centages shown in the table are directly comparable. Layrisse and Martinez Torres¹ showed a high correlation between the absorption of a small dose of "extrinsic" inorganic iron given with vegetable food and the absorption of "intrinsic" iron in the food, the latter being biosynthetically labelled. The validity of this method was confirmed with a variety of foods, including wheat, and over a wide range of absorption. On this basis we have calculated the absolute amounts of iron absorbed from wholemeal and white bread, allowing for the "dilutional" effect of the higher iron content of wholemeal bread. Widdowson and McCance² showed no change in haematological values in undernourished children over a year whether they were fed wholemeal or white bread. This supports the suggestion based on our findings that supplementation of white bread with iron may be unnecessary. The lower iron content of white bread is compensated for by the higher availability of the iron.

Our experimental study suggests that a higher fibre meal of wholemeal bread has a marked inhibitory effect on iron absorption. Iron balance is therefore likely to be more precarious on a high-fibre diet, particularly if there is chronic blood loss such as in diverticular disease. In tropical countries where iron deficiency due to intestinal parasite infestation occurs a high-fibre diet is consumed. Like the British vegans referred to by Drs Sanders and Ellis,³ these populations will have a high dietary intake of iron "but because the diets are largely based on cereals, the iron is not readily available for absorption."⁴ Whether the dietary vitamin C is able to compensate for the effect of fibre in these circumstances is uncertain. Similar considerations may apply to elderly vegans with atrophic gastritis or diverticular disease. We suggest that further studies of iron status are now indicated in such groups.

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¹ Martinez-Torres, C, and Layrisse, M, *Clinics in Haematology*, 1973, 2, 339.

² Widdowson, E M, and McCance, R A, *MRC Special Report Series No 287*. London, HMSO, 1954.

³ Ellis, F R, and Montegriffo, U M E, *American Journal of Clinical Nutrition*, 1970, 23, 249.

⁴ Callender, S T, *Medicine*, 1977, 31, 1760.

Imported enteric diseases

SIR,—Last year, out of a total of 175 cases of typhoid fever contracted outside Great Britain, 115 cases (66%) were imported into this country from the Indian subcontinent alone¹ and this trend has been going on for quite some time now. For paratyphoid A fever the corresponding figure is again 66% (28 out of 42 imported cases). Although on an average we see three cases of typhoid fever in our hospital every year, this year in the first two weeks of May alone we had three cases in the same paediatric ward, in children returning from Pakistan who had not had any TAB inoculation before they set off on their journey. This was followed by a fourth case in the same ward three weeks later which was not connected epidemiologically with the others. This situation is aggravated by the fact that many of the adult sufferers, being either restaurant or grocery shop owners, handle cooked food. It is usual practice to screen household, school, and working-place contacts, when a minimum of three, sometimes

six, specimens each of faeces and urine are examined from all persons. Since it is quite common at the height of the outbreak for a public health laboratory, because its geographical catchment area for providing diagnostic laboratory facilities is much larger than that of a hospital laboratory, to deal with contacts of half a dozen cases of typhoid fever simultaneously, this creates an undue burden on the already overstretched resources of the laboratory. At the same time, as long as the adult contacts are put off duty they have to be paid by the Social Security Department for loss of earnings.

Dr R G Thompson and his colleagues (4 June, p 1468) urge that wider publicity should be given to the Asian communities about the need for antimalarial prophylaxis. I agree, but would also add the need for inoculation against typhoid fever, despite the fact that TAB inoculation is not fully effective. Since quite a few Asian immigrants do not either speak or understand English, this can be achieved only if the Department of Health could arrange with the organisers of the weekly Asian programmes on the television and radio to inform intending travellers at regular intervals of the threat of typhoid and the ease with which this can be contracted. Then with any luck the message will get across and, it is to be hoped, will reduce unnecessary suffering and hardship.

The views expressed here are mine and may not be interpreted as the official recommendation of the PHLS Board.

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¹ Public Health Laboratory Service, *Communicable Disease Report 77 13*. Unpublished.

