

with and without probenecid in penicillin-resistant gonococcal infections.

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¹ Percival, A, *et al*, *Lancet*, 1976, 2, 1379.

² Phillips, I, *et al*, *Journal of Antimicrobial Chemotherapy*, 1976, 2, 31.

³ Selwyn, S, *Journal of Antimicrobial Chemotherapy*, 1977, 3, 161.

Treatment of children with diarrhoea and vomiting

SIR,—I refer to the article by Dr C R Pullan and others entitled "Survey of gastroenteritis in children admitted to hospital in Newcastle upon Tyne in 1971-5" (5 March, p 619). The appendix of this article outlined the management of children with diarrhoea and vomiting and in several places referred to a solution of "5M saline 4% dextrose." I am uncertain as to what the authors mean by this solution. I suspect that it is a misprint for one-fifth isotonic saline, but I am concerned that such an error should occur. 5M saline, to me, implies a solution containing 5000 mmol of sodium chloride per litre, which would, of course, be an extremely dangerous solution to use. While it would appear unlikely that anyone would make this mistake in actual practice, I feel that we cannot be too careful in the prescription of fluid and electrolyte therapy.

In this context it is time the term "normal" disappeared. The term "normal saline" is still frequently used to indicate an isotonic sodium chloride solution, which is 0.15 molar, whereas a normal solution to a chemist implies a molar concentration. I know of at least one child who sustained irreversible brain damage after rehydration with 0.5 molar sodium chloride when half-normal saline was ordered.

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*.*Dr McCredie is quite right: "5M saline" should have read "fifth-normal saline." This was a subeditorial error which unfortunately slipped through uncorrected and for which we apologise and accept full responsibility. We can only hope, with Dr McCredie, that the error was so gross and so obvious that nobody was likely to be misled by it in practice. We also agree with him that the term "normal saline" is a dangerous one that should no longer be used. We shall use every effort to eliminate it from our pages in future.—ED, *BMJ*.

How dangerous is obesity?

SIR,—Dr Garrow, in his criticism (21 May, p 1345) of the leading article "How dangerous is obesity?" (30 April, p 1115), makes several valuable comments, but his main thesis—that overweight of apparently any degree is dangerous to health—is not proved.

Gross obesity is certainly dangerous, for a variety of reasons. The evidence for the dangers of moderate obesity, however, is much less certain. In the first place the DHSS/MRC report¹ referred to both by Dr Garrow and in the leading article states that "we need more quantitative information about the relation between the degree of fatness and

the risk of disease," and again that it is possible "that, particularly for women, the risk associated with mild or moderate degrees of obesity is small and does not justify imposing a way of life which may cause practical difficulties, anxiety and feelings of guilt."

Furthermore the table referred to by Dr Garrow in the same report is derived from life insurance data, and for several reasons—not least the atypical nature of the population which takes up voluntary life insurance—it is difficult to apply these findings to the general population.

Finally, there is the observation of Stamler and his colleagues in the Chicago People's Gas Company Study² that obesity (assessed by the body mass index, W/H²) has, at least in men, a quadratic rather than linear relationship with mortality. The lowest mortality occurred among men whose body weight was 25-35% over the Metropolitan Life Insurance Company ideal weight.³ When the 1233 Chicago employees were divided into five equal groups on the basis of their body mass index the highest death rate (246 deaths have occurred so far) was found in the least obese group, whereas the lowest mortality was found in the second or third most obese groups. In other words, as the authors concluded, in this group at least "moderate overweight appears to be a sign of good health."

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¹ Department of Health and Social Security and Medical Research Council, *Research on Obesity*. London, HMSO, 1976.

² Dyer, A R, *et al*, *Journal of Chronic Diseases*, 1975, 28, 109.

³ Metropolitan Life Insurance Company: *Statistical Bulletin*, 1959, 40, 1.

Motorcyclists' injuries

SIR,—Your leading article on motorcycle injuries (11 June, p 1491) rightly gives some prominence to the value of improved design in crash helmets. Some police and road safety officers do have reservations, however, about the full-face design since deaths have occurred by choking with the lower facepiece. In the primary prevention of accidents you mention only in passing the use of prominent clothes and daytime lighting. Yet a "flick of a switch" and a "flash of orange" would possibly do more than any other measure to prevent accidents to motorcyclists. This is because around one-third of all motorcycle accidents occur as a result of failure by a car driver to see an approaching motorcycle (information from local road safety officer). At present daytime lights and brightly coloured jackets are rarely used by teenage boys, yet this is the very group most prone to motorcycle accidents. Is this yet another case for enacting legislation which is so often claimed to infringe on our personal liberties? Or is it a case for a stricter driving test?

Since anyone over the age of 16 can put up "L" plates and drive off on a potentially lethal machine without any training whatever one possible answer lies in better motorcycle training. Perhaps the "L" licence for motorcycles should be given only after completion of a special training course. Such courses are already carried out in some centres under RAC/ACU/local authority initiative and it may not be too difficult to extend this activity and make it compulsory.

Information supplied to me by the Royal Society for the Prevention of Accidents and the Road Research Laboratory indicates that no firm data are yet available in Britain to prove that motorcycle training schemes effectively reduce accidents. Evidence^{1,2} is available, however, to show that the National Cycle Proficiency Training Scheme has reduced accidents to child cyclists. A recent encouraging development is the Schools Traffic Education Project (STEP), but even this, in common with the RAC/ACU schemes, still covers only a very small proportion of the new riders going on the road. These schemes may well be "preaching to the converted" and still missing out the high-risk groups. Of all school-leavers, some 4% will proceed to death or serious injury in road accidents within 10 years of leaving school and about another 12% will experience some recorded road accident injury (percentages crudely calculated from accident and population statistics). The majority of these will have ridden to their death or injury without the benefit of any kind of formal motorcycle training and many of the car accident victims will also have been inadequately trained.

Sadly, the media give far greater prominence to the rare cases of brain damage following whooping-cough immunisation than they do to the major epidemic of teenage motorcycle accidents and all their consequences. Yet an enlightened treatment of the problem in the media could well result in significant reductions in casualties. The answer to the perennial conflict between allowing teenagers freedom to explore new horizons and preventing them doing permanent injury to themselves is surely to make every effort to see that they are as competent as possible before being allowed on the road. Even with high training standards there will still be accidents, but at least the chances will have been cut down to the barest minimum.

Finally, your leading article, perhaps wisely, failed to consider whether there is any association between the rise in teenage drinking and the rise in motorcycle accidents. No immediate solution will be found to that problem until better ways are found of enforcing existing drinking and driving legislation.

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¹ Craft, A W, *Children, the Environment and Accidents*, ed R H Jackson. Tunbridge, Pitman Medical, 1977.

² County of Hereford and Worcester, *Children and Cycling*. Worcester, 1976.

Fellows of the Royal Society

SIR,—A large pile of scientific and medical journals accumulated during my stay of four months in Australia and it has taken some time to work through them; hence this belated comment on Dr W B Hepburn's review (9 April, p 966) of the *Biographical Memoirs of Fellows of the Royal Society*.

This is a strange review. Of the two and one-third columns printed, more than one column presents the writer's reminiscences. In the third line the Royal Society is referred to as the "rich man's Mensa" and three further on it is pointed out that the majority of the deceased came from poor families. There is no evidence that they were rich when they died. The statement that few of the fellows took an