may produce destruction of the eye. And the periosteal or bony lesions of this stage may cause, through participation or by their pressure effects, disease of the eye or of its conducting apparatus, which leads to blindness. An early recognition of the specific taint, and prompt and energetic measures against it, constitute the sheet-anchor of success in all diseases dependent thereon.

(21) *Gonorrhœal Conjunctivitis.*—This is a most virulent form of purulent ophthalmia, due to inoculation of the conjunctiva with the discharge from a specific urethritis or vaginitis. The material is conveyed to the eye by accident or by carelessness, through unwashed hands in persons with gonorrhœa, or in those treating it, and the use of towels or of linen which have become contaminated. Perfect cleanliness and care, observed by gonorrhœal subjects and by their attendants and associates, would expel this disease from the category of eye affections.

(22) *Scrofulous Diseases of the Eye.*—The strumous condition is a fruitful source of eye disease, yet the diseases to which it most frequently gives rise—ophthalmia tarsi, phlyctenular troubles, etc.—seldom cause blindness. One of its diseases, however—cyclo-keratitis—is a most serious disease, and often produces blindness. It was first described by Dalrymple, and is sometimes spoken of as Dalrymple's disease. It is fortunately rare. Lupus is usually considered a strumous disease, and this may lead to destruction of the eye—whether attacking the eye primarily, or involving it secondarily. Tuberculosis may also cause blindness, through choroiditis, iritis, and keratitis.

(23) *Irido-choroiditis with Meningitis.*—This disease is commonly spoken of as metastatic choroiditis, and is caused by an extension of inflammation from the head to the eye in simple meningitis, or, as is more frequently seen in cerebro-spinal meningitis, by metastasis. The disease usually destroys the eye, and treatment is ordinarily unavailing.

(24 and 25) *Atrophy of the Optic Nerve (Cerebral and Spinal).*—It is often difficult and sometimes impossible to locate the lesion upon which optic-nerve atrophy depends, and it will be convenient to consider these two forms together. According to Galezowski, who tabulated 166 cases of optic-nerve atrophy, about 50 per cent. are due to diseases of the brain and spinal cord; 13 per cent. are traumatic; 9 per cent. are due to alcoholism; 8 per cent. to syphilis, and the remaining causes are of the most varied kind. And according to von Graefe, about 30 per cent. of cases of primary atrophy of the optic nerve are due to spinal disease.

Cerebral optic-nerve atrophy may be consecutive to optic neuritis (of central origin), or it may follow lesion of the chiasm, of the cerebral centres, or of the cortex about the angular gyrus, or it may be caused through pressure upon the nerve by an exostosis, tumor, or aneurism; through narrowing of the optic foramen by hyperostosis or by pressure upon the chiasm from distention of the third ventricle. Meningitis, chronic or acute, may also cause ptosis, or atrophy without recognized neuritis, etc. *Spinal atrophy* occurs with locomotor ataxia, of which it may be the earliest symptom; or it may, as is often the case, come as a late manifestation of the disease.

(26) *Atrophy of the Optic Nerve, or Neuritis after Hæmatemesis.*—Loss of blood is occasionally followed by affection of vision, which may be temporary or permanent. It is with the latter that we have to deal, and this usually depends upon either neuritis or atrophy. Clinical experience has taught that hemorrhages from the gastro-intestinal tract cause disturbance of vision more frequently than hemorrhages from other localities (thirty-five per cent.). The connection between the loss of blood and disease of the optic nerve has so far received no satisfactory solution. The same connection probably exists between *atrophy of the optic nerve after bleeding from piles* (27), and *after dysentery* (28).

(29) *Atrophy of the optic nerve after vomiting* is rare, and the connection between the two is obscure. The straining and consequent congestion may produce retro-ocular hemorrhage, or serous effusion; or it may be due to the connection which exists between the stomach and the corpora quadrigemina.

(30) *Optic-nerve atrophy after facial erysipelas* is usually caused by an extension of the cellulitis to the tissue of the orbit, and the resulting damage to the trunk of the nerve.

(31) *Atrophy of the Optic Nerve with Insanity.*—Atrophy sometimes occurs among the insane, and most frequently in subjects of general paresis—though it sometimes occurs in dementia and in other forms of insanity. It is a degenerative change, associated with similar lesions in the central nervous system.

(32) *Atrophy with Epilepsy.*—It does not appear that idiopathic epilepsy has connection with any form of eye disease. It is only in such cases as are dependent upon gross intracranial lesions that changes are observed in the disc, and the atrophic changes here differ in no way from those seen in the usual forms of brain disease.