Childhood hypertension

SIR,—Your leading article on childhood hypertension (9 July, p 76) questions the value of measuring blood pressure in children, a topic of burgeoning interest in the past few years.^{1 2} You stress the importance of due attention to cuff width and length but then curiously state that "the mercury column must fall less than 5 mm Hg each minute." Who says so? Moss and Adams³ recommend a 5 mm Hg fall per second and Lieberman⁴ likewise, while the US "task force"⁵ suggests 2-3 mm Hg per second. To allow the mercury to drop at 5 mm Hg per minute would necessitate spending 20 min awaiting a fall from 160 to 60 mm Hg. Surely a misprint?

The "task force" on blood pressure control in children in the US concluded that "blood pressure measurement should be included in the physical examination [of children 3 years and older] as part of the continuing care of the child, not as an isolated screening procedure."⁵ Apley's aphorisms describe the paediatrician as a "measuring doctor," who should "measure the measurable." Why not routinely measure the blood pressure in all children presenting to hospital or to their doctor? Blood pressure has been measured in 900 Dublin school-children⁶ and the range of values found to be similar to those published by Londe⁷ and the "task force."⁵

You conclude by suggesting that palpation of femoral pulses in infancy (surely now a routine practice) "would prevent more hypertension than measuring blood pressure."

Palpation of femoral pulses will pick up one case of coarctation of the aorta for every 1550 infants examined (assuming the incidence of congenital heart disease to be 8 per 1000 live births, and coarctation to account for approximately 8% of the total).⁸

We do not know the incidence of "hypertension" in children, nor do we recognise "essential hypertension" in adolescence, probably because blood pressure is not regularly measured in children. Since hypertension is often asymptomatic in childhood and since many children presenting with unequivocal hypertension have had no prior blood pressure measurements we will not know the prevalence of childhood hypertension until measurement of blood pressure becomes routine.

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¹ Kilcoyne, M M, *American Journal of Medicine*, 1975, 58, 735.

² VonBehren, P A, and Lauer, R M, *Medical Clinics of North America*, 1967, 61, 487.

³ Moss, A J, and Adams, F H, *Problems of Blood Pressure in Childhood*, p 13. Springfield, Illinois, Thomas, 1962.

⁴ *Clinical Pediatric Nephrology*, ed G Lieberman, p 2. Philadelphia, Lippincott, 1976.

⁵ Task Force on Blood Pressure Control in Children, *Pediatrics*, 1977, 59, suppl.

⁶ Gill, D G, *Irish Journal of Medical Science*. In press.

⁷ Londe, S, *Clinical Pediatrics*, 1966, 5, 71.

⁸ Hoffman, J I, in *Pediatrics*, ed A M Rudolph, 16th ed, p 1404. New York, Appleton-Century-Croft, 1977.

***The leading article was intended to be provocative and has succeeded in its purpose. Dr Gill perhaps has not grasped that routine school medical examinations of children in the UK would involve the entire population attending school. Such a group is clearly worthy of intensive epidemiological study, as the article indicated. However, he is talking about a population who are self-selected by virtue of the fact that they present to their doctor or in hospital. Of course the blood pressure of such patients should be measured, but as part of good individual medical care, not as an attempt to establish prevalence, because in such a selected population this effort would be largely wasted.

He correctly points out that screening of femoral pulses would but rarely detect coarctation of the aorta. However, evidence suggests that this would prevent some lifetime hypertension. To refute the point made in the article he would have to demonstrate that routinely measuring blood pressure in children would prevent more hypertension than feeling femoral pulses, yet he has provided no such evidence.

He is absolutely right about the rate at which the mercury column should be allowed to fall (5 mm Hg/s was the recommendation intended). The results of screening in Dublin children are awaited with interest.—Ed, *BMJ*.

Medical hazards of air travel

SIR,—The correspondence on this subject is memory-provoking.

Despite being charged extra by BOAC in June 1971 to carry a medical bag as well as a small grip, I did not demur when the classic call went out on the (packed) New York-bound jumbo. An American film producer was hyperventilating furiously and the cabin crew worried because the oxygen was making him worse. The use of an airsickness bag in the classic manner provided relief for all concerned as his PCO₂ rose to normal again.