

A 62 year old man presented with fever and diarrhoea. He had a history of partial gastrectomy for duodenal ulceration and had had anterior myocardial infarction 4 years previously. Stool and blood cultures grew *S. panama*. He was treated with intravenous ampicillin and chloramphenicol for 2 weeks. He relapsed one week after discharge and *S. panama* was again isolated from blood cultures. He was treated with oral ciprofloxacin for one week and again discharged. Three weeks later he was re-admitted with a transient right hemiparesis. He had fever, splinter haemorrhages, a dyskinetic apex beat and a variable systolic murmur. A two dimensional echocardiogram showed an apical left ventricular aneurysm containing thrombus. He was treated with intravenous ciprofloxacin 2.25 g daily, but was referred for cardiac surgery because of persistent fever, embolic phenomena and cardiac tamponade. An abscess was found at the base of the aneurysm. The thrombus was removed and the aneurysm was resected. He was discharged after a further 2 weeks of antibiotic therapy.

Infection of ventricular mural thrombus has rarely been reported.<sup>1-3</sup> Although there are reports of such infection with *Salmonella* species, we believe that one due to *S. panama* has not been described previously. In this case, the previous gastrectomy may have reduced the host defences against ingested salmonella.<sup>4,5</sup>

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#### *Listeria monocytogenes* meningitis in previously healthy adults

Sir,

We read with interest the paper by Hearmon and Ghosh<sup>1</sup> but wish to discuss several points made therein.

Firstly, there is no convincing evidence that *Listeria monocytogenes* may be transmitted venereally. The isolates incriminated by Rappaport *et al.*<sup>2</sup> were subsequently identified as *Lactobacillus* spp. (Seeliger, 1988, oral com-

munication), and the association between *Listeria monocytogenes* and recurrent abortion has yet to be conclusively demonstrated.<sup>3</sup> In addition, we wish to emphasize that most cases of neonatal listeriosis are of the so-called 'early onset' type, i.e. presenting within the first 5 days of life. This form of the disease, manifesting as septicaemia and multi-organ sepsis, often following a maternal flu-like illness, is frequently associated with chorio-amnionitis and almost certainly results from haematogenous spread from the mother rather than ascending infection from the vagina or cervix.<sup>4</sup>

We agree with Hearmon and Ghosh that listeriosis is not confined to the classical at-risk groups. Indeed in the outbreak in Canton de Vaud, in which soft cheese was the vehicle of transmission, 60% of the adult cases had no identifiable risk factor.<sup>5</sup>

The incidence of listeriosis in the UK is commoner in males in all age groups except in patients aged 75 years or older.<sup>6</sup> We disagree with Hearmon and Ghosh's hypothesis that this excess is due to partial immunity as a result of vaginal carriage in the female. Higher carriage rates in the vagina compared to those in the male urethra are likely to result from the proximity of the female genital tract to the anus. The prevalence of faecal carriage does not vary significantly between the sexes.<sup>7</sup>

We agree that listeria meningitis is difficult to diagnose but several clinical features may suggest the diagnosis. The illness may have a subacute onset with fluctuating levels of consciousness and nuchal rigidity may be absent in up to 20% of adult patients. In addition, movement disorders such as ataxia, myoclonus and tremors are more common in listerial meningitis than in the classical pyogenic meningitides. It should be noted that hypoglycorrhachia is not a consistent finding.<sup>7</sup>

Finally, we wish to emphasize that all apparently sporadic cases of listeriosis should be investigated promptly and vigorously. A detailed food history should be elicited and comprehensive sampling of all foods in the domestic refrigerator and 'high risk' foods from other locations, e.g. raw seafood from deep freezers, vegetables etc. should be undertaken without delay.

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because of severe hypertension (230/130 mmHg) and impairment of renal function disclosed postanastomotic stenosis of the right renal artery localized 3 cm distally to the ostium. With PTA this stenosis was again dilated. The patient started steroid therapy and she remains normotensive without antihypertension drugs and with no impairment of renal function.

Takayasu's aortitis is classically considered a process with an initial period which precedes another period of obliterative vascular disease that is slowly progressive.<sup>3,4</sup> In the present case, Takayasu's aortitis appears as an aggressive disease with three recurrences after successful therapeutic manoeuvres. This recurrent form is a very unusual pattern in Takayasu's disease.

### Recurrent renovascular hypertension in Takayasu's disease

Sir,  
Takayasu's arteritis is an uncommon inflammatory and obliterative process affecting the large and medium sized arteries.<sup>1</sup> Usually, it is not an aggressive disease.<sup>2</sup> We describe here one case of Takayasu's disease with surprising tendency to recur.

An 38 year old woman presented with progressive intermittent claudication of the legs. Blood pressure was 220/120 mmHg and a weak femoral artery pulse was found. Aortography (October 1986) showed severe stenosis of the infrarenal portion of the abdominal aorta and the left renal artery. The patient was referred for surgical correction by insertion of an aortic patch graft and by-pass to the left renal artery. The pathological diagnosis was Takayasu's disease. The hypertension improved partially. Because of poor control of the hypertension a digital subtraction angiography (DSA) was performed (June 1987) and disclosed stenosis of the left renal artery. Another DSA performed because of increasing hypertension (November 1987) revealed stenosis of the right renal artery. A right kidney autotransplant was performed. Hypertension persisted with minimal impairment of renal function. Another DSA performed because of further severe hypertension (February 1988) showed postanastomotic stenosis localized 1 cm distally to the ostium of the right renal artery resolved successfully with percutaneous transluminal angioplasty (PTA). Another DSA performed (June 1988)

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