(33) *Retinitis nephritica* occurs in about twenty-five per cent. of cases of chronic Bright's disease. It is more important as a means of diagnosis than as a cause of blindness, for not infrequently it is the first symptom which leads to a detection of disease of the kidney. It rarely causes blindness, however, in spite of the marked pathological changes that are noticeable in the retina, and often in the optic nerve.

(34) *Diseases of the Eye with Typhoid.*—Loss of sight has been many times observed during convalescence from typhoid fever, and, subsequently, optic-nerve atrophy has usually been found. In some of these cases cerebral symptoms have been observed, and in others there was none. Keratitis is sometimes seen, and blindness may be one of its consequences.

(35) *Blindness from measles* may be due to optic neuritis, or it may result from neglected diseases of the external eye, *i.e.*, conjunctivitis, keratitis, etc.

(36) *Disease of the Eye from Scarlatina.*—The frequency with which renal disease accompanies scarlet fever renders affections of sight not very rare consequences of the disease. Yet neuro-retinitis does occur without the presence of renal disorder. Atrophy of the optic nerve may also be the result of scarlatina. In malignant cases sloughing of the cornea has been observed, and in other cases keratitis may produce blindness.

(37) *Disease of the Eye from Variola.*—Variola may cause neuro-retinitis or atrophy of the optic nerve; but its chief danger is from diseases of the external eye, almost any part of which may be the seat of the eruption. The most dangerous seat is the cornea, where ulceration often leads to blindness. Iritis has also been observed.

TABLE XII.

Preventable causes of blindness.	Per cent.	Probably preventable blindness.	Per cent.	Unpreventable blindness.	Per cent.
Ophthalmia neonatorum	10.876	Diseases of the cornea	4.034	Diseases of the cornea	4.034
Trachoma and blennorrhœa	9.402	Direct injuries of the eye	2.017	Direct injuries of the eye	2.017
Diphtheritic conjunctivitis	.356	Unsuccessful operations	1.978	Tumors of eye and surroundings	.356
Choroiditis myopica	.949	Irido-choroiditis, cyclitis, iritis	4.430	Irido-choroiditis, cyclitis, iritis	4.430
Detachment of retina	3.746	Detachment of retina	1.000	Injuries to the head	.277
Glaucoma	8.000	Glaucoma	.978	Scrofulous diseases	.039
Sympathetic ophthalmia	4.509	Unclassifiable	1.681	Unclassifiable	1.681
Gonorrhœal ophthalmia	.910	Diseases of the eye from syphilis	.238	Disease of eye from syphilis	.238
Diseases of eye from smallpox	2.216	Choroiditis, chorio-retinitis	.369	Choroiditis, chorio-retinitis	.738
Intoxication amaurosis	.039	Idiopathic optic-nerve atrophy	2.000	Idiopathic optic-nerve atrophy	5.751
		Optic-nerve atrophy, cerebral	2.000	Optic-nerve atrophy, cerebral	4.961
		Optic-nerve atrophy, spinal	.333	Optic-nerve atrophy, spinal	2.000
		Typhoid, measles, scarlatina, etc	1.165	Typhoid, measles, etc	1.165
				Irido-choroiditis with meningitis	1.424
				Other causes, including 3.835 per cent. of congenital blindness	5.412
	41.093		22.223		34.523

Important as the local treatment of these disorders may be, the prophylactic measure of vaccination should supersede them all, and thus prevent entirely the disease upon which they depend.

(38) *Disease of the Eye from Heart Trouble.*—The most frequent cause of blindness from heart disease (valvular) is the so-called embolism of the central artery of the retina. This is usually monocular, but sometimes both eyes are affected. Thrombosis of the central vein of the retina behind the eye, in association with disease of the heart, may also produce blindness. In ulcerative endocarditis retinal hemorrhages often occur, and sometimes panophthalmitis is observed.

(39) *Diseases of the Eye from Childbirth or Pregnancy.*—In pregnancy we are liable to have albuminuric retinitis, and, following childbirth, we may have metastatic choroiditis, or retinal hemorrhage; and cases of atrophy of the optic nerve are sometimes dependent upon lactation.

