Correspondence

Archives of Disease in Childhood, 1976, **51**, 645.

Prevalence of *Listeria monocytogenes* in the newborn

Sir,

We studied duplicate rectal swabs collected within one hour after birth, and umbilical cord sera from 463 infants, representing 14.2% of the total births at the Grace Maternity Hospital, Halifax, from May 1974 to March 1975. Using Gray's cold enrichment technique (Gray *et al.*, 1948), *Listeria monocytogenes* 4b, was isolated from one infant (0.22%), twin A of a set of twins of 36½ weeks of gestational age. Labour was spontaneous. This infant was undergrown (1650 g), had increased tone, and was 'jittery'. From 6 hours of age to day 8 he was given penicillin 30 000 units/kg per day divided into two doses. He remained 'quite irritable' and his irritability lasted throughout his stay in the nursery. His progress was good at discharge at 29 days of age.

Antibody to *L. monocytogenes* was not detected in this or any other infant in the study using the method of Larsen and Jones (1972).

This study was supported by National Health Grant 603-1019-28 from Health and Welfare Canada.

S. W. MACDONALD, J. A. EMBIL,
S. A. BUSTAMANTE, and K. E. SCOTT
*Department of Microbiology and Paediatrics,
Dalhousie University,
Izaak Walton Killam Hospital for Children,
Halifax, Nova Scotia, Canada B3J 3G6.*

REFERENCES

- Gray, M. L., Stafseth, H. J., Thorp, F., Jr., Scholl, L. B., and Riley, W. F., Jr. (1948). A new technique for isolating listerellae from the bovine brain. *Journal of Bacteriology*, **55**, 471.
Larsen, S. A., and Jones, W. L. (1972). Evaluation and standardization of an agglutination test for human listeriosis. *Applied Microbiology*, **24**, 101.

Life tables for cystic fibrosis

Sir,

I read the article by Drs. Robinson and Norman on life tables for cystic fibrosis (*Archives*, 1975, **50**, 962)

with much interest. They express their disappointment at not finding any difference between the life expectancy of children presenting during their first year and that of all cases. In fact the former may be a little worse. Is it not what should be expected?

Since infection is known to be present as early as the first month of life (Esterly and Oppenheimer, 1968), the diagnosis is probably late in nearly all cases. Do the authors not point out the necessity of an evaluation of neonatal screening? On the other hand, and logically, one can expect that a very late diagnosis is consistent nowadays with a very mild case—and the best therapeutic results! Shwachman's report of patients over 17 years of age (Shwachman, Kulczycki, and Khaw, 1965) seems to support this belief: only 12% of the series had been diagnosed before one year of age.

Therefore I think we should evaluate the course of late presenting cases (after one year of age for instance) separately since a large delay in diagnosis may be a clue to the mildness of the disease.

JACQUES LACROIX
*Hôpital de la Salpêtrière,
Pavillon Ribadeau-Dumas,
47 Boulevard de l'Hôpital,
75634 Paris Cedex 13.*

REFERENCES

- Esterly, J. R., and Oppenheimer, E. M. (1968). Observations in cystic fibrosis of the pancreas. III. Pulmonary lesions. *Johns Hopkins Medical Journal*, **122**, 94.
Shwachman, H., Kulczycki, L. L., and Khaw, K. T. (1965). Studies in cystic fibrosis: a report of sixty-five patients over 17 years of age. *Pediatrics*, **36**, 689.

We showed this letter to Dr. Norman who replied as follows:

Thank you very much for letting me see Dr. Lacroix's letter, with which we entirely agree. The question of space prevented us from developing the argument as to the relatively poor life expectancy of children presenting in their first year. Personally we believe that this should be improved if the diagnosis can be made before any lung damage occurs.

A. P. NORMAN,
*The Hospital for Sick Children,
Great Ormond Street,
London WC1N 3JH.*