sight beyond a mere clinical field. It is not sufficient to abolish an undesirable disease if, as a consequence, more misery is produced later. A parallel situation has occurred in response to a precaution taken by the prescription of malaria by removing an agent of population control has led to widespread starvation.

When the effects of reduced smoking bear fruit, we shall have an increased life expectancy and a larger number of elderly citizens. The people who have smoked are at present likely to die at an age when the younger generation is finding them a burden and is paying for their smoking. We must therefore equally share the exhortations for the abolition of smoking a call for advanced creation of suitable homes and geriatric services, in accordance with the new population bulge that will develop.—I am, etc.,

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Diagnosis of Cystic Fibrosis

SIR,—I would like to comment on Dr. A. G. F. Davidson and Professor Charlotte M. Duncan (16 November, p. 162) reference to the screening of meconium for the presence of albumin. They state, quite correctly, that 10-15% of patients with cystic fibrosis have no clinical evidence of malabsorption and that such cases may not show a positive meconium test.

I mentioned earlier (11 September, p. 639) the routine screening programme being carried out in this teaching hospital. One of the aims of this experiment is to find out how many cases of cystic fibrosis are missed for this, or any other reason.

We do not know as yet if absence of malabsorption automatically means that a meconium test is negative, but even if this is so we feel it is still more than worth while to diagnose the remaining 85-90% at birth.—I am, etc.,

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"Stroke Units"

SIR,—In your leading article (6 November, p. 313) you suggest that we seriously consider the development of stroke units in this country, similar to those which have grown up in the United States. The conditions in the two countries are not, however, comparable. The majority of strokes occur in older patients and in the United Kingdom we already have a national network of geriatric units, which have done their best, with limited resources, to develop rehabilitation services. For many years these units have attracted stroke patients and many important contributions to the British literature of stroke have originated from such departments.

When the geriatric assessment unit of the Glasgow Royal Infirmary group of hospitals was established at Lunteburn Hospital in 1968 one ward of 30 beds (15 male and 15 female) was set aside for stroke rehabilitation. A few patients are admitted from their own homes direct to this unit, but most strokes occurring in the area served by the hospital group are admitted in the first instance to the general medical wards of Glasgow Royal Infirmary, where they undergo intensive care, if appropriate, and have ready access to neurosurgical and investigative facilities. Many patients are treated to conclusion in the medical wards, but each year between 150 and 200 patients are referred to the physicians in charge to the geriatric service, and are transferred, after assessment, to the stroke ward in the geriatric unit. One-quarter of stroke patients are at risk of having strokes in the first 6 months, and some of them have been referred to the stroke ward. The stroke rehabilitation ward is organized along the lines of a standard geriatric rehabilitation ward, with the addition of a team consisting of physiotherapists, occupational therapists, speech therapist, medical social worker, and after-care services. The additional activities include a daily recreation programme organized by the geriatric unit, pre-discharge home assessment, post-discharge follow-up, a club for relatives, group speech therapy, and group therapy for relatives of aphasic patients. A day hospital is also being planned.

This arrangement has worked well, and similar collaboration between general physicians, neurologists, neuropsychologists, and geriatricians might prove a suitable pattern for the management of stroke patients in Britain. The unit depends heavily on its small staff of physiotherapists, occupational therapists, and speech therapists, and the continuing shortage of these grades of staff is the major obstacle to the needed expansion of stroke rehabilitation throughout the country.—I am, etc.,

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Epieth for the M.C.H.C.

SIR,—Dr. F. Nour-Eldin (30 October, p. 298) is referring specifically to the M.C.H.C. (mean corpuscular haemoglobin concentration) nor the M.C.H. (mean corpuscular haemoglobin) convey anything of particular clinical value (16 October, p. 169) and then goes on to raise a number of points. It must be made quite clear that Dr. Rose is referring specifically to the M.C.H.C. as calculated by automatic apparatus and is being compared with the value derived from the haemoglobin level and the packed cell volume measured by manual methods. That these two figures do not always mean the same thing has now become obvious as is explained by Dr. J. M. England and others (23 October, p. 232).

(1) The M.C.H.C., as measured by the Coulter Model "S," does not fall in hypo- chromia, a fall being recorded in the severe anaemia of iron deficiency. Therefore, when measured in such apparatus, it cannot "return to normal on successful treatment of hypochromic anaemia." The M.C.V. (mean corpuscular volume) on the other hand, does fall relatively early in iron deficiency and is an excellent parameter both for assessing the degree of the deficiency and for following the response to therapy.

(2) The traditional teaching of textbooks of haematology that the absolute values, the M.C.V. and M.C.H. are unacceptably inaccurate because they depend upon the red cell count, which has a large inherent error —of the order of ± 400,000 cells out of a total of 5,000,000 cells if a visual count is done on 500-1,000 cells. The introduction