all adults. It is likely that ischaemia, rather than haemorrhage, was the more frequent pathogenic mechanism.

The other disease which you did mention is diabetes. Diabetes, like hypertension, is a predisposing factor. In large series the frequency of previously recognized diabetes was 10-14%. However, when glucose tolerance tests are performed many new cases are discovered, and the frequency of abnormal results increasing with age. The frequency of overt and latent diabetes in patients with Bell's palsy is thus similar to that previously reported in ocular motor palsy. Patients have been observed to have detectable levels of diabetic antibodies to their own insulin, and also to detect antibodies to several viruses, but the results have been negative thus far.

The seasonal variation in the incidence of Bell's palsy which is frequently mentioned and which you quote is of course only circumstantial evidence that the disease is infectious. As Leibowitz remarked, similar climatic influences have been shown on the occurrence of myocardial infarction (and also cerebral vascular disease). Leibowitz has subsequently demonstrated (and not in the paper you mistakenly quoted) clustering of cases of Bell's palsy. This interesting finding is open to similar alternative interpretations.

A final point concerns the theory that water retention is a predisposing factor in the development of Bell's palsy. I have found that septicemic women are more susceptible to Bell's palsy than expected, particularly just before delivery, and also in the puerperium. Water retention could be a factor there too. I am etc.

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4 Aitken, R. S., and Brain, R. T., Lancet, 1933, I, 1, 19.
5 Leibowitz, U., Neurology (Minneapolis), 1966, 16, 169.
7 Resnick, A. D., Acta Neurologica Scandinavica, in press.

No Smoking and Life Expectancy

Stir.—In recent months the B.M.J. and numerous others have discussed the dangers of smoking. Everywhere, however, there appears one great omission. In its anxiety to persuade the public to abandon tobacco and the consequent illnesses and disability produced as a late penalty, it is important that the medical profession should be far sighted 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 recent years where the pretreatment 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 too unwieldy to bear. We must therefore couple with our exhortations for the abolition of smoking a call for advanced creation of suitable homes and geriatric services to cope with the new population bulge that will develop. I am etc.

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Diagnosis of Cystic Fibrosis

Stir.—I would like to comment on Dr. A. F. G. Davidson and Professor Charlotte M. Aitken's reference to the screening of meconium for the presence of albumin (11 September, p. 690) and to the routine screening programme being carried out in this technique. 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"

Stir.—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 Llandub 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 neuromuscular 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 such patients are readmitted as geriatric cases, many being suitable for intensive neurosurgical and medical treatment, and the majority are referred for occupational therapy, physiotherapists, occupational therapists, speech therapist, medical social worker, and after-care services. The additional activities include a daily recreation programme organized as an exception to the 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 being planned.

This arrangement has worked well, and similar collaboration between general physicians, neurologists, neurourologists, and geriatricians might prove a suitable pattern for the management of stroke 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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Epithag for the M.C.H.C.

Stir.—Dr. F. Nour-Eldin (30 October, p. 298) has related that neither the M.C.H.C. (mean corpuscular haemoglobin concentration) nor the M.C.H. (mean corpuscular haemoglobin) convey anything of particular clinical value for the diagnosis of anaemia. He 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 ignoring this with the erroneous transfers 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. I. 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 hypochromia, in contrast to 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, is likely to 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 is that the absolute values, the M.C.V. and M.C.H., are unacceptable inaccuracy 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
excrete a maximum of six grammes of cephaloridine each day, though this amount decreases over the age of 50. If higher total daily doses are used, or if the dosage is not reduced appropriately in the elderly or in patients who have renal impairment,illy because of disease, the concentration of the antibiotic in the plasma and tissues may accumulate and achieve possibly toxic levels.

I analysed 36 cases of possible cephaloridine nephrotoxicity reported in the world literature and found the following factors common to many of the patients: a dosage of more than 6 g/day, excessive by any standard; patients with either definitely impaired or doubtful renal function before treatment, often treated without an appropriate dosage reduction; patients’ age mostly over 50 years; bacterial endocarditis as the primary diagnosis; intercurrent penicillin or cephaloridine hypersensitivity reactions, in some cases possibly responsible for kidney damage and reduced function; the concurrent use of other potentially nephrotoxic antibiotics; and use of potent diuretics. As a result of this latter observation I suggested that potent diuretics, particularly frusemide, may enhance the potential nephrotoxicity of cephaloridine and this was later confirmed in laboratory animals. In many of the 36 patients a fatal outcome to renal failure was avoided by either stopping or, at least, reducing the dosage of cephaloridine as oliguria and increasing uraemia developed. As Drs. Rosenthal and Boichis state cephaloridine should be used with care but this is a recommendation that applies to all drugs. Is it not timely to plead for drugs, the concentration of, at least, the manufacturers’ standard information sheets on their products— I am, etc.,

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Use of English

SIR,—Readers and participants on this subject may be interested in the views of Sir Arthur Quiller-Couch, sometime King Edward VII Professor of Literature at Cambridge University. His lecture concerning the practice of writing (1913) contains the passage set out below.

"But I have another word for our men of science. It was inevitable, perhaps, that Latin—so long the Universal Language—should cease in time to be the language of the pens. It was impossible, perhaps, to substitute by consent, some equally neat and austere modern language, such as French. But when it became an accepted custom for each nation to use its own language in scientific treatises, it certainly was not foreseen that men of science would soon be making discoveries at a rate which left their skill in words outstripped; that having to invent their terms as they went along, yet being careless and contemptuous of a science in which they have no training, they would bombast out our dictionaries with monstrously invented words that not only would have made Quintilian stare and gasp, but would affront the decently literate of any age."—I am, etc.,

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Nephrotoxicity of Cephaloridine

SIR,—Dr. T. Rosenthal and Dr. H. Boichis (9 October, p. 115) report a patient in Israel who died in acute renal failure following the administration of cephaloridine. Of the few details given the following are important and probably relevant to the possible nephrotoxic reactions.

The patient had subacute bacterial endocarditis; a penicillin hypersensitivity reaction was elicited by ampicillin immediately before the start of cephaloridine and progressive oliguria developed soon after. Although no antibiotics other than cephaloridine were used, it is certainly a possibility that the cephaloridine, because of the renal function impairment, exacerbated a pre-existing nephrotoxic reaction to ampicillin. The patient had also been treated with frusemide, a potent diuretic that may well have contributed to the development of the reaction.

The normal human adult kidney can