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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

SI Units

Str.—The recommendation by the Department of Health and Social Security for the introduction of SI units into clinical work by the end of 1975 has already caused comment in your columns. While many clinicians feel some doubts about the value of this changeover (and many older general and hospital practitioners will experience real difficulty in fitting the new values and ranges into their clinical experience) it is not only clinicians who have anxieties.

Pathologists also have serious concern for the safety of patients and are responsible for supervising the introduction of these units. We are led to believe that "clinical" measurements (such as blood pressure) will be changed at a later date. I suspect that if it had been proposed that all clinically relevant measurements were recorded in SI units by the end of 1975 the changeover would never have been accepted; but since the change is to be made I wish to draw attention to the need for great care by all doctors, not only in interpreting the new units, but especially by those who originate laboratory reports.

In this laboratory within a few weeks these errors have been noted: (1) in a well-known bench/pocket book of biochemical values in clinical medicine (now in its fourth edition)1 the "conversion factor" supplied for bilirubin is incorrect by a factor of 1000; (2) an internationally reputable chemical manufacturer2 has supplied a glucose standard solution containing 100 mg/100 ml which the label states is 55-6 mmol/l (it is actually 5-55 mmol/l); (3) a commercial quality-control serum was accompanied by a list of values of contained substances, one of which was inaccurate. (This error has been rectified in recent data.) Uncritical acceptance of such material raises frightening possibilities.

The lesson is clear. Even experts are fallible. Pathologists and clinicians must exercise extreme caution in accepting published information in SI units. Such data must be checked locally before being introduced into routine laboratory use. All calculations should be performed independently by a second person. The use of a bench or pocket calculator reduces this chore to a few seconds' work, and in training institutions it would be a constant reminder as to how and why SI units are derived. In clinical areas potentially lethal situations (such as where serum calcium is reported in mmol/l, the intravenous replacement fluid is labelled in mlEq/l, and the ampoules of added chemicals are labelled in g/100 ml, or even as "per cent") must be anticipated.

"The price of safety is eternal vigilance."—I. A. R., etc.,

J. J. Taylor

States of Jersey Pathological Laboratory, Jersey, CI.

2 Sigma Chemical Company, St. Louis, Missouri, U.S.A.

Medical Examination of the Baby to be
Adopted

Str.—We applaud Dr. R. R. Gordon's plea (5 April, p. 31) for better examination of the baby to be adopted.

We should like to stress the importance of early and repeated physical, including complete neurological, examination and developmental assessment of babies available for adoption by paediatricians trained in such assessments. By this means deviations from normal are discovered early and physically and mentally defective infants are likely to be identified. If such problems are first found after initial placement, when the adopting parents have grown to love the child, rejection may give rise to feelings of guilt, while acceptance may be incomplete even if the adoption is finalized.

In North America there is an increasing demand by adopting parents for handicapped children, and in our experience these can be very satisfactory adoptions. If handicapped children are placed the adopting parents must fully understand the implications for the child's future and for that of the adopting family.—We are, etc.,

Norah Brown, F.R.C.P. Margaret Cox

Communication/Development Clinic, St. John's Newfoundland

Is Hypocalcaemia Protective against
Hyperlipidaemia?

Str.—Professor V. Linden (12 April, p. 87) states that he has found an association between vitamin D intake and serum cholesterol levels. In recent years the occurrence of a moderate vitamin D deficiency accompanied by hypocalcaemia in the elderly has been well established.1 If Professor Linden's findings are correct it might be expected that the serum calcium level would be positively correlated with the serum lipid levels in the elderly. We report here a study which seems to indicate that this is not the case.

From 80 subjects randomly selected during a study of morbidity and general health in a 60-year-old population group in Glosrup

1 Bright Medical Journal: first published as 10.1136/bmj.3.5977.226-b on 26 July 1975. Downloaded from http://www.bmj.com/ on 16 September 2023 by guest. Protected by copyright.
County, Denmark, blood samples were drawn in the fasting state at 8 a.m. for determination of serum levels of calcium, protein, cholesterol, and triglyceride. The serum calcium levels were corrected to a constant serum protein level. All determinations were made in duplicate, and the coefficients of variation (C.V.) of duplicate measurements and the mean values and standard deviations (S.D.) are given in the table. A highly significant inverse correlation was found between serum calcium and serum cholesterol (r = 0.03, P > 0.05).

<table>
<thead>
<tr>
<th>Serum Levels</th>
<th>No. of Subjects</th>
<th>Mean</th>
<th>S.D.</th>
<th>C.V. (from duplicate measurements)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium (mmol/l)</td>
<td>80</td>
<td>2.46</td>
<td>0.06</td>
<td>0.8%</td>
</tr>
<tr>
<td>Cholesterol (mmol/l)</td>
<td>80</td>
<td>7.04</td>
<td>1.48</td>
<td>1.5%</td>
</tr>
<tr>
<td>Triglyceride (mmol/l)</td>
<td>80</td>
<td>1.27</td>
<td>0.95</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

Conversion: SI to Traditional Units—Calcium: 1 mmol/l = 4 mg/100 ml. Cholesterol: 1 mmol/l = 38.6 mg/100 ml. Triglyceride: 1 mmol/l = 88.5 mg/100 ml.

