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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 being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

important if a genetic register system is to be really effective in helping prevent serious genetic disease within the community.

ALAN E H EMERY

University Department of
Human Genetics,
Western General Hospital,
Edinburgh

Genetic counselling and genetic registers

SIR,—Dr A J Caro and his colleagues (14 August, p 420) have recently emphasised the need for detecting individuals at risk of having children who might develop Huntington's chorea so that they may be given genetic counselling. While I entirely agree with these sentiments, the problem is in fact much wider than this, for it exists with many other dominant disorders with late onset (such as polyposis coli, polycystic kidney disease, and myotonic dystrophy) and several X-linked disorders (such as haemophilia and Duchenne muscular dystrophy) where there are often many family members at risk of having affected children who may be unaware of this. In a study of the families of individuals referred to this department for genetic counselling over a four-year period we estimated that there were 950 relatives at high risk (greater than 1 in 10) of having a child with a serious genetic disorder, yet of these only 138 (15%) had had any genetic counselling. Further, 81 affected children were born to parents who a priori were at high risk of having affected children and at least a proportion of these might have been prevented by genetic counselling.

From these findings it would seem reasonable to assume that the extent of the problem is much greater than is reflected by the number of individuals who attend a genetic counselling clinic. There is at present no defined procedure for ascertaining and follow-

ing up such individuals. Herein lies the value of a genetic register system which, for this reason, has been advocated by a WHO scientific group.¹ Such a system was first established in Edinburgh in 1970 under the acronym RAPID (Register for the Ascertainment and Prevention of Inherited Disease)² and has been fully operational for at least a year. For ease of storage, updating, and retrieval of family data the system has been computerised, and strict safeguards for confidentiality have been incorporated into the system. Individuals are included in the register system only with their full approval and written consent (or that of their parents). No relatives are contacted without the permission of the index case and also the relatives' family doctor. The latter is considered especially important as there may be factors unknown to the medical geneticist or index case which would make it imprudent or unnecessary to contact certain family members. Particularly important in such a system is the maintenance of data on individuals who are at high risk of having affected children or of developing a genetic disorder but as yet are too young for counselling.

In the past few years a number of similar genetic register systems have been established in various countries, including Canada, Norway, the United States, and Belgium.³ The latter is particularly interesting because it has been organised on a national basis. This is

¹ WHO Technical Report Series No 497. Geneva, World Health Organisation, 1972.

² Emery, A E H, et al, *Journal of Medical Genetics*, 1974, 11, 145.

³ *Registers for the Detection and Prevention of Genetic Disease*, ed A E H Emery and J R Miller. Symposia Specialists Medical Books. New York, Stratton International. In press.

Metabolic bone disease in Asians

SIR,—Your leading article on this subject (21 August, p 442) was welcome in drawing attention to a problem which should be a primary concern to all those working in public health. As the article points out, Asians appear to be peculiarly susceptible to rickets, a deficiency disease for which we have long known the cure and the means of prevention. The situation referred to in Bradford was an estimate based on a study of hospital admissions done over four years ago, but there are many other fully documented examples (such as that of Goel *et al*¹) of a state of affairs which should not be allowed to continue.

Fortification of chapati flour is one way of tackling the problem. However, this solution has its limitations: very young children, who are the members of the family probably most in need of extra vitamin D, would receive least of the fortified flour, while there are Asians who eat rice in preference to chapatis. There