In our experience many doctors and medical students believe that dextrose is a carbohydrate that is different from glucose and do not realise that dextrose is the name given in the *British Pharmacopoeia* (1973) and the *British Pharmaceutical Codex* (1973) for glucose monohydrate. This causes confusion in understanding disease and in treatment. Glucose is the scientifically acceptable trivial name for D(+)-glucose. We make a plea for the universal use in medicine of "glucose" as the only name for this compound and of "glucose monohydrate" when it is necessary to specify that the glucose molecule is not anhydrous (as it carries one molecule of water)—and for the abandonment by pharmacists of the name "dextrose."

D N BARON
NEIL MCINTYRE

Royal Free Hospital and
School of Medicine,
London NW3

Accidents on holiday

SIR,—With the holiday season beginning, may I make a plea for co-operation between the accident and emergency services throughout the country?

As usual, holiday-makers will injure themselves while away from home and return for their further care to their home areas. May I ask that all casualty and orthopaedic staff consider this as part of the management of the injured patient and allow these people to bring their x-rays and a record of their previous management with them when they return home? Already this season I have had experience of hospitals not forwarding the information "because they did not know to which department a patient was going to be referred," and of information retained by the patient's general practitioner on his return home even though local hospital follow-up had been requested by him.

Although the carriage of clinical information by the patient himself is open to abuse, I feel this is more desirable than the frustration and exasperation I feel when a patient walks in with a plaster on and with a note saying "please continue his care" and no other information.

M J MERLIN

Accident and Emergency Department,
Walsall General (Sister Dora) Hospital,
Walsall, W Midlands

Dangers of tinted glasses for driving

SIR,—Professor R A Weale's anxieties (15 May, p 1212) on the subject of the danger of wearing photochromic lenses when driving deserves the very widest support. One hopes that he will be supported not only by ophthalmologists but also by the various other optical professions.

It is, however, also appropriate to remind all drivers and the public at large that it is not only photochromic glasses that may present a source of danger but that all forms of tinted or light-absorbing lenses and windscreens may present quite hidden dangers. These can arise when the wearer or user is confronted unawares with an unusual combination of light sources, sudden change of illumination, and/or selective absorption on the part of a visualised object (such as a cyclist at night).

While, like many other unnecessary human

activities, the wearing of tinted glasses is to be deprecated but at the same time tolerated, it is high time that all those who are aware of the genuine potential dangers—and this includes certain motoring organisations and journalistic sources which should know better—play their part in an intelligent campaign to underline in commonsense and comprehensible terms the dangers that can be involved.

M J GILKES
Chairman,
Ocular Safety Subcommittee,
Faculty of Ophthalmologists

London WC2

Management of motor neurone disease

SIR,—Your leading article (12 June, p 1422) rightly emphasises the problems of these patients but says little of means to overcome some of the problems.

As the arms gradually become weaker an electric wheelchair must be prescribed, but only after accurate assessment in a rehabilitation department; too often one sees patients to whom the wrong chair has been supplied; it then has to be changed and this wastes more of the little time that these patients have. Mobile arm supports may be fitted to the chair to counterbalance the weight of the arms and eliminate the force of gravity. The patient may then use his arms to type, eat, and drink or for other activities.

An environmental control system such as Possum is invaluable to control an electric front door lock, lights, radio, TV, etc and to make telephone calls, in- or out-going; this last facility also enables the fit spouse who is at work to communicate with the patient. All that these systems need to actuate them is any muscle movement or suck-blow breath control; modern engineering and electronics can do much to help these patients.

The speechless patient may be able to communicate through a Possum typewriter, the input to the machine being actuated by any remaining muscle function or by suck-blow breath control. Speech is not always the last function to go; I have one patient at present who is speechless but still mobile enough to go out. He has been supplied with a "talking brooch" in which a small typewriter keyboard controls a display of five letters at any one time in a "brooch" worn on the clothes. The display moves along as in some advertising signs and he is able to communicate. It may be slow, but it is an advance; the keyboard is small and easy to carry about. The same patient is able to use an ordinary electric typewriter when at home, having sufficient residual power although speech is unintelligible.

In a letter one cannot cover all the other problems that can be helped, like access and modifications to the home and car or the financial benefits claimable by a disabled person.

JOHN GOODWILL

King's College Hospital,
London SE5

Multiple sclerosis among immigrants

SIR,—Dr J F Kurtzke (19 June, p 1527), referring to the paper on this subject by my colleagues and myself (10 April, p 861), points out that there has been a big increase in new Commonwealth immigrants between 1961 and 1971 and that our study was based on the 1966

census. The populations were given in the paper and it is very simple to work out the number of immigrant years of exposure for their risk of a first admission to hospital for multiple sclerosis.

It may also please Dr Kurtzke to know that there will be a follow-up study based on the West Midlands and using the 1971 census and also that a report will follow on admission to hospital for motor neurone disease in Greater London and the West Midlands. This disease was used as a control.

The very low rate of admission to hospital for multiple sclerosis among new Commonwealth immigrants is confirmed by the low mortality rate from this disease among these immigrants. This is very strong confirmatory evidence that multiple sclerosis is indeed uncommon among non-White immigrants from Asia, new Commonwealth Africa, and new Commonwealth America.

GEOFFREY DEAN

Medico-social Research Board,
Dublin

Folate-responsive neuropathy

SIR,—I was interested in the report of Drs M Manzoor and J Runcie (15 May, p 1176), whose conclusions accord with mine and those of my colleagues on the basis of studies in epileptic, neurological, psychiatric, and geriatric populations over the past 10 years.¹⁻⁴

The response of their 10 patients to folic acid therapy rightly suggested to Drs Manzoor and Runcie a need to review orthodox concepts of folate in relation to nervous system function, and I have recently attempted to do just this in a review of the relevant literature.⁴ The issues raised by this review are too complex and numerous to cover in a brief letter, but it should perhaps be emphasised that the association of neuropsychiatric illness and folate deficiency (or, indeed, vitamin B₁₂ deficiency) does not always imply a causal relationship and will, therefore, not always result in the type of therapeutic response reported by Drs Manzoor and Runcie, myself, and other authors. In geriatric, psychiatric, and epileptic patients folate deficiency is commonly the result of neuropsychiatric illness for dietary, drug, and other reasons. However, even in these circumstances folate deficiency may well aggravate the underlying disorder, especially if severe and prolonged, and such deficiency should be corrected, except perhaps in the uncomplicated epileptic patient in whom fits may sometimes be exacerbated. Furthermore, pure folate deficiency is relatively uncommon and there may be associated deficiencies which are also exerting an adverse effect on nervous function. Finally, I have suggested that, contrary to orthodox concepts, the neurological manifestations of vitamin B₁₂ deficiency are the result of a secondary disturbance of folate metabolism, which is also widely believed to be the explanation for the megaloblastic manifestations of vitamin B₁₂ deficiency.⁴

E H REYNOLDS

University Department of Neurology,
Institute of Psychiatry and King's
College Hospital Medical School,
London SE5

¹ Reynolds, E H, *et al*, *Epilepsia*, 1966, 7, 261.

² Reynolds, E H, Rothfeld, P, and Pincus, J, *British Medical Journal*, 1973, 2, 398.

³ Reynolds, E H, *Epilepsia*, 1975, 16, 319.

⁴ Reynolds, E H, in *Clinics in Haematology*, vol 5, No 3, ed V Hoffbrand, p 661. London, Saunders, 1976.