responded to administration of nystatin suspension. There had been no travel outside the country.

When seen in the emergency room, the infant weighed 3.4 kg. He was pale and very lethargic. Body temperature was 38.5°C, taken rectally. The liver edge was palpable 2 cm below the right costal margin and the spleen was enlarged to 6 cm below the left costal margin. The rest of the physical examination gave normal findings. Laboratory data included a leukocyte count of 7,900 per cu mm with 19 percent neutrophils, 11 percent band cells, 68 percent lymphocytes and 2 percent monocytes. The hemoglobin measured 7.9 grams per dl, the hemotocrit 21.9 percent, the reticulocyte count was 3.0 percent, and there were 90,000 platelets per cu mm. An estimated 2 percent to 3 percent of the red cells contained malaria parasites which were later identified as *Plasmodium vivax*. Analysis of cerebrospinal fluid and urine gave results within normal limits. Cultures of urine, cerebrospinal fluid and blood were negative.

The patient was admitted to hospital with a diagnosis of congenitally acquired *Plasmodium vivax* malaria. He was treated immediately with chloroquine phosphate, 5 mg base per kg of body weight, by gavage. The same dose was given 6 hours, 24 hours and 48 hours after admission. The patient became afebrile within 36 hours and thick and thin blood smears for malaria were negative within 48 hours. Two weeks after admission, the patient was seen in clinic and was thriving. Smears for malaria were negative and the anemia had improved.

Thick and thin smears of the mother's blood made at the time of diagnosis were negative for malaria parasites. A thin smear made at the time of delivery was reviewed and was also negative. Nevertheless, the mother was treated with both chloroquine and primaquine.

As a result of this experience and with the increasing incidence of congenital and imported cases of malaria,[1-3] we are reminded to consider the diagnosis of malaria in all Southeast Asian children with fever, especially if there is hepatosplenomegaly. We continue to study the problem of screening pregnant women who have lived in or traveled through endemic areas.

CHARLES J. BERLETTI, MD
Contra Costa County Health Services
Martinez, California

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Still More HAFE

TO THE EDITOR: Your publication of the recent state of the art letter by Drs. Auerbach and Miller on high altitude flatus expulsion (HAFE)[1] demands applause. Certainly, the importance of the syndrome cannot be overstated. While few practitioners of the art and science of medicine will encounter high altitude pulmonary edema (HAPE), many will be forced to deal with the devastating effects of HAFE with victims loudly announcing their need for medical intervention.

Unfortunately, because of psychosocial factors which mitigate against self-designation, the reporting of incidence, frequency and severity of this disorder is entirely inadequate. The resultant medical ignorance, or perhaps even medical neglect, casts a pall over the credibility of the entire medical profession. Without an adequate data base, we in the medical community cannot even begin to explore the anatomy, physiology and appropriate therapy of HAFE. We therefore propose the establishment of an international reporting system for the collection of all data relevant to this and related disorders. The acronym SCHTOOOL seems most appropriate and easily recalled—Society (for the) Collection and Historical Tabulation of Olfactory and Otherwise malOdorous Literature.

In recognition of the pioneering work and perceptual powers of the authors of this landmark report, we urge these physicians to accept the call to become overseers of all information relevant to this vital subject. Whenever possible, a representative aliquot of the pathologic material should be collected and sent to them, and they should be encouraged to do a prospective study.

In addition, the journal must be congratulated for recognizing the importance of this paper and appropriately airing it before an eager audience. Dissertations such as this are a breath of fresh air in a wilderness of largely irrelevant medical eructations.

CHARLES R. McELROY, MD
Associate Professor of Medicine
Director, UCLA Emergency Medicine Center
Los Angeles

JEROME R. HOFFMAN, MD
Assistant Professor of Medicine
UCLA School of Medicine
Los Angeles

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