ginning but the end result of persistent well directed effort. The committee has organized its work to consist of three distinct steps: First, to find out the problem, or, in other words, a survey of conditions as they are, a comprehensive systematic survey of each hospital of the State, with a written report of the findings based upon complete and personal inspection by men familiar with every phase of hospital problems. The second step of development is the establishment of a hospital survey section, a follow-up service as it were, which, through continuously applied sympathetic effort, may be utilized by the hospitals to correct for themselves as many of their shortcomings as possible; this service always to be available for the organization of new hospitals, the correction of shortcomings in existing hospitals, and when necessary, to furnish expert personal assistance on the ground.

The third and final division of the Section's work is that of classification of hospitals, the establishing of a membership list of acceptable institutions, and disregarding altogether those who are unable to reach the minimum requirements of good service and standard of good service in their communities.

The employment of the three methods suggested above, we are encouraged to believe, will lead to constant improvement in the hospital situation, so that all hospitals worthy of the name will have an earnest desire and make an earnest effort to become accredited members of the hospital association.

Each of these three phases of the work will be dealt with in subsequent articles.

Clinical Department

CASE HISTORIES FROM THE CHILDREN'S DEPARTMENT, UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL AND HOSPITALS.

Case No. 1. November 19, 1915. Mexican. Age 8 years. No. 10310.

Complaint: Jaundice.

Family History: Father dead at the age of 30 (8 years ago) of "stomach trouble." No history of jaundice. One paternal uncle dead of "jaundice." Otherwise negative.

Past History: A seven-months' premature infant. Extremely small, weak, frequently ill during first 3 years of life. Development delayed. Subject to upper respiratory infections with pneumonia at the age of 4¾ years. Frequent gastro-intestinal upsets, but no previous jaundice. History of measles, mumps and pertussis.

Present Illness: Two weeks' duration with the first symptom scleral and skin icterus, followed by epistoxis, slight chill, epigastric distress, and a diarrhoea of offensive, yellowish, sometimes white stools. There was no vomiting or fever. The jaundice has been deepening progressively and the urine has become dark, yellow or green. The subjective signs have been very slight. There was no history of acute infection and no unusual indiscretion in diet.

Physical Examination: Fairly well developed and nourished, asymmetrical head, skin and sclerae deeply jaundiced, carious, rachitic teeth; cryptic, infected, enlarged tonsils, coated tongue, injected gums, foul breath. There was a slight granular conjunctivitis.

Chest: Dilated superficial venules. Otherwise negative.

Heart: Evidence of slight hypertrophy and chronic mitral regurgitation, well compensated.

Lungs: Negative except for evidence of tracheobronchial glandular enlargement.

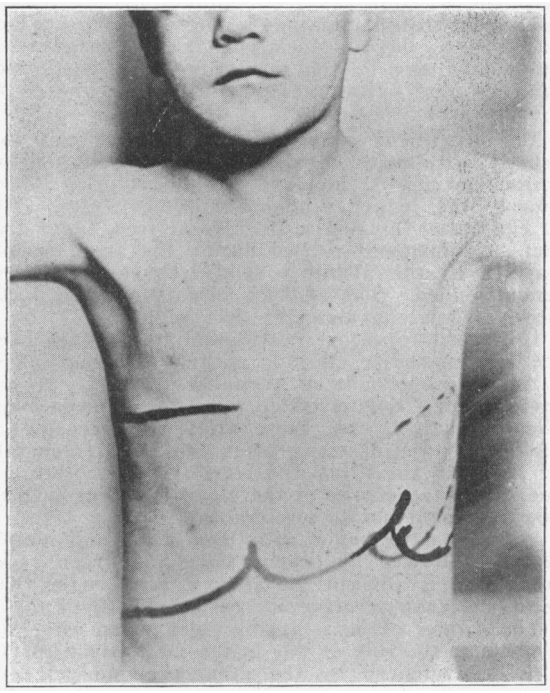
Abdomen: Protuberant, soft, bulging in right hypochondrium and epigastrium.

Liver dullness from 4th space to 5 cm. below costal margin in nipple line.

Liver: Palpable, smooth, firm, not pulsating or tender, 6 cm. below costal margin in nipple line, 7 cm. in anterior axillary line, 10 cm. in mid-line with notch distinctly felt just above umbilicus, slightly to the right.

Spleen: Palpable 2 cm. below costal margin in nipple line, extending under edge of liver; both freely movable. No caput medusae or other evidence of venous block.

Examination otherwise negative.



Laboratory Examinations: Von Pirquet, Wassermann in the blood serum, blood cultures and urine culture negative. Nose and throat cultures show staphylococci and streptococci predominant; negative for Klebs-Löeffler bacilli.

Urine: Large trace of albumen (0.3%). Bile +++, urobilinogen ++. Many hyaline and granular casts, occasional r. b. c.

Blood: Hb. 75%, R. B. C. 4,328,000, W. B. C. 15,400, Polys. 57%, E. 0%, B. 1%, Lymphocytes 29%, Large Monos 13%—central pallor, small amount of basophilic granulation.

Stool: Foul, grey, pasty, with mucus. Blood—negative. Fat +++, Bile 0, Urobilin +.

