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CORRESPONDENCE

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

SIR,—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 manufacturer[2] 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 mEq/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 am, etc.,

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1 Eastham, R. D., *Biochemical Values in Clinical Medicine*, 4th edn., p. 23. Bristol, Wright, 1971.
2 Sigma Chemical Company, St. Louis, Missouri, U.S.A.

Medical Examination of the Baby to be Adopted

SIR,—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.,

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Is Hypocalcaemia Protective Against Hyperlipidaemia?

SIR,—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 Glostrup