infants described, none seems to have had pneumonia or pneumonitis.

We have recently had occasion to treat a newborn whose main presenting complaint was respiratory failure and pneumonia.

Case history

A girl weighing 2290 g was born to a 21 year old single primigravida mother in a general practitioner maternity unit outside Belfast. The mother had not booked for delivery and had received no antenatal care. The baby was believed to be 31 weeks' gestation and was transferred to a nearby district general hospital for treatment of respiratory distress. On arrival there blood gas analysis showed pH 6·88, arterial carbon dioxide tension 11·7 kPa (89 mmHg), arterial partial pressure of oxygen 5·5 kPa (42 mmHg), bicarbonate 8·6 mmol/l, and base excess −18·7. The baby was immediately intubated and transferred to Royal Maternity Hospital, Belfast, for mechanical ventilation.

At 4 hours of age the baby was examined at the Regional Neonatal Intensive Care Unit and found to have pronounced hepatosplenomegaly with liver 4 cm and spleen 5 cm below the costal margins. In addition, the hands and feet showed reddish-purple blotchy areas with white patches. Estimated getational age on clinical appearance was 34 weeks. Chest radiograph showed extensive patchy opacity throughout both lungs, most pronounced in the upper zones. The dorsal spine was 79 mm in length, corresponding with a gestational age of 35 weeks. Other investigations showed haemoglobin 123 g/l, white cell count $23{\cdot}3\times10^9$/l, and the platelet count 82×10^9/l.

A diagnosis of congenital pneumonia was made, and it was believed that the likely cause was either syphilis or group B β haemolytic streptococcus. The baby was treated with a high dose intravenous penicillin and made a very satisfactory recovery. All bacterial cultures subsequently proved negative. Serology results were Venereal Disease Research Laboratory test negative, *Ireponema pallidum* haemagglutination test positive in titre >1280, and fluorescent treponemal antibody (absorbed) test positive. At follow up one year after birth the baby was normal.

We believe that it is important to add congenital pneumonia or pneumonitis to the list of presenting features of early congenital syphilis given by Ewing *et al.*[1] We agree entirely that the presence of hepatosplenomegaly and rash, especially if confined to the palms and soles, is very suggestive of a diagnosis of congenital syphilis.

Reference

[1] Ewing CI, Roberts C, Davidson DC, Arya OP. Early congenital syphilis still occurs. *Arch Dis Child* 1985;**60**:1128–34.

H L Halliday, M McC Reid *and* B G McClure,
Royal Maternity Hospital,
Belfast BT12 6BB

Cot deaths

Sir,

I wish to bring to the attention of your readers the very positive role that our local coroner plays in helping mothers whose babies have died of a 'cot death'.

Most mothers feel an enormous sense of guilt or failure, or both, when their baby dies in this manner, and it is often very difficult to remove such feelings.

Our local coroner writes a letter to the parents in every case of an uncomplicated 'cot death', and, apart from explaining very briefly the nature of a 'cot death' and enclosing literature about the Local Cot Death Support Group, he also takes care to include the words 'the pathologist found your baby to be in good physical condition and a credit to you'.

All the mothers who have received such a letter say that they find that particular sentence particularly reassuring, and indeed many keep the letter for many years and refer back to it from time to time. It is, they say, 'official' recognition of the fact that they were not to blame, and it is a great help in coming to terms with the death.

Might I suggest that paediatricians contact their local coroner to see if such a letter could be sent to all parents whose babies have died from an uncomplicated 'cot death'?

S E Barnes
Odstock Hospital,
Salisbury SP2 8BJ