(40) *Intoxication Amaurosis.*—Under this head are included cases of blindness resulting from the abuse of certain noxious agents, chief among which are alcohol and tobacco. It is claimed that the free and long-continued use of either of these substances not infrequently leads to a form of optic-nerve atrophy possessed of certain distinctive peculiarities. There seems to be good reason for attributing such to alcohol, but the reasons in favor of tobacco are not so strong.

(41) *Blindness from Diseases of the Orbit.*—Inflammatory processes in the orbit, whether in the cellular tissue or in the periosteum or bone, may cause either simple atrophy of the optic nerve or neuritis and consecutive atrophy. With much swelling of the orbital tissue there is danger that the nutritive supply of the globe may be cut off by pressure, and that the inflammation or sloughing which results may produce blindness. Tumors of the orbit may act as inflammatory products, or, the disease extending to the eye, may directly cause destruction of this organ.

An important matter in the consideration of the causes of blindness, is the proportion composed of those whose origin is unavoidable, and the course of which is beyond control. If arranged under the headings of *Preventable*, *Probably Preventable*, and *Unpreventable Blindness*, we are at once struck with the large number included under the *first* and *second* headings, and the small proportion embraced under the *last*. Absolute accuracy in this arrangement is, of course, not claimed, but it will serve the purpose of illustrating the large amount of blindness arising from avoidable causes, and such as are amenable to treatment.

It may be of interest to state that the first institution for the blind was founded in Memingen, by Weef VI., in 1178: the second in Paris, by St. Louis, in 1260; the first for the employment of adult blind was opened in Edinburgh, by Dr. Johnston, in 1793. There were, in 1873, one hundred and forty-eight institutions for the blind in the world.

There are certain *irregular forms of blindness* which will be treated of under appropriate headings elsewhere, and it will be necessary to refer to them here only in a general way. The free exhibition of *quinine* or of *salicylic acid* sometimes causes blindness, and it has been observed in rare instances to follow the use of *silver*, of *mercury*, and of *lead*. Prolonged exposure to the fumes of *sulphide of carbon* may produce amblyopia; and the fumes of *osmic acid* may bring about the same condition. The circulation, in the blood, of a superabundance of *urea* is apt to cause transient attacks of blindness. And in *migraine*, or sick headache, attacks of blindness are not infrequent. The attacks of blindness in the foregoing conditions of the system are usually transient, and perfect recovery quickly follows: yet, if they are often repeated, permanent impairment of sight may result, which in some instances declares itself as a low grade of optic neuritis or atrophy. *Hysterical amblyopia* is a recognized condition. It is temporary and irregular, and is usually attended by other hysterical symptoms. Temporary blindness may occur as the *aura* of an *epileptic attack*. Cases of *word-blindness* which were dependent upon lesions about the angular gyrus have been observed in individuals who could talk and even write. *Night-blindness* or *moon-blindness*—hemeralopia—is a condition of torpor of the retina which usually affects those who have been long exposed to bright lights—as sailors or marching soldiers, in the tropics. Insufficient food, either as to quantity or quality, seems also to be a factor in the disease. *Day-blindness*, or *nyctalopia*, is a form of retinal hyperæsthesia which is also usually caused by long exposure to glistening surfaces brilliantly illuminated by the sun. *Snow* or *ice blindness* is a variety of nyctalopia, though there are usually with this form signs of conjunctival implication. *One-sided blindness*, or *hemianopsia*, which may exist in various forms, is occasionally seen, and it is often of importance in locating intracranial lesions. *Blindness from disuse—amblyopia ex anopsia*—is claimed by many to result from the long-continued disuse of an eye. *Simulated blindness* can usually be detected, yet it is often done with difficulty. *Color-blindness—achromatopsia*—may exist in various forms. It is of great importance, and receives ample consideration elsewhere.

Prevention of Blindness.—Much can be done toward peventing blindness through a better understanding of its causes by the laity, while the profession should not only be alive to these points, but should be able quickly to recognize diseases of the eye, and acquainted certainly with the simpler forms of treatment. The most prolific source of blindness—ophthalmia neonatorum—can be stamped out by the observance of the simplest procedure—Credé's method—already referred to. So important is this disease that the legislatures of some of the European countries, and of some States in our Union, have enacted laws for the guidance of those concerned.

The act of New York, which will serve as an illustration, is given here:—

"An Act to Prevent Blindness.

"Sect. 1. Should any midwife or nurse having charge of an infant in this state notice that one or both eyes of such infant are inflamed or reddened at any time within two weeks after its birth, it shall be the duty of such midwife or nurse, so having charge of such infant, to report the fact in writing within six hours to the health officer, or some legally qualified practitioner of medicine, of the city, town, or district in which the parents of the infant reside.