Temperature: 37.6, Pulse 88, Respiration 30.

Diagnosis: Acute Intestinal Indigestion with jaundice. Secondary, Chronic Tonsillitis with hypertrophy, Chronic Endocarditis (mitral), Tracheo-Bronchial glandular enlargement, Hepatic enlargement Splenic Tumor, Toxic Nephritis, Granular Conjunctivitis.

Discussion and Treatment: Bile aids the emulsification of fats, increases the fat-splitting properties of the pancreatic juice eight or more times (due to the cholic acid element) and also increases the solubility of the soaps. With a shutting off of bile, therefore, from the duodenum, the metabolism of fats is most seriously interfered with.

In a mechanical way, sugar has also been found to cause trouble in these cases. This is due, in all probability, to the increased growth of fermentative bacteria in the upper intestine and possibly an added inflammation of the duodenum. Starch, however, because of its slower liberation, does not cause this danger to the same extent.

Constipation or diarrhoea are encountered. The latter is due to the secondary intestinal indigestion following before the stagnation and decomposition of the fats, with the resultant irritation of the mucus membrane.

The etiology is to a certain extent obscure, but on account of the sudden onset, usually with fever, an infectious origin is to be suspected. The possibility of a relation to the spirochaetal jaundice of Weil is now being considered. The usual theory is one of blocking due to more or less inflammation and swelling of the common duct generally secondary to inflammation in the duodenum, which in turn may be a sequela of a single gastritis, or the whole may be the result of an indigestion or infection and irritation from some deteriorated or toxin bearing food.

The treatment consists in an original catharsis usually with calomel, alkalies for their dissolving action on mucus, no food for twenty-four hours, then broths, junket, skimmed milk, beef juice, white of egg, toast, etc., in a strictly fat free, sugar free diet. Confinement to bed during the acute period, warmth to the abdomen, and frequent baths are recommended. The addition of fats must be made slowly when convalescenec has begun.

In regard to catharsis, calomel has always been the drug of choice, the oily purgatives being judged harmful on account of their fat content. It has been recently demonstrated, however, that calomel, phenolphthalein, etc., cause an active irritation of the urinary and digestive tract, evidenced frequently by blood in the urine and feces. It is therefore a question whether one of the bland laxatives such as cascara would not be preferable.

It is wise to begin with lean meat and simple cereals, followed by orange juice and green vegetables. It is advised to "always wait longer than seems necessary before increasing the diet."

The danger of fat is readily seen when reference is made to the role of bile in the metabolism of fat. This is evidenced by the great preponderance of the soaps in the stools. The presence and amount of urobilinogen (Ehrlich's Test) in the stool serves as a ready clue to the degree of block and as a guide to the progress of the case.

In accordance with these principles, this patient was confined to bed for a period of ten days, with a primary purgation by means of calomel and restriction to a fat free, approximately sugar free diet. By that time the stools were showing coloring matter, and the urine had practically cleared of bile. The diet was then gradually enlarged to include meats, cereals and vegetables, and the patient was allowed out of bed for increasing periods each day, until after two and one-half weeks' residence he was up most of the time. The jaundice faded very slowly, but had practically disappeared on discharge, one month after entry, although the liver was still palpable three centimeters below the costal border. At no time was a temperature recorded, since his entrance was two weeks after the onset of symptoms and the acute stage had passed. This slow clearing of the skin, and diminution in size of the liver is usually encountered in these cases, although subjectively the patient feels perfectly well.

The patient's teeth were placed in a healthy condition, and an adeno-tonsillectomy performed, thus removing at least two foci of infection.

He was discharged in good condition, on a practically normal diet, with all symptoms and signs of the acute condition regressing satisfactorily.

State Board of Medical Examiners

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The tax is payable for the right to practice for any portion of the year and is not payable upon the installment plan.

Upon March 2nd (leap year, March 1st) the tax becomes delinquent, the name is eliminated from the directory and the possessor of such license loses the right to practice in California.

The license will be restored upon the payment of a registration fee of $10.

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If a certificate is granted between March 2nd and December 31 and the licentiate neglects to pay the tax the penalty is not imposed but the name of the licentiate will not appear in the directory for that year. On January 1st succeeding the date of the certificate so issued, an additional $2 payment is due for the current year.

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A certificate holder who was commissioned in the U. S. army, etc., and was in the discharge of his official duty subsequent to March 1st of any year who paid his tax for such year is not entitled to a refund.

Any certificate holder commissioned as aforesaid, subsequent to March 1st of any year, in the discharge of his official duty, who did not pay his tax and did not pay the penalty, must pay $10.

A student who was drafted and later received a certificate, after a successful examination and commissioned as aforesaid will not be required to pay either the tax or the penalty for the period of time up to the date of his discharge, but will be required to pay the $2 tax for the balance of the period from the date of discharge to the end of the year. If such licentiate was discharged within the sixty days from January 1st to March 1st, and neglected to pay such tax before March 2nd, then such licentiate would be liable for the penalty of $10.

The date of the issuance or receipt of commission will not be accepted as the beginning of any period of exemption but the date upon which such licentiate actually reported for duty if in his home city or county, otherwise the date upon which licentiate left his home under orders to report for duty.