Our results seem to be supported by the findings that serum cholesterol is lower than normal in patients with hyperparathyroidism and that the serum concentration of lipids increases after operation. They indicate that in the elderly serum calcium levels in the lower part of the normal range are not protective against raised serum lipid levels. —We are, etc.,

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A. R. CRAPP
J. POWIS
CHARLES CLARK
M. R. B. KEGERLEY
J. ALEXANDER-WILLIAMS
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Lactase Activities in the Irritable Colon Syndrome

Sir,—In your leading article on lactose malabsorption (17 May, p. 351) the relevance of hypolactasia to the irritable colon syndrome is discussed. The evidence from Oxford and Denmark is mildly contradictory on this point, though in the latter study jejunal lactase activities were measured in only nine of the 78 patients under review. We wish to add our own experience in 15 patients (four male, 11 female) diagnosed as suffering from the irritable colon syndrome by previously established criteria. The patients were all Caucasians living in this region. Mcusosal lactase activities were measured using whole specimens taken with a hydraulic biopsy instrument. Our control range was established by reference to recent measurements in 32 subjects with histologically normal mucosa. The mean jejunal lactase activity in the patients was 3.6 IU/g tissue (wet weight), the actual results ranging from 1.6 to 5.8 IU/g. This compared with the control range of 1.9–10.1 IU/g (mean ± 2 S.D. obtained by log transformation). In only one case was the value below the control range. Our findings, like those of the combined study of Pena and Truelove that in most cases a cause other than hypolactasia is responsible for the symptoms of the irritable colon syndrome.—We are, etc.,

MARTIN FAIRMAN
BRIAN SCOTT
M. LOSOWSKY
University Department of Medicine, St. James's Hospital, Leeds

SIR,—We have recently completed a prospective randomized clinical trial to evaluate the effect of systemic prophylactic lincomycin on postoperative sepsis after bowel surgery, no other antibiotic was administered. No case of pseudomembranous colitis occurred among the 33 patients who received lincomycin for five days, though the complications were widely sought. Prophylaxis reduced the incidence of anaerobic but not aerobic infection.

Since this trial we have been combining systemic lincomycin with another broad-spectrum antibiotic and had begun a prospective assessment on patients undergoing elective or emergency resection for large-bowel cancer. Of the 18 patients so far treated, six have developed postoperative pseudomembranous colitis and one has died as a result. In each case the amount of lincomycin received was small (between three and nine 600-mg doses at eight-hour intervals given by intramuscular injection). All six patients received additional broad-spectrum antibiotics (two received gentamicin, three tobramycin, and one co-trimoxazole). No patient had concurrent disease or debility and hypotension was not observed at any stage during anaesthesia.

The association between lincomycin and pseudomembranous colitis is well recognized, but the pathogenesis of the condition is not understood and is probably multifactorial. Several points arise from our recent experience: firstly, small doses of lincomycin do not prevent the complication of colitis; secondly, the combination of lincomycin with a broad-spectrum antibiotic such as an aminoglycoside may increase the incidence of colitis; and finally, our present prospective study—a combination of lincomycin and an aminoglycoside as prophylaxis against postoperative sepsis has been discontinued on ethical grounds.—We are, etc.,

N. E. Cetti
British Military Hospital, Dhekela, Cyprus


2 Sir,—On 15 July 1974 a coup a staged in Nicosia and this was followed by an invasion by Turkish troops on 20 July and a subsequent "push" by these troops to Famagusta on 14 August. The British Military Hospital at Dhekela received wounded of both Cyprus communities and of the contingents serving with the United Nations Forces. In all, 59 patients were admitted with injuries associated with this violence. The sites of wounding were: upper limbs, 16 (three with fracture); lower limbs, 32 (six with fracture); head, four; neck, one; chest, seven; abdomen, eight; multiple fragments, two. (Some patients had more than one wound.)

The wounds were caused by mine, shell or bomb fragments, high and low velocity bullets, and (in one instance) a bayonet thrust. Treatment followed standard military lines which lay emphasis on the following points: (1) Adequate intravenous resuscitation with fluids and blood. (2) Exploration and rigorous debridement of all but the most superficial of wounds. (3) All wounds of muscle left open for delayed primary suture in five to six days. (4) Compound fractures subjected to manipulation at the time of debridement, held in padded plaster casts, and internally fixed only if required after sound soft-tissue healing (in none of our cases was this required). (5) Damaged colonic segments exteriorized and formed into a double-barrelled colostomy for later closure. We found the prophylactic use of dexamethasone and hyperhydration extremely effective in the management of our head wounds.

Cases of interest included the following:

(1) Temporal fracture and subdural haemato-

The treatment of asthma is a complex process requiring careful consideration of the individual patient's condition and lifestyle. The choice of therapy should be guided by the severity of the disease and the presence of any associated conditions. The article correctly