healthy baby boy weighing 3.54 kg. The mother developed a productive cough 4 days later, and on day 9 the infant became irritable and febrile. Two days later the CSF contained 3.5×10^8 /l WBC and 125×10^6 /l RBC, protein 3.15 g/l, and glucose 0.7 mmol/l (12.6 mg/100 ml). *L. monocytogenes* was grown from his CSF and blood. It was not grown from the mother's vagina, but she had just received co-trimoxazole. He was treated with IV ampicillin and chloramphenicol, and later with oral amoxycillin for a total of 4 weeks, with apparent complete recovery.

Although widespread in animals and reported in epidemics,¹⁻⁴ the epidemiology of listeriosis remains obscure and most cases are sporadic. Regardless of the German origin of one of Robertson's cases, the close proximity of our two sets of cases of this rare condition does raise the possibility of a connection between them, and therefore we plea that there should be greater awareness and reporting of this disease.

A Swedish report⁴ suggests that the late meningitic form may be acquired from congenitally infected babies in the newborn nursery, which would be in keeping with the sequence in which our own two babies became ill.

Despite the susceptibility of this organism to a wide range of antibiotics on *in vitro* testing, high-dose ampicillin seems to be the drug of choice,⁵⁻⁶ although it might be wise to use this with chloramphenicol rather than with gentamicin, if there is any likelihood of meningitis. Our two critically ill babies responded well to treatment. Although it has been previously pointed out by New Zealand workers,³ it does not seem to be widely appreciated that if such patients are adequately treated there is likely to be complete recovery.

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Normal children with large heads

Sir,

I should like to draw the attention of Day and Schutt (*Archives*, 1979, **54**, 512) to the Cronqvist index.¹⁻² This

relates the size of the cranial vault to a dimension of the face and appears to distinguish megalencephaly due to hydrocephalus from a normal, large skull. It would be valuable if Day and Schutt could measure this index in their cases and confirm its value.

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Technique for facilitating tendon reflexes in children

Sir,

Tendon reflexes, such as the patellar, are often difficult to elicit. The best known manoeuvre for facilitating tendon reflexes is Jendrassik's, and consists of pulling the interlocked hands apart. As this needs the patient's collaboration, it is rarely applicable in children. I have observed that during or immediately after throat inspection the knee reflex is elicited without difficulty. If a tongue-depressor is introduced until the child gags (the mother can do this) the patellar reflexes become easy to elicit.

I have been unable to find reference to this simple manoeuvre and would like to know if anyone else has applied it.

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Systemic blood pressure and intraventricular haemorrhage in the newborn

Sir,

I read with great interest the report by Fujimura *et al*. (*Archives*, 1979, **54**, 409). I was surprised that they state that the relationship between systemic blood pressure and cranial blood flow in the neonate is not known. Using venous occlusion plethysmography.¹⁻² I have shown that healthy term babies display autonomy of their cranial flow.³

However, in the context of sick babies, the work of Lou *et al*.⁴ is more interesting; they demonstrated that in acidotic and asphyxiated babies the cerebral flow is

dependent on systemic blood pressure. It is this possible link between blood pressure and cerebral bleeds that makes the work of Fujimura *et al.* of such interest.

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Giant exomphalos—conservative or operative treatment?

Sir,

I would like to comment on the successful use of conservative treatment of giant exomphalos by Gough and Auld (Archives, 1979, **54**, 441). Their 6 patients on conservative treatment had the intact sac painted daily with 2% aqueous mercurochrome. Two of these patients had complications of mercury intoxication, one with failure to thrive at age 8 weeks and one who became mentally retarded with microcephaly. The risk of mercury poisoning in conservative treatment of giant exomphalos can be avoided by using 1% aqueous gentian violet. I successfully treated 6 infants with exomphalos measuring

more than 5 cm in diameter in Singapore between 1969 and 1972. Three had the intact sac painted with 1% aqueous gentian violet and 3 with 2% aqueous mercurochrome. All survived and none developed complications during the 2 years that they were followed up. The infants treated with 1% gentian violet paint responded with epithelialisation and healing of the abdominal defect within 12 weeks while those treated with mercurochrome did not heal until 20 weeks. The only disadvantage of using gentian violet was that it stained the linen.

All my patients required secondary surgery to the ventral hernia which replaced the exomphalos.

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Mr Gough comments:

I agree that mercury intoxication remains a significant risk when mercurochrome applications are used daily in the management of large omphaloceles. However, one of our patients had 3 exchange transfusions for hyperbilirubinaemia and it is difficult to know what part this played in his subsequent poor progress. The second case illustrated in the article has developed normally despite high urine mercury excretion when aged 8 weeks, and thus the risks may have been overstated.

I have recently treated a patient with gentian violet applications, as Dr Chan describes, and can confirm the favourable progress which he noted, and his letter gives further support to the concept that conservative treatment is both effective and safe.

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