reported by Professor Morris and his colleagues with high fibre intake (and lower incidence of ischaemic heart disease) would obtain 200 mg magnesium per week more than the low-fibre group from their brown bread alone, and this is 5-10% of the weekly total required to stay in magnesium balance.⁴ It may be the metal content of brown bread rather than the fibre which protects the consumer from ischaemic heart disease.

The data collected by Professor Morris and his colleagues could be used to estimate the weights of magnesium, potassium, and iron consumed by their subjects, and this would be worth further investigation.

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¹ Chipperfield, B, and Chipperfield, J R, *Lancet*, 1973, **2**, 293.

² Behr, G, and Burton, P, *Lancet*, 1973, **2**, 450.

³ Anderson, T W, et al, *Canadian Medical Association Journal*, 1975, **113**, 199.

⁴ Seelig, M S, *American Journal of Clinical Nutrition*, 1964, **14**, 342.

⁵ Chipperfield, B, and Chipperfield, J R, *American Heart Journal*, 1977, **93**, 679.

⁶ Chipperfield, B, and Chipperfield, J R, *American Heart Journal*. In press.

⁷ McCance, R A, and Widdowson, E M, *The Composition of Foods*, MRC Special Report No 297, London, HMSO, 1960.

Allergic bronchopulmonary aspergillosis

SIR,—Your recent leading article on bronchopulmonary aspergillosis (3 December, p 1439) states that continuous oral corticosteroid treatment diminishes the frequency of the acute episodes and reduces the likelihood of permanent and severe lung damage. It is then stated that "mandatory treatment with corticosteroids" is to be given as soon as the diagnosis is made.

It would be reassuring to know that continuous corticosteroids can prevent the severe lung damage that sometimes occurs, but these statements have been made without any references to support them. We need to be able to see the evidence before submitting so many patients to regular and lifelong steroid treatment.

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*.*Asthmatics whose disease is complicated by chronic allergic bronchopulmonary aspergillosis have been shown in a comparative study to have more severe respiratory damage than those not so complicated. It is a common clinical impression that some patients with allergic aspergillosis become respiratory cripples with extensive lung fibrosis and bronchiectasis.¹ These complications are the result of allergic reactions in bronchi and lung associated with aspergillus hypersensitivity. Corticosteroids have been shown to reduce the duration² and the number³ of acute radiographic shadows which are associated with these allergic reactions. Moreover, it has also been demonstrated that many of these reactions are subclinical and so cannot all be controlled by giving intermittent corticosteroids on the basis of symptoms. It would seem reasonable therefore to maintain patients who have evidence of recurring allergic episodes on continuous moderately low-dose corticosteroid therapy. Prospective studies of patients diagnosed and selected for treatment at the very

start of the disease could provide proof of whether continuous corticosteroids do help, but such a study has not been carried out, and the practical difficulties of doing such a study are formidable.

However, most experts in allergic pulmonary diseases subscribe to the view that long-term corticosteroids is the treatment of choice and that the risk of leaving the patient known to be experiencing frequent radiographic shadows without continuous corticosteroids is greater than the risks of long-term moderate dose corticosteroids.—Ed, *BMJ*.

¹ Malo, J I, Pepys, J, and Simon, G, *Thorax*, 1977, **32**, 262.

² McCarthy, D S, and Pepys, J, *Clinical Allergy*, 1971, **1**, 261.

³ Saffirstein, B H, et al, *American Review of Respiratory Diseases*, 1973, **108**, 450.

Scan-demonstrated ilioportal shunt with resolution

SIR,—The letter from Dr E P Wraight (25 February, p 507) prompts us to report the following case.

A 64-year-old man presented with 24 h swelling of the whole of the left leg. Ascending x-ray venography revealed occlusion of the upper femoral and iliac veins. Radionuclide venography was performed with injection of 2 mCi of ^{99m}Tc-macroaggregated albumin into a dorsal vein of each foot with venographic pneumatic tourniquets to direct the isotope into the deep veins. The scan revealed a normal right deep venous system and inferior vena cava, but occlusion on the left from the mid-femoral region to the vena cava. Multiple collaterals were noted, passing upwards over the abdominal wall and across to the opposite iliac veins. During subsequent lung scanning uptake of isotope was noted in the left lobe of the liver—seen on both anteroposterior and lateral views—demonstrating collateral circulation via the umbilical vein. The patient was treated with thrombolytic therapy (streptokinase) and complete lysis of all major thrombi was achieved. When the scans were repeated at the end of thrombolytic therapy (five days), in addition to confirming complete lysis, it was noted that there was now no uptake of isotope in the liver, demonstrating that the umbilical vein ilioportal shunt had closed.

As radionuclide venography becomes more widely used this phenomenon will be seen with greater frequency. Our observations confirm the findings of Dr Wraight, but we would like to point out that the presence of this sign does not necessarily imply inferior vena caval obstruction. As in our case it may occur when there is major occlusion of the femoral and iliac veins with extensive collateral circulation even though the vena cava is normal.

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Ban on dental anaesthetics

SIR,—An ad hoc meeting of 16 anaesthetists of the North-west Region was held in Manchester on 2 February to discuss the recent recommendation made jointly by the BMA and the Association of Anaesthetists (24-31 December, p 1680) that we "discontinue giving dental anaesthetics under the NHS as from 1 January 1978, except to children under 16, old age pensioners, and cases of special hardship, particularly the mentally ill." They have asked me to write on their behalf to

say that, while agreeing that the current fees for dental anaesthetics were derisory and applauding the, albeit hitherto unsuccessful, efforts of the profession's representatives to improve them, they were of the unanimous opinion that

(1) Withdrawal of services from selected cases would be ineffective. The only effective action would be withdrawal from all general anaesthetic services to dental patients under the NHS by all types of practitioner including dentists. Such unanimity was unlikely to be achieved.

(2) Such action might place our dental colleagues in a difficult position vis-à-vis their legal responsibilities.

(3) Such action would encourage the administration of dental anaesthetics by relatively unskilled persons. Therefore no member of the meeting was willing to implement the recommendation as it stood.

(4) On the other hand dental surgeons should be encouraged to accept patients on a private rather than an NHS basis.

(5) Full use should be made of the "special fee" provisions.

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*.*A list of the names of those who attended the meeting was appended to Dr Young's letter.—Ed, *BMJ*.

SIR,—The present campaign to achieve a more realistic scale of fees for the administration of dental anaesthetics, although a welcome step in the right direction, is, I believe, misdirected, and because of that it is going to find the attainment of the desired goal long and difficult to achieve. Refusing anaesthesia to adults is striking at the least vulnerable. It may appear hard to suggest it, but the most likely lever to apply is to refuse to anaesthetise children and old age pensioners. This strikes at the Department of Health and Social Security. The children are in no danger of being hurt and many of the old age pensioners attract a special fee. The children in theory at least can be seen and treated by the local authority clinics and school dental services, except that these clinics are not geared to managing the problem which would be thrust suddenly upon them. They would be swamped and their capability demonstrated to be inadequate. The authorities would then be forced either to concede our demand or properly to equip and greatly increase the number of clinics and to staff them with nurses, dentists, and properly qualified anaesthetists. I believe they would rather not be faced with this unpredictable expense. And even if they were, a new proper service could be negotiated, this time with realism.

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Distinction awards

SIR,—Once again the controversy over distinction awards is raised. The "have-nots" oppose and the "haves and might-gets" support.

I oppose. Let us have a system in which designated posts attract designated salaries, with high rewards for university professors, teaching hospital consultants, regional specialists, and "senior consultants" (one for each