few of whom were in a position to give an informed opinion; 15% did not reply but those who did were obviously indulging in wishful thinking that the diet regimen would be helpful as 92% of them were already themselves on the diet! It is time that we neutralised such unacceptable "evidence."

Professor Jens Dedichen,² of Oslo, recently admitted responsibility for introducing low-fat diets following observations by himself and Strom 25 years ago on the decline of recorded coronary deaths in the war years, which might have been related to fat deprivation. From 1955 he strongly pursued this policy and stuck to a low-fat diet himself, criticising colleagues who would not support him. He now confesses that in spite of the Norwegian effort (soy bean oil consumption in Norway increased fivefold) there had been no fall in coronary mortality but rather a steady increase. He regrets the anxiety created by this advice to the population. During these 25 years "it has become increasingly clear that we are on the wrong track." Could increasing consumption of polyunsaturated fats in Norway have caused the increase in coronary mortality? We do not know.

Professor Bengt Borgstrom,³ of Lund, an outstanding leader in fat biochemistry, says that pursuit of these policies of saturated fat reduction and more unsaturated fats is "irresponsible, as it would have far-reaching economic, agricultural, and psychological effects." There might be quite unknown consequences of altering the nature of our dietetic fats. Even now we can be certain that a diet rich in polyunsaturated fats will increase the risk of gall stones.

With the absence of any proof of benefit from reduction of blood lipids we have reached the stage where we must admit that this regimen has failed when tried out on subjects at risk of coronary disease and therefore the imposition on the public of dietetic restrictions for its prevention has no scientific justification.

The fatty streaks which occur in young children are not the beginning of atheroma. The Bromley Health Authority⁴ has been advising mothers of babies about the avoidance of eggs and discarding the cream on the top of the milk. This is creating alarm in the public and it is urgent that our professional advice should get back on to an even keel and put a stop to this propaganda, which threatens to become a cruel imposition terrifying mothers of families.

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¹ Norum, K, *Tidsskrift for den Norske Laegeforening*, 1977, **97**, 363.

² Dedichen, J, *Tidsskrift for den Norske Laegeforening*, 1976, **96**, 915.

³ Borgstrom, B, *Sartryk ur Livsmedelsteknik*, 1976, **7**, 302.

⁴ Leaflet issued by Bromley Area Health Authority and produced with the support of the Flora Project for Health Education.

MRC treatment trial for mild hypertension

SIR,—On p 1437 of this week's *BMJ* an account is given of the pilot phase of the Medical Research Council's multicentre treatment trial for mild hypertension.

If it is undertaken, and this is under present consideration, the main trial would need to recruit another 150 clinics, most of which are likely to be group practices. The need to

recruit quickly so that the trial would give an answer in the shortest time means that we should now see which practices would be interested in collaborating. In the pilot stage financial assistance was provided towards the compiling of age/sex registers and for additional nursing or medical sessions required. Equipment, laboratory facilities, postal arrangements, and compensation for the use of cardiographs were also provided and no practice was out of pocket as a result of its participation. It would be expected that this pattern would continue.

Practices with total lists of at least 7500 (preferably 10 000 or over) are required and ideally those with accommodation which will allow one room to be used specifically for follow-up clinics at regular times each week (inside or outside normal surgery hours) and for storage of records, drugs, and instruments. The initial blood-pressure screening of those aged 35-64 years would be carried out by locally recruited and specially trained nurses, largely in purpose-built mobile clinics which would relieve busy surgeries of much of the additional load imposed by the trial.

Several centres currently participating are willing to be contacted or visited by others wanting to know more about what the trial involves. Their names and addresses and further information on the study can be obtained from the Co-ordinating Centre, MRC Treatment Trial for Mild Hypertension, MRC/DHSS Epidemiology and Medical Care Unit, Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.

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Breath, alcohol, and the law

SIR,—Dr B M Wright (7 May, p 1216) is wrong; we would take issue with him on his contention that our results are "much worse than those obtained in recent years by a number of reputable observers." Dr Wright does not name these reputable observers but by implication they seem to include himself. Of the two papers he quotes in this connection, that of Jones, Wright, and Jones¹ claims that a comparison between capillary blood values and those of breath shows a line of best fit at a ratio of 2300:1, but no hard data are provided to allow an independent check. However, in a separate and earlier publication which is not quoted by Dr Wright, Jones² reported a blood:breath ratio which averaged 2361:1. What is not clear is whether Dr Wright and his colleagues have carried out a separate independent study or whether the results presented have been derived from the earlier work of Dr Jones. Perhaps Dr Wright will enlighten us on this point.

The second paper to which Dr Wright refers, that by Dr Dubowski,³ contains much that is interesting and valuable but it contains no quantitative data on the blood:breath ratio that can usefully be compared with our own results. Thus the only data available for comparison are those of Dr Jones, and these do

not differ substantially from our own figures, especially if it is taken into account that in our study breath analysis was begun immediately after drinking had ceased—that is, before equilibrium had been reached and when the effects of mouth alcohol were still evident.

Finally, we would emphasise yet again that breath analysis is not an acceptable method for accurately determining blood alcohol concentrations.

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¹ Jones, A W, Wright, B M, and Jones, T P, *Proceedings of the 6th International Conference on Alcohol, Drugs, and Traffic Safety*, p 509. Toronto, Addiction Research Foundation, 1975.

² Jones, A W, PhD Thesis, University of Wales Institute of Science and Technology, 1974.

³ Dubowski, K M, *Clinical Chemistry*, 1974, **20**, 294.

Malaria in returning travellers

SIR,—We wish to illustrate, using our recent experience, the ever-increasing trend of imported malaria in the UK mentioned by Dr Salil K Ghosh and I Nicholson (30 April, p 1136). Nineteen cases of malaria have been diagnosed in our health area since the beginning of the year; nine of them have presented since the beginning of May. All but one have been infections with *Plasmodium vivax* and have occurred in Asians returning from the Indian subcontinent; the exception was in a young soldier found to be infected with *Plasmodium falciparum* on returning from a tour of duty in Gambia.

May we remind our clinical colleagues of the possibility of malaria when considering febrile patients from abroad with possible infection, since we are now at the beginning of the tourist season? Furthermore, we would suggest that wider publicity should be given to the Asian communities so that they are made aware that on returning to Asia or Africa they may well acquire malaria there unless adequate precautions, such as antimalarian prophylaxis, are taken while overseas.

We are indebted to our colleagues in the haematology departments of our hospitals for giving us the opportunity to see blood films and acquire data on the cases quoted.

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Making better use of our nurses

SIR,—Your leading article (21 May, p 1306) makes it appear that it is the "attached" nurses employed by area health authorities who work only 23 hours a week. This confuses our finding¹ that two-thirds of general practices in England have one or more nurses "attached" to them with our finding that it is the nurses employed by the general practitioners themselves who work an average of 23 hours a week. In our survey¹ we did not inquire about the work of attached nurses, but since then we have