be seriously reconsidered and perhaps abandoned. Possibly, however, complete resection of the thymus cannot be assured whatever operative procedure is used.


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Infecitive dose of Campylobacter jejuni in milk

Unpasteurised milk is now recognised as a vehicle of infection for Campylobacter jejuni. Fourier milk-associated outbreaks involving more than 4000 cases have been investigated in the last three years in Great Britain, and there is evidence that sections of the population that regularly consume unpasteurised milk have a higher level of detectable antibodies to C. jejuni than does the general population (unpublished observations). One of the features of these outbreaks has been the enormous dilution of the original contaminating dose in the bulk tank in which the milk is stored. As C. jejuni, unlike salmonelae, will not grow in milk, the occurrence of cases suggests a very low infective dose.

Case report

On 6 December, two hours after a light breakfast, I swallowed 500 organisms of a known serotype of C. jejuni in 180 ml of pasteurised milk. The strain originated from a milk-borne outbreak in 1979. Feces were examined twice in the week before the experiment and Campylobacter was not found. Feces were then examined daily from the start of the experiment and C. jejuni of the same serotype was cultured at a titre of at least 10⁴/g from a specimen obtained on day 2. The count increased to 9 × 10⁵/g on day 5 and declined thereafter. Abdominal cramps and mild diarrhoea accompanied mucus but no blood developed on day 4 and lasted three days. Complement-fixing antibody to C. jejuni, which was not present before or on the day of the experiment, was detected at a titre of 1/8 on day 4.

Comment

It is clear that infection can follow the ingestion of small doses of C. jejuni when the organism is taken in milk. This finding helps to define the mechanisms concerned in milk-borne outbreaks of C. jejuni in man. In addition, although a human experiment has been reported before, I think this is the first time that the requirements of Koch’s postulates have been met definitively for C. jejuni in man.


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in our patient, however, occurred in the absence of such stimulation. Myelococcus as defined by Gastaut2 may occur as a result of any lesion from the motor cortex to the spinal motor neurone, but these movements were not myelococytic in our patient. The patient described by Campbell and Garland3 with subacute myelococytic spinal neuritis had more rapid myelococcus in the legs associated with fever and possible spinal cord infarction. Our patient's involuntary movements fit Hughlings Jackson's description of focal epilepsy.4 Nittner5 states that epileptic seizures are rarely caused by spinal cord tumours but reviewing the case reports he found these seizures restricted to patients with tumours around the foramen magnum. Gowers6 cites Brown-Sequard's comment that "spinal epilepsy" is a suitable description for a violent muscle spasm followed by clonic movements occurring in a patient with a known spinal cord lesion. There is no other published description of spinal epilepsy with such a clear focal motor event occurring in a patient with a spinal lesion. Immediate cessation of these attacks after the removal of the meningioma emphasised the cause and effect relation.

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Postoperative legionella pneumonia diagnosed by percutaneous lung aspiration

Isolation of Legionella pneumophila is often difficult, and a definitive diagnosis of legionella pneumonia may depend on serological tests. We describe a patient with postoperative pneumonia, presumably acquired in hospital, in which the diagnosis was established by percutaneous lung aspiration.

Case report

A 62-year-old man who presented with an 18-month history of breathlessness and giddiness was found to have aortic stenosis and coronary artery disease. On 26 September 1980 he was admitted for aortic valve replacement and coronary artery bypass graft. After a successful operation on 30 September he was transferred to the intensive care unit and returned to the ward on 2 October. Prophylaxis for the operation was the standard regimen of penicillin, flucloxacillin, and gentamicin, which was continued for three days. During this time he had a low-grade fever but was otherwise well. On the fourth day after operation he complained of weakness and cough with tachypnoea. The temperature reached a maximum of 38.7°C, and peripheral white cell count rose to 21.0 x 10^9/l with 75% neutrophils. A chest radiograph on 7 October showed consolidation in the anterior segment of the right upper lobe and the antibiotic regimen was restarted. By 10 October the chest was clear on auscultation. A sputum sample was negative for Legionella. Following a successful operation on 12 October he was transferred to the intensive care unit and returned to the ward on 2 October. Prophylaxis for the operation was the standard regimen of penicillin, flucloxacillin, and gentamicin, which was continued for three days. During this time he had a low-grade fever but was otherwise well. On the fourth day after operation he complained of weakness and cough with tachypnoea. The temperature reached a maximum of 38.7°C, and peripheral white cell count rose to 21.0 x 10^9/l with 75% neutrophils. A chest radiograph on 7 October showed consolidation in the anterior segment of the right upper lobe and the antibiotic regimen was restarted. By 10 October the chest was clear on auscultation. A sputum sample was negative for Legionella.

Calcium and calciferol antagonise effect of verapamil in atrial fibrillation

Verapamil is an antiarrhythmic and antianginal drug used increasingly to control supraventricular arrhythmias. We report on a patient successfully treated with verapamil for atrial fibrillation of long duration in whom atrial fibrillation reappeared after the ingestion of calcium and calciferol. The patient recovered from sinus rhythm after the intravenous administration of verapamil, fluids, and frusemid.

Case report

Atrial fibrillation developed in a 70-year-old woman with a seven-year history of grade 1 functional calcific aortic stenosis. A 20 mm Hg aortic valve gradient, and systemic hypertension. Because of hypersensitivity to digoxin and quinidine verapamil was started. Two days later she converted to sinus rhythm. Serum calcium concentration was 2.45 mmol/l (9.8 mg/100 ml). During 13 months of treatment with verapamil her clinic visits averaged 1.5 per month. Each visit included a complete physical examination and electrocardiography. Both showed normal cardiac sinus rhythm. Because of diffuse arthropathy she was prescribed a 24-hour drip of calcium and calciferol 3000 IU/day (Destrol Calcium, Teva) was prescribed.