"Sect. 2. Any failure to comply with the provisions of this act shall be punishable by a fine not to exceed one hundred dollars, or imprisonment not to exceed six months, or both.

"Sect. 3. This act shall take effect on the first of September, 1890." *James Lancelot Minor.*

BLISTERS.—This subdivision of agents, otherwise and technically known as vesicants or epispastics, belongs to the larger order of so-called Irritants. They also belong, in the arbitrary classification of drugs, to the Neurotics—on account of their counter-irritant action, which effect is produced largely through the nervous system. There are four degrees of irritant action, and these are expressed in the following classification: (1) Rubefacients; (2) Vesicants or Epispastics (blisters); (3) Pustulants or Suppurants; and (4) Escharotics. Each of these, which differ only in degree, represents substances, which, when applied to the skin, produce more or less irritation, *i.e.*, vascular reaction or excitement. Rubefacients, by rousing the capillaries, are intended to excite mere redness; if allowed to remain in contact with the skin too long, they sometimes produce vesication. Epispastics applied to the skin excite not only redness but also more or less local inflammation, accompanied by the transudation of serum beneath the cuticle. Such fluid transudations, forming between the epidermis and the dermis, at first minute, soon coalesce into one or more larger accumulations, called a *blister*.

The list of principal vesicants includes cantharides, iodine, the volatile oil of mustard, the confined vapor of ammonia, the confined vapor of chloroform, chloral hydrate crystals (if confined), glacial acetic acid, rhus toxicodendron, euphorbium, mezereon, heat in the form of Corrigan's hammer, the moxa or plain boiling water, also turpentine and other agents. All of these may act either as mere rubefacients or as vesicants, according to the length of time during which they are permitted to remain in contact with the surface of the skin, and also according to their degree of concentration.

Physiological Action.—When a blister is applied to the integument, the superficial vessels, and particularly the capillaries, become engorged; and at the same time the subject of the experiment feels a sense of warmth and tingling, which latter soon gives way to heat, burning, and actual pain. Reflexly, the deep-seated vessels may also undergo dilatation, and in this consists the *counter-irritant action* of blisters. After a variable length of time—dependent upon the character and activity of the vesicant employed, as well as, also, to some extent, upon the histological character of the tissue to which the blistering agent is applied—clear serum, plasma, and finally, in some instances, more or less blood corpuscles escape from the vessels and collect between the epidermis, which is now raised, and the true skin, forming what is known as a bleb, blister, bulla, bulle (French), Blase (German). Occasionally, where the blistering material is weak, its action may cease with mere capillary dilatation, heat and redness (rubefacient effect). On the other hand, it is possible, for a very strong and active epispastic, if kept for too long a time in contact with the skin, to act with such force, as to cause pustulation. The size of the vesicle is proportionate to the dimensions of the blistering material used, the surrounding skin being more or less inflamed and erysipelatous in appearance. Primarily, a stimulant action is observed not only in the organs and parts in close proximity to the blister, but also in the entire superficial circulation. With this is associated a corresponding diminution in the deep-seated vascular pressure, and this secondary depression is proportionate to the size of the blister or, more properly, to the amount of albumin abstracted from the blood. Under certain circumstances, and especially in old or debilitated persons, this depression may become alarming.

The exact *modus operandi* of vesicants is not clearly understood. By some the counter-irritant action is thought to play the most important part, and these persons explain this action as taking place through the nervous system. They maintain, that, by a determination of nervous as well as vascular energy to the blistered part, there is produced a derivative or revellent effect in the deeper structures,—an effect, which is accompanied not simply by anæmia, but also by changes in the nutrition and secretion of the organ or part affected. Other authorities attach importance to the stimulant action, which is exerted, by extension, upon the capillaries of the inflamed structure or structures (in behalf of which the blister was applied to the skin).

