At 32 hours a repeat chest x-ray showed more diffuse lung disease with absence of interstitial emphysema. At 41 hours the infant began to cry, became deeply cyanotic, and remained so on 100% oxygen. Heart rate and respiratory rate increased from 140 to 160 beats/min and from 60/80 breaths per min. Breath sounds were clear and equal bilaterally and the peripheral pulses were absent. A chest x-ray showed a large pneumopericardium without pneumothorax or pneumomediastinum (Fig. 2). A No. 22 Jelco (Jelco Laboratories, Raritan, NJ) catheter was placed in the pericardial sac and approximately 5 cm air aspirated. The infant responded quickly with improvement of colour, return of pulses, and a decrease in heart and respiratory rates. The catheter was connected to a water seal and intermittent aspiration was required to maintain patency. Within 2 hours the infant again deteriorated secondary to a massive right pneumothorax which responded to placement of a chest-tube. The pericardial catheter was removed after 48 hours without recurrence of the pneumopericardium. The infant was breathing room air by day 6 and, after removal of his chest tube, had no further problems.

There has been only one other case report of a pneumopericardium in infancy in the absence of resuscitative procedures or assisted ventilation. Our patient had a fairly typical clinical presentation with hypotension, absent pulse pressure, increased respiratory distress, and cyanosis. His tachycardia was an unusual finding, bradycardia being more commonly described. Intense cyanosis and agitation with hypotension, poor peripheral perfusion, muffled heart tones, and normal breath sounds are the key elements of clinical diagnosis in pneumopericardium alone, but some infants are asymptomatic and the diagnosis is made incidentally on routine roentgenological examination. Infants without evidence of cardiac tamponade may be managed conservatively but in those who deteriorate rapidly, pericardiocentesis is imperative.

References


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Perinatal listeriosis

Sir,

We agree with Robertson et al. (Archives, 1979, 54, 549) that perinatal listeriosis may be under-reported (or even underdiagnosed) in Britain. This belief is supported by 2 further cases which must have occurred at about the same time in an adjacent health district to that of Robertson et al.

Case 1

A 29-year-old music teacher had a severe cough in late pregnancy. Two weeks later in the 37th week of pregnancy she went into spontaneous labour, which was accompanied by fever and generalised aches. Liquor stained with meconium was drained and emergency caesarean section resulted in the birth of a baby girl weighing 3·49 kg. Her Apgar score was only 4 at one minute. She had increasing respiratory difficulty, unresponsive to treatment of hypoglycaemia. X-ray of chest showed diffuse coarse mottling, and Listeria monocytogenes was cultured from the infant's blood, eye swab, umbilicus, and nose, as well as from the mother's vaginal swab. CSF was sterile on culture, but two bacteria were seen on microscopic examination. IV chloramphenicol (50 mg/kg per day) and ampicillin (400 mg/kg per day) were given for 2 weeks. For several days she had diarrhoea, abdominal distension, enlarged liver, irritability, and fits, with intractable hypocalcaemia, although slowly her condition improved. Now at almost one year she is developmentally and physically normal. Three months before this child's birth the family cat had been ill with cat flu treated with chloramphenicol. Feline stool culture at the time of the child's illness failed to isolate Listeria.

Case 2

After an uneventful term pregnancy a Pakistani woman underwent elective caesarean section to be delivered of a
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 ± 10³/l WBC and 125 ± 10²/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 report5 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,6-8 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,6 it does not seem to be widely appreciated that if such patients are adequately treated there is likely to be complete recovery.

Reference

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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.

References

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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