baby to adopt. This is a fallacy: adoption societies exist to help babies and children offered for adoption to find a home, and they know from long experience that nothing less than the best is good enough for adopted children.

While mongolism may be least disturbing in a family, nevertheless to have a mentally handicapped child for an older sib is not the best environment for an adopted child, who will certainly have problems needing parental and family support in due course. Adoption societies are fully conscious of family psychodynamics, thinking particularly to teenage years, when there could be competition for parental time if there is a handicapped child of any description in the family. Case committees who make the decisions are very sensitive to these facts, and as they usually have more good homes without problems than babies available they are able to be selective. Furthermore, they think in terms of adoption families where two or more babies may be placed to give support to each other in time.

It would be a very fine couple to cope successfully with a mentally handicapped child and adopted children as a family. They would need resources and support within the family. I am sure that if a couple could present an adequate case that they had the requisite essentials they might get a sympathetic hearing from a reputable adoption society. But the society would need convincing, for no society would place a baby even in a home such as Dr. Bicknell recommends, where there is any possibility of that family remaining as two children.—I am, etc.,

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Fluctuating Course in Acoustic Neuroma

SIR,—The tendency for neoplasms to be progressive can hardly be challenged, but Dr. N. B. S. Sarkari and Dr. E. R. Bickerstaff (5 April, p. 21) are to be congratulated for emphasizing the possibility of marked fluctuation of symptoms and signs before the progressive nature becomes apparent. They are correct in supposing that "an extrinsic tumour impinging on the brain stem might be found which might be capable of surgical eradication." Acoustic neuroma is an example, and remission is one feature (sudden onset is another) which can make diagnosis difficult.

In a series of 15 patients whom I have seen personally and who later had an acoustic neuroma removed eight showed some degree of fluctuation, and in seven this was sufficient to suggest an alternative diagnosis initially. In one a sensory deficit in the trigeminal area cleared up for several months, which seemed to confirm an earlier presumption of disseminated sclerosis, and in another recurring unilateral headache with visual disturbance suggested migraine. There was fluctuating hearing in two, acute episodes of vertigo in four, and recurrent facial palsy over a period of eight years in another.

This is something which needs to be stressed, since it is so much at variance with the usual textbook descriptions. Where doubts remain air or iophendylate in the ventricular system and vertebral angiography, as was suggested, will help, but may not demonstrate a small tumour in the cerebellopontine angle, which nevertheless would be outlined by myeloencephalography.—I am, etc.,

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Vitamin B_{12}, Serum Folate, and Hypochromic Anaemia

SIR,—The letter from Mr. P. H. Johnson and others (8 March, p. 643) prompts us to report similar findings, though our interpretation of these is different.

Of 60 patients with idiopathic iron deficiency anaemia 10% had a subnormal serum vitamin B_{12}, 27% a subnormal serum folate, and 38% an excess of hypersegmented polymorphs. Six of 42 had giant metamyelocytes in the marrow. The presence of abnormal myeloid cells was not always due to vitamin deficiency, for such cells were found when both serum vitamin B_{12} and folic acid clearance, the most sensitive test of folate deficiency, were normal. This has been observed by others.[1,2] This does not, however, exclude an altered metabolism of either vitamin in iron deficiency. The addition of folic acid to the iron therapy of those patients with a subnormal serum folate did not enhance haemoglobin response, nor was vitamin therapy needed to reduce the hypersegmented polymorphs to normal.

We agree, therefore, that vitamin deficiency is common, though in respect of folic acid the defect is slight, since no patient tested had a subnormal red cell folate. Low serum folates have been observed before in iron deficiency anaemia,[3,4] but we do not consider that the vitamin deficiency is being masked by the iron deficiency, since iron therapy alone caused correction of the defect, in contrast to the exaggeration of the signs of vitamin deficiency observed when iron is given to patients with dimorphic anaemias.—We are, etc.,

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Ophthalmic Disease and the Pill

SIR,—Ocular complications of oral contraceptives have aroused interest for some years. In 1965 Cogan[1] drew attention to certain neuro-ophthalmic affections being reported in the U.S.A., but doubted if they were related to the contraceptive pills. Walsh *et al.*[2] produced 69 case reports of neuro-ophthalmic interest, but the authors were not sure of the link between these diseases and the contraceptive pill.

A married woman aged 29 was admitted to the Royal Eye Medical Ophthalmological Unit on 3 October 1967 with a history that for four days she had noticed a black shadow in the lower part of the right visual field which had persisted. The patient had been taking megestrol acetate (Volidan) tablets for four years. Five months prior to this incident she had increased the dose to two tablets daily because of breakthrough bleeding. On examination the right fundus showed an occlusion of the superotemporal arteriole with a corresponding field defect and a visual acuity of 6/6 part. Full investigation, including carotid angiography, revealed no abnormality. At present the right vision is 6/6 and the visual field defect is unchanged. The upper temporal arteriole is narrowed with sheathing and there is temporal pallor of the disc.

It seems clear that there is an association between taking oral contraceptives and some types of thromboembolic disease, perhaps due to an induced change in the clotting mechanism of the blood.[3-5] The cerebrovascular system is probably involved in this correlation. With the patient reported there was no clinical or radiological evidence of an extracerebral source of the embolus to account for her retinal artery occlusion. We considered that megestrol was an important factor in this case. The relationship is impossible to prove and can only be suspected because of the rarity of this particular lesion in a young woman.

In addition to this case we have examined seven other patients with ocular disease, five with optic neuritis, one with central serous retinopathy, and one with superficial retinal haemorrhages, all of whom were taking oral contraceptives. We considered that, though the aetiology of these conditions is not fully understood, oral contraceptives should not be incriminated, as these conditions do occur in women during the reproductive years. It is difficult to evaluate cause and effect, as ocular side-effects of the pill appear to be rare.[6-8] In Britain the Committee on Safety of Drugs has received few confirmed reports of ocular complications from these drugs.

Clinical trials with controls involving large numbers of patients would have to be carried out to assess the true incidence of ocular side-effects in view of the conclusion[4,5] that thrombo-embolic disorders occur in 1 in 2,000 women on the pill.—We are, etc.,

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Chronic Bacteriuria

SIR,—Your leading article "Chronic Bacteriuria" (15 March, p. 661) raises the question of bacteriuria in old age, its origin, and the desirability of treating it.

We have investigated the incidence of urinary infection in a normal elderly population—that is, all those aged 65 and over in a general practice in Beckenham—557 people.[1] In round terms we find the incidence of significant bacteriuria to be 20% in females over 65. In males over 70 the incidence was also