from severe vomiting of late pregnancy. She was given intravenous fluids via the right cephalic vein using an Intracath Bard Davol catheter. Later the drip was leaking, therefore the catheter was withdrawn and adjusted. As this was still unsatisfactory a second infusion was set up. The first catheter was removed and found to be incomplete. *X*-rays were taken which showed the missing portion to have migrated through the superior vena cava into the right atrium.

She was transferred to Hammersmith Hospital and treated firstly with intravenous fluid, anticoagulants, and antibiotics. On the sixth day, because of her continued vomiting, rising blood pressure, albuminuria, and the failure of surgical induction a caesarian section was performed and a live baby delivered. Recovery was uneventful.

A week later the position of the catheter in the right atrium was checked by another *x*-ray; then through a median-sternotomy incision we exposed the heart and by introducing a finger into the right atrial appendage 12 cm. of catheter was hooked out. She was discharged on the twelfth day.

We must stress that when these catheters are used the manufacturers' instructions must be followed and that the catheter must not be pulled back through the needle to "adjust the drip." This was most probably the manoeuvre which, in this case, caused division and subsequent migration of the catheter. Happily, the outcome was good, but the patient had to undergo an extra operation and a cardiotomy.—We are, etc.,

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REFERENCE
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Haemophilus aphrophilus Endocarditis

SIR,—I was very interested to read the case report on *Haemophilus aphrophilus* endocarditis by Drs. R. M. Pine and H. Ballard (9 May, 1970). The condition is certainly rare. Spicer and Mitchell[1] reported a case of subacute endocarditis due to *Haemophilus aphrophilus* and briefly reviewed the only other 11 case reports they were able to find. Farrand *et al.*[2] recorded a case which was not published at the time of the review. The case reported by Drs. Pine and Ballard appears to be the first in which there was no pre-existing cardiac lesion. Although they state their case was similar in this respect to the original description of the disease by Kharait,[3] a careful reading of the post-mortem findings suggests that the mitral valve which was infected by *Haemophilus aphrophilus* was scarred by rheumatic heart disease.

Haemophilus aphrophilus is rarely isolated from any source. Only four strains had been isolated by the National Collection of Type Cultures, London, up to June 1969. Two were from cases of cerebral abscess in man, one from subacute bacterial endocarditis in man, and one from the forelimb of a rabbit. (S. P. Lapage, personal communication.) Experience of treating *Haemophilus aphrophilus* endocarditis is therefore limited. Penicillin is effective treatment, and cephaloridine and streptomycin appears to be an effective alternative regimen when the patient is hypersensitive to penicillin.

The origin of *Haemophilus aphrophilus* and the portal of entry are not known, but there is some evidence that dogs may act as a reservoir. There are two reported cases of brain abscess due to *Haemophilus aphrophilus* in which the organism was isolated from the mouths of the patients' dogs, which habitually licked them about the face and neck.—I am, etc.,

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2 Farrand, R. J., Maccabe, A. F., and Jordan, O. W., *Journal of Clinical Pathology*, 1969, **22**, 486.
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Cervico-oculo-acoustic Dysplasia

SIR,—There has been recent interest[1-4] in the above rare condition which is essentially a development defect with brevicollis and ocular and auditory disturbances. There may also be mental deficiency. Descriptions of it have come from radiologists, otologists, oculists, and specialists in mental deficiency. Most cases so far described have been in children and usually females. I would like to report a case in an adult.

The patient was born on 17 February 1937 and was the last of five children. The parents were aged 42 years at her birth and they and the other children were normal. Pregnancy and birth were normal; but there was an occipital meningocoele. She is a helpless idiot. In stature she is small, with small hands and feet. There is Klippel-Feil syndrome with brevicollis, low hairline, and small low-set ears. She is mute, with a small, smooth tongue; and partially deaf, with small, relatively acellular mastoids. The middle ear elements cannot be identified on the right side. She is blind. There is ptosis, and paresis of all the ocular muscles. There are lateral nystagmus and contracted non-reacting pupils. There is bilateral optic atrophy of primary type. There are flexion contractures of the legs with exaggerated tendon reflexes and bilateral ankle clonus; plantar reflexes are flexor.

She is epileptic, her first fit having been at the age of 12 years, and although the epilepsy is now well controlled she used to go into status. Menarche was at the age of 14 years. Leucocyte chromosome analysis shows a normal female karyotype. Kahn test and plasma amino-acids are normal; there is no galactosaemia.—I am, etc.,

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Illustrated Lectures

SIR,—Dr. A. K. Zealley rightly points out that many slides seen at conferences are useless (20 June, p. 734). Futile slides are, regrettably, still shown despite advice from Ollorenshaw[1] and others.[2-5] Seldom does one attend a meeting without seeing a slide that resembles a page from a railway timetable. One—perhaps this was a record—contained 560 facts and 10 seconds were given for their assimilation. A pair of field glasses is needed to read some slides.

I cannot agree that positive—that is black on white—slides are more legible than negative. A trial performed on an audience of physicians indicated no definite preference.[6] Negative slides have the advantage that lettering can be easily coloured; dimmed light, not blackout, is sufficient for either. Legibility of any slide is ensured by lettering large enough to be read by the naked eye without projection. This also simplifies the slide and helps when sorting out slides for lectures.

A common fault when showing a slide is for the speaker to read the writing aloud as if his listeners were half-witted or suffered from dyslexia, instead of remaining silent.—I am, etc.,

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Acute Malaria in Newborn Infants

SIR,—Because of the incidence of acute malarial fever in newborn infants within 48 hours of birth, 50 consecutive mothers who had prenatal care (including prophylactic treatment against malaria) and were later delivered at the Eastern Nigeria Medical Centre (now called Enugu Medical Centre), Nigeria, had their blood tested for presence of malarial parasites in the peripheral blood on admission for delivery. In the delivery room smears were taken from the cord blood. Within one hour of delivery smears of the peripheral blood of both the mothers and their babies were taken.

In more than one third of the cases malarial parasites were found in the cord blood and in the peripheral blood of the mothers and their babies. All the infants who had positive malarial parasite smears were given 0·3 ml. to 0·5 ml. chloroquine intramuscularly. This study was done from 1965-7.

I should like to know the experiences of other doctors working in the tropics as my findings are contrary to those of Blacklock and Gordon.[1]—I am, etc.,

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