Uses of Blisters.—To relieve pain; to reduce swelling and to allay deep-seated inflammation; to facilitate absorption; to stimulate secretion; to recall suppressed discharges or to recall suppressed inflammation, as in mumps (see below); to stimulate the whole body, as in syncope (or in coma), or a part of the body, as in paralysis; to prepare a surface for endermic medication. Blisters are employed to good advantage in chronic inflammation of joints, either of rheumatic or of gonorrhœal origin; in chronic thickening about the joints; in chronic synovitis and periostitis; in spinal and in cerebral meningitis; in insolation (sunstroke); in optic neuritis and in iritis (applied behind the ears); in otitis media; in mastoid inflammation and in inflammation of the sinuses (frontal sinus, antrum of Highmore, etc.); in neuralgia, gastralgia, enteralgia; in pleurodynia; in hysterical paralysis; in facial paralysis; in reflex cough; in aphonia; in obstinate vomiting; in enuresis; in spermatorrhœa; in alcoholic or opium narcosis; in lumbago; in sciatica; in endocarditis, pericarditis, and pleuritis; in hydropericardium or in dropsy of other sacs, especially in hydrocephalus; in hepatitis, splenitis, ovaritis; in metastatic orchitis (of mumps, when it is well to place the blister over the parotid); in prostatitis and in chronic gleet. Blisters are also employed to stimulate indolent ulcers or fissures; and in chronic eczema and other chronic dry and scaly skin disorders, especially of a somewhat inflammatory character, to substitute a healthy, acute inflammatory action for the existing, long-continued, chronic inflammation. What the action of blisters is in such cases is not known, but they have been used to good advantage in erysipelas, as a means of preventing the spread of the process. In functional diseases of the nervous system, the counter-irritant action and the stimulant as well as the moral effect of the blister almost invariably prove salutary. Good results have also been reported from the application of a blister over the perineum in spermatorrhœa, over the back of the neck in incontinence of urine, and over the epigastrium in persistent nausea.

Contraindications.—Blisters should be avoided in the very young, in the very old, and in those who are debilitated, or who have depressed vital forces. They should never be applied in the following situations: directly over an inflamed part, over a bony prominence, over a part pressed upon by clothes, over recumbent parts which are pressed upon in bed, over parts which are deprived of vitality by the presence of cicatricial tissue or by paralysis—in a word, over any part in which the circulation is poor, and in which consequently the blister might cause gangrene and sloughing. In parts of the body, where there is considerable loose connective tissue—such, for example, as the scrotum, the labia, the eyelids, or the axilla—blisters should not be applied. In pregnancy, also, it is best not to make a blistering application about the breasts. Diabetes, scurvy, purpura, and the acute exanthemata contraindicate the use of blisters. Too long contact of the vesicating material with the skin should be carefully avoided, as deep ulceration may occur, and a special warning must be given in regard to cantharides, which should not be allowed to remain too long over any portion of the thorax or abdomen, lest inflammation of the pleura or of the peritoneum arise. Cantharides should blister in from four to seven hours. The confined vapor of aqua ammoniæ fortior acts in from three to ten minutes, but a blister thus produced is very painful. For this reason, the following mixture, called Granville's lotion, is preferable: it consists of five parts of the aqua ammoniæ fortior, two parts of the spirit of camphor, and one part of the spirit of rosemary. A piece of flannel is saturated with this lotion and laid on the skin. It will produce a blister in from three to ten minutes. Gondret's vesicating ointment is also very satisfactory. It is prepared with two parts of expressed oil of almond, melted together with thirty-two parts of lard, and to which seventeen parts of aqua ammoniæ fortior are added. It will blister in ten minutes, causing less pain than plain ammonia does. Pain is not always a safe guide, as regards the time when the blistering agent should be removed, and this is especially true in cases in which blisters are applied as stimulants—as, for example, in syncope or in the shock following hæmorrhage or injury,—for, in these conditions, pain may be entirely wanting. Cantharides, the prince of blistering agents, is contraindicated, as a rule, in renal disease, also in inflammatory conditions of the genito-urinary tract, in which it is accused of producing priapism, erotic excitement, strangury, pain, tenesmus, bloody urine, and the like. These latter very distressing effects of cantharides may be prevented, at times, by the use of powdered camphor or bicarbonate of soda, sprinkled on the blistered surface. A thin piece of silver paper, spread over the blister, is also said to prevent strangury.

