investigations for organisms that cannot readily be isolated by conventional culture methods such as Coxiella burnetii, Chlamydia spp and the recently recognised Bartonella (previously Rochalimaea) spp, which incidentally give serological cross reactions with Chlamydia spp.1

In conclusion, it is important to emphasise that the greatest advances in the successful management of infective endocarditis since the advent of penicillin have come from cardiology and cardiac surgery. Remarkably, some hospital clinicians are still reluctant to refer patients for specialist care; this is quite unacceptable. As we approach the millennium it would be gratifying if the UK guidelines on prophylaxis and treatment (to which the BSAC working party devote much time) could be followed by more doctors.

5 Guntheroth WG. How important are dental procedures as a cause of infective endocarditis? Am J Cardiol 1984;54: 797-801.