recommendations, as at present stated, are at risk of being interpreted as the ideal, physiologically speaking.

Our further criticisms are as follows. Firstly, in recommending a reduction in the consumption of fats and oils to 36% of dietary energy, the authors ignore the suggestion of the joint committee of the British Cardiac Society and the Royal College of Physicians that the reduction in fat intake should take place at the expense of the saturated fat sources. Secondly, while an increased consumption of potatoes would provide a good source of dietary fibre and vitamin C, it is unlikely, as the authors imply, to provide a significant quantity of protein, with <5.0 g protein/day. Thirdly, we wonder on what basis the authors feel that it is unrealistic to recommend a substantial increase in the consumption of fish, pulses, and nuts, especially considering the increasing use of textured vegetable protein by the catering industry and the apparent increased popularity of pulses with housewives. An increased consumption of pulses and pulse products, if substituted for meat, would permit a decreased intake of fat, while maintaining protein intake constant.

Finally, however eminent the authors may be in the field of nutrition, we dispute their wisdom in prescribing a "better British diet." In view of the disagreement on matters relating diet to health, might not three equally eminent nutritionists propose a different better British diet in this or some other journal?

R GRIMBLE
MICHAEL J GIBNEY
JANE MORGAN

Department of Nutrition,
School of Biochemical and
Physiological Sciences,
University of Southampton,
Southampton SO9 5NH

¹ Brown, C L, Brown, A M, and Naismith, D J, *Proceedings of the Nutrition Society*, 1977, **36**, 96A.

² Ministry of Agriculture, Fisheries and Food, *Household Food Consumption and Expenditure*, 1956. London, HMSO, 1957.

³ Department of Health and Social Security, *Diet and Coronary Heart Disease*. Reports on Health and Social Subjects No 7. London, HMSO, 1974.

SIR,—Dr R Passmore and his colleagues are to be congratulated on their recommendations contained in their article "Prescription for a better British diet" (24 February, p 257). Three nutrition authorities have recommended changes to improve our national diet. These changes are moderate; they are designed to improve health and prevent disease; and they should not place too great a strain on agriculture and trade if they are spread over the next ten years.

The British proposals make no reference to comparable but more drastic changes recommended by the United States Senate Select Committee on Nutrition and Human Needs. US medical experts had given evidence to the committee that the current US diet was a major factor in coronary heart disease, obesity, hypertension, and other diseases. The US committee therefore recommended increasing consumption of starch derived from whole cereals and potatoes by 100%. British recommendations were an increase of grain products by 20% and potatoes by 15%. They made no recommendations concerning the replacement of white flour products by wholemeal, although the latter contains more protein, vitamins, minerals, and fibre. Other US recommendations were also very drastic: total fat reduced from 40% to 30% energy and sugar reduced from 24% to 15% energy. These recommendations for large dietary changes caused considerable concern in US agricultural and trade circles. Their justification certainly demands detailed study.

There is another striking difference between the British and US recommendations. The former made no mention of salt; the latter recommended that salt intake, which ranged from 6 to 18 g/day in the average US adult diet, should be reduced to 3 g/day; but this figure was increased in the second edition of *Dietary Goals for the United States* to 5 g/day. There is much interest in the US² but little in Britain³ concerning the role of high salt intakes as a causative factor in essential hypertension in salt-sensitive individuals.

It may prove difficult for people in Britain to study the evidence that led to these drastic recommendations to change the US national diet. It is contained in five reports all entitled *Diet Related to Killer Diseases*.⁴ It is also desirable to study any modification of these drastic recommendations in the second edition of *Dietary Goals for the United States*. I have made repeated efforts at several English bookshops to obtain a copy of this second edition but have failed and am informed that it is unobtainable.

Both the US and British recommendations agree that dietary fibre intakes should be increased and that this should prove beneficial. It has indeed proved difficult to review the expanding literature on dietary fibre; editorial articles and reviews are scanty and it was only in 1977 that the *Index Medicus* began to include the item "Dietary Fiber—see under Cellulose."

It behoves those who have put forward hypotheses that dietary fibre might be a causative factor in certain diseases of unknown aetiology to produce a bibliography by means of which others can examine the evidence and plan prospective studies. A bibliography of dietary fibre in human nutrition, with over 1000 citations, and with subject and author indexes, has been published recently.⁵

HUGH TROWELL

Fordingbridge, Hants

¹ United States Senate Select Committee on Nutrition and Human Needs, *Dietary Goals for the United States*. Washington, US Government Printing Office, 1977.

