(6.5, 8, 16, and 32 mg.) on the first, second, third, and fourth days, respectively, and then $\frac{1}{2}$ gr. (32 mg.) on each of the remaining 14 days of the in-patient period: the subsequent increments (see Table) were prescribed from the out-patient clinic. Within 19 days of the beginning of

Dosage of Dry Thyroid and Weight of Infant

Age in Months	Average Daily Dose of Dry Thyroid (B.P.)	Weight
5-6	1.2 gr. (78 mg.)	At 6 months 12.1 lb. (5.49 kg.)
7-8	1.7 " (110.5 mg.)	" 8 " 14.6 " (6.62 kg.)
9-10	2.2 " (143 mg.)	" 10 " 18.8 " (8.53 kg.)
11-12	2.8 " (182 mg.)	" 12 " 22.2 " (10.07 kg.)

treatment the typical therapeutic response was obvious and the baby improved dramatically in appearance and general symptoms. She continued under close observation, being examined and weighed at weekly intervals, and the parents, who were regarded as reliable observers, were informed of the issues and asked to report any looseness of the motions, undue sweating, restlessness, or other untoward symptom which could be regarded as evidence of intolerance to the increasing thyroid dosage. They also recorded the sleeping pulse rate.

No clinical evidence of intolerance did, however, occur, even though an average daily dose of 2.8 gr. (182 mg.) was

FIG. 3.—Radiograph of wrist at 15 months.

reached during the eleventh and twelfth months; it was at this stage decided to make no further increase. At 15 months radiographs of the wrist (Fig. 3) showed that ossification, which had initially been retarded, was now very advanced. Six carpal centres were present as well as those for the lower end of the radius and the head of the fifth metacarpal. According to the standards described by Todd (1937), ossification had therefore

advanced to a degree expected in a female child of 4 years 3 months. The patient's length, which was 22 $\frac{1}{2}$ in. (57.2 cm.) at 18 weeks of age, was now 31 in. (78.7 cm.) and her weight was 23 $\frac{1}{2}$ lb. (10.7 kg.).

From 15 months of age the thyroid dose was substantially reduced, but her bone age at 3 years was still advanced, being equivalent to that of a child of 5 years 9 months (Todd, 1937). Her height was 39 $\frac{1}{2}$ in. (99 cm.). A satisfactory aspect of the case was that the child's mental development seemed to be within normal limits and she was also tall, but a future possibility which must be considered is that of premature union of the epiphyses with the diaphyses of the growing bones.

ADDENDUM.—Since the submission of this report for publication attention has also been drawn by Drs. B. Schlesinger and O. D. Fisher (*Lancet*, 1951, 2, 289) to the acceleration of ossification that may follow high thyroid dosage in cretinism.

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Bacterial Endocarditis Caused by Coagulase-Negative Staph. Albus

Matthew (1951) reports two fatal cases of bacterial endocarditis in which the infecting organism was a coagulase-negative *Staphylococcus albus* and comments on the rarity of this organism as a cause. A similar case is here presented with brief clinical details; recovery took place after treatment with penicillin and streptomycin.

Case Report

A man aged 72 was admitted to hospital on August 18, 1950. He gave no past history of acute rheumatism, but had had an attack of mild congestive failure after unwonted exertion two years before; at this time an apical systolic murmur was heard and an x-ray film showed cardiac enlargement; recovery was rapid and no further symptoms occurred.

The present illness started four weeks before admission, with fever up to 101° F. (38.3° C.), general malaise, headache, night sweats, and shooting pains in the hands and legs; the serum twice showed no agglutination with enteric, salmonella, or brucella organisms. The patient gave no history of furunculosis, but his wife had a whitlow during the month preceding his illness.

On examination general appearances were normal except for some pallor of mucous membranes. His temperature was 99.4° F. (37.4° C.), pulse rate 100, and respirations 22. Clinical enlargement of the heart was noted, a systolic murmur was heard over most of the praecordium, and a soft diastolic murmur, which became much louder in the course of a week, down the left side of the sternum. The spleen was just palpable. No finger-clubbing or peripheral embolic phenomena were found, though a week after admission a small subconjunctival petechial haemorrhage was noted. His blood pressure was 150/80; E.S.R. (corrected), 18 mm. in one hour; R.B.C., 4,400,000; Hb, 74%; W.B.C., 9,400 (neutrophils 85%); and urine deposit showed occasional red cells. Blood culture gave a haemolytic coagulase-negative *Staph. albus*; this was repeated with a similar result. The organism was insensitive to "sulphatriad," moderately sensitive to "aureomycin," chloramphenicol, and streptomycin, and sensitive to 6 units of penicillin in 1 ml. but insensitive to 3 units in 1 ml.

On August 23 penicillin, 1,000,000 units, soon increased to 2,000,000 and then to 4,000,000 units daily, was started. Three days later the patient complained of pain of indefinite type in his chest, but this quickly subsided and no evidence of pericarditis was found at any time. On September 3, as the temperature was still rising on most evenings to 100° F. (37.8° C.) or higher, streptomycin, 2 g. daily, was given in addition. Blood culture a week later was sterile, the spleen was no longer palpable, and the temperature gradually became and remained normal. A further blood culture was sterile, no R.B.C. were found in the urine, and Hb was 90%. Penicillin was discontinued on September 22 and streptomycin on October 13, and the patient returned home for further rest and convalescence.

It was soon necessary to readmit him for 14 days on account of acute dermatitis, which was thought to be possibly due to streptomycin and which responded to anti-histamine drugs and local treatment. On returning home a second time he unfortunately developed a small pulmonary embolus, but soon recovered. At the time of writing he is free of symptoms and leading a relatively active life.

I wish to thank Dr. Goodman Platts and Dr. Olive Cameron for pathological work and Dr. E. S. Vergette for clinical notes.

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