

CORRESPONDENCE

Correspondents are asked to be brief

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Survival in Severe Congenital Heart Disease

SIR,—Your recent leading article on this subject (26 June, p. 723) indicated the large number of babies born with malformations of the heart (at present they number over 7,000 a year in the U.K.); that 40% of them at present die before they reach school age, most in the first few months of life; and that in a significant proportion successful surgical correction is now possible if it is carried out soon after birth. It was rightly emphasized that this necessitated early referral to special centres at which the babies can be investigated immediately and treated surgically without delay, at any hour of the day or night.

All those with experience of dealing with these babies would agree that this is so. Unfortunately, the full implications of the demands which such investigation and treatment make upon the staff of such special centres were not explained; namely, that before such services can be made available to all babies in Britain in need of them considerable increases in staff—medical, nursing, and ancillary; senior and junior—will be essential, and many more cots will have to be provided in centres for paediatric cardiology throughout the country.

In the meantime, existing staff are strug-

gling to investigate and treat some of these babies while others die untreated. Moreover, the necessity to admit them without delay is resulting in a rapid increase in the number of older children with congenital heart lesions awaiting admission for surgical treatment. The condition of some of these is deteriorating while they wait, so that the risks of operation when it is performed are increased and the benefits which may be expected from it are diminished. This is certainly the case in Liverpool and must also be true of other centres serving large populations in which attempts are being made to provide a comprehensive service for infants and children with congenital heart disease.

The need for a rapid expansion of existing services for paediatric cardiology is, therefore, urgent and must be undertaken without further delay if the general public is not to reach the conclusion that the National Health Service is unable to provide adequate investigation and treatment for children born in this country with a malformation of the heart.—I am, etc.,

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Atypical Gonorrhoea

SIR,—I agree with your leading article on "Atypical Gonorrhoea" (7 August, p. 322) that the condition of benign gonococcaemia is often missed, though relatively common. Between 1964 and 1970 six cases of benign gonococcaemia were diagnosed in hospitals of the Chelsea and Kensington Group, four of them in the infectious diseases unit of the Western Hospital.¹ Only one of the six cases was a male. I report another male case.

The patient, a homosexual aged 36, was

admitted to this hospital on 30 June 1971. Sixteen days before admission he developed pyrexia, malaise, and vomiting. He said that he felt as if he was suffering from 'flu. After a few days he improved, but a week after this he had a similar attack, which was more severe; this lasted for two days only. He then had another remission until four days before admission, when he developed attacks of shivering and painful discoloured skin lesions on his extremities. These con-

tinued to appear at intervals until the day of his admission. This was associated with painful swelling of the right ankle. There was no history of urethritis. His last sexual contact with a male had taken place three months before the onset of his illness.

On admission, his temperature was 38.7°C. He had pustular lesions, surrounded by erythema, on the extensor surfaces of his elbows, over his knees, and on his hands and feet. Some of these lesions were characteristically haemorrhagic. He also had a discrete maculopapular rash on his trunk and a few maculopapules on his face. As he was not very ill and there was no evidence of endocarditis it was decided not to treat him until the diagnosis was confirmed bacteriologically.

He was afebrile on 2 and 3 July and pyrexial again on 4 and 5 July, when the temperature reached 38.5°C. The temperature then became normal spontaneously and remained so until the day of his discharge. On 7 July he developed painful swelling of the right wrist. The skin lesions continued to appear in crops, mainly on the elbows, knees, hands, and feet, until treatment was started. *N. gonorrhoeae* was isolated from a small ulcer in his rectum and from his urethra after prostatic massage. Blood culture was negative on two occasions. Gram-negative intracellular diplococci were seen in a smear taken from a pustule but no organisms were cultured from this lesion. The gonococcal complement fixation test was strongly positive. He was given 500,000 units of penicillin intramuscularly from 7 to 20 July. Two days after starting treatment all the skin lesions had crusted over and the swelling of the right wrist had subsided. Smears and cultures from the affected sites after treatment were negative.

Blood cultures are often negative; smears from skin lesions sometimes show the organisms but it is unusual to culture them.¹ A negative gonococcal complement fixation test is usual and does not exclude the