² Meneely, G R, and Battarbee, H D, in *Nutrition Reviews: Knowledge in Nutrition*, 4th edn, p 259. Washington, Nutrition Foundation, 1976.

³ *Lancet*, 1978, **2**, 1136.

⁴ United States Senate Select Committee on Nutrition and Human Needs, *Diet Related to Killer Diseases*, vols 1-5. Washington, US Government Printing Office, 1977.

⁵ Trowell, H C, *Dietary Fibre in Human Nutrition: a Bibliography*. London, Libbet (80 Bondway, SW8), 1979.

Fats and atheroma: an inquest

SIR,—The role of prostacyclin in the prevention of platelet aggregation outlined by Dr J R Vane (2 February, p 484) accords well with inhibition of atheroma and thrombosis as viewed by Virchow and Rokitsansky.

There is another aspect of diet in the coagulation process. Chargaft¹ described coagulant and anticoagulant sphingomyelin, and I and my co-workers²⁻⁶ described sphingomyelin lipoprotein anticoagulant released from lung, liver, spleen, and kidney. We suggested⁷ that these probably played a role in inhibiting coronary clotting. The venous blood draining from these organs is delivered rapidly to the heart and so to the coronary circulation. Liver, spleen, and kidney are good sources of this anticoagulant. Brain perfusion⁸ on the contrary enhances the thrombin system. The hind legs and pelvis operate similarly. Diets containing the high-

density anticoagulant lipids probably operate to reduce the risk factor of cardiac infarction.^{9,10}

E R TRETHEWIE

Walter and Eliza Hall Institute
of Medical Research,
Melbourne, Australia

¹ Chargaft, E J, *Journal of Biological Chemistry*, 1938, **125**, 677.

² Trethewie, E R, *Australian Journal of Experimental Biology*, 1945, **23**, 231.

³ Trethewie, E R, *Medical Journal of Australia*, 1945, **2**, 328.

⁴ Trethewie, E R, *Australian and New Zealand Journal of Surgery*, 1946, **15**, 286.

⁵ Trethewie, E R, Cleland, J B, and Pengelly, T, *Australian Journal of Experimental Biology*, 1947, **1**, 321.

⁶ Binet, F, Trethewie, E R, and Gaffney, F, *Australian Journal of Experimental Biology*, 1951, **29**, 233.

⁷ Trethewie, E R, *Medical Journal of Australia*, 1947, **1**, 129.

⁸ Trethewie, E R, *Australian Journal of Experimental Biology*, 1946, **24**, 185.

⁹ Berg, K, et al, *Lancet*, 1976, **1**, 499.

¹⁰ Rhoads, C, et al, *New England Journal of Medicine*, 1976, **294**, 293.

Prophylactic co-trimoxazole in biliary surgery

SIR,—We are pleased that Professor J McK Watts and others (6 January, p 58) agrees with the main conclusions of our study (12 August, p 462). We note that he deplores the fact that the wound sepsis rate after cholecystectomy appears to be higher in the United Kingdom than in the United States and Australia. To support this contention he quotes three prospective studies from the United Kingdom and three studies from the United States, two of which were retrospective. It is well recognised that retrospective studies seriously underestimate the incidence of wound sepsis.¹

As regards the mean duration of post-operative stay in hospital, there are obvious socioeconomic differences between Glasgow and Adelaide: many patients in Glasgow come from areas of social deprivation and require an additional period in hospital. Wound sepsis rarely declares itself within one week² and in our study only one of 12 patients developed wound sepsis before the seventh post-operative day, a point at which Professor Watts has already discharged his patients "whether or not their course was complicated."

C MORRAN
W McNAUGHT

Victoria Infirmary,
Glasgow

COLIN S MCARDLE

Royal Infirmary, Glasgow

¹ Robson, M C, Bogart, J N, and Heggors, J P, *Surgery*, 1970, **68**, 471.

² Cunha, B A, Pyrtex, L J, and Quintiliani, R, *Lancet*, 1978, **1**, 207.

Chronic subdural haematoma

SIR,—In your leading article on chronic subdural haematoma (17 February, p 433) I was surprised that there was no mention of ultrasonography as a method of diagnosis for this condition. Skull radiographs are often of poor quality and the pineal gland is very often not localised. In the average provincial hospital ultrasound either by an A scale or by the more sophisticated midliner is a quick, easy, cheap, and accurate method of determining whether there is any shift of the midline. This causes no inconvenience to the patient and can be performed when his degree of restlessness makes satisfactory radiography impossible. If the patient is found to have a shift of