Synergists.—On the absorbents, the action of blisters is aided by alteratives; and it is also probable that the various drugs, that belong to the class of stimulants synergize vesicants. The blister either may be permitted to heal or it may be converted into a running sore, just as the physician may prefer. Perpetual blisters, however, are very seldom employed to-day. In fact, the hitherto very commendable custom of blistering has fallen into an undeserved disrepute in recent years. So soon as the blister has formed, it is well to puncture it at its most dependent point, allowing the serum to escape. Then a simple dressing of cerate or any other bland, unirritating material will favor prompt healing. Basilicon salve or other more irritant ointment may be employed in those cases in which it is intended to maintain the discharge. When the vesicant has been removed, and no blister forms, a bread-crumb poultice, made with milk, will help it to develop. Lead water and laudanum is recommended as an application for painful blisters. A succession of small blisters, applied one after the other, whereby continuous counter-irritant action is obtained, represents what are termed "Flying Blisters." Besides the commonly employed Spanish fly plaster, which is made by mixing ceratum cantharidatum with wax and spreading it on a thin cloth, there are numerous other cantharidal preparations—ethereal, alcoholic, watery, and hydrochloric extracts of cantharides,—all more or less active; and, among these, none is more useful than cantharidal collodion. It possesses one great advantage: it can be applied to any surface, no matter how irregular it may be. As an application in alopecia circumscripta (functional) and in tinea tonsurans and circinata, collodium cantharidatum is much used. The cantharis vittata or potato fly, inhabiting the potato plant of the United States, contains a percentage of cantharidin, and resembles, in its effect, the imported Spanish fly.

It is to be hoped that the pendulum will one day, in the near future, swing back from its present extreme position, and give to this branch of our therapeutic armamentarium its proper place. The statement has been made by the former writer upon this subject in a previous edition, that venesection, only, can so quickly and radically induce changes in the physical and physiological condition of limited areas of surface or of extensive parts or organs as vesication. If this statement be true, and we believe that it is, then it were well for steps to be undertaken to instruct the profession in a therapeutic procedure which is fast disappearing.

Leon L. Solomon.

BLOCK ISLAND.—This island (Lat. 41° 13′ N., Long. 71° 35′ W.), lying some ten miles out at sea, and situated about midway between Point Judith, on the Rhode Island coast, and Montauk Point, the eastern extremity of Long Island, is, with perhaps the single exception of Nantucket, farther distant from the mainland, and consequently more thoroughly exposed to purely maritime influences, than is any other resort lying along the Atlantic coast of the United States. According to "Lippincott's Gazetteer," the length of the island, from north to south, is eight miles; its breadth from east to west varies between two and five miles. The greater part of the island is considerably elevated above sea level. The rocky bluffs lying upon its southern and southeastern shores are said to rise some two hundred feet above the water, rendering this part of its coast exceedingly picturesque and bold in appearance; while an elevation of some three hundred feet is said to be attained in some parts of the interior. The general surface of the island by no means consists, however, of a uniformly elevated tableland, but is decidedly undulating and of uneven configuration. On the eastern shore, where the chief hotels are located, there is a fine beach for bathing. The facilities for boating and for fishing are also said to be unsurpassed. Besides the meagre account of Block Island contained in the pages of "Lippincott's Gazetteer," the writer has hitherto seen no description of the island, save that contained in the two pamphlets circulated as advertisements of its hotels. In these pamphlets, however, there is to be found a long extract from an account of Block Island as a health resort, written by Dr. H. Holbrook Curtis, of New York, a physician who was formerly in the habit of passing his summers at this seaside resort. The reputation of this gentleman is such as to give the greatest weight to his comments, which are based, moreover, upon personal experience. In this article, published originally in the pages of the New York *Medical Record*, Dr. Curtis bears witness to the exceptional purity of atmosphere existing at Block Island, to the coolness of the place in summer, to the bracing and remarkably tonic, as well as soothing, effect of its climate, and to the decided benefits attainable and attained by a summer sojourn at this spot in cases of nervous prostration, insomnia, malarial poisoning, and in some cases of pulmonary phthisis. The doctor also testifies to the good quality of the water supply, the comfort of the hotels, and the perfect system of drainage in vogue at the latter. His article also contains a table, showing the temperature at noon for each day of the two months of July and August, 1880, as taken by a gentleman who was staying at the island. Similar tables for those two months during the years 1881, 1882, and 1883, based also upon private observations, are given elsewhere in the two pamphlets already referred to. From the figures of these four tables the present writer has deduced by calculation the following chart, which shows the average noon temperature for July and August, in each of the four years specified (1880, 1881, 1882, and 1883), as also the absolute maximum and absolute minimum noon temperatures, the average maximum and minimum at noon, the absolute and the average range, and also the absolute and the average number of days in each month upon which the mercury rose to 80° F. or above, and upon which it stood at 70° F. or lower, at the hour specified. A glance at this table will show not only the coolness, but also the great evenness of the midday temperature at this exceptionally and truly maritime resort.