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.

Some spare champagne from the first class mollified my earlier resentment.

At Kennedy, Immigration and Customs were delightful when I showed them the bag and the GMC certificate of full registration. Only later did I realise that the two ampoules of diamorphine were *completely* illegal. Dr Drummond Rennie's mention of imprisonment (20 August, p 515) is not therefore to be taken as jest.

Returning (by TWA, but another packed Boeing with elephantiasis) the lady behind us had an infarct but luckily stayed in sinus rhythm. A little heroin intramuscularly and oxygen by mask helped, and we put her in an ambulance at the ramp and all went straight round to the excellent airport medical centre. Picture my confusion then, in the middle of the usual Heathrow traffic jam, hypothalamic time clock inverted, sans ticket, passport, or money, and wife and baby son still with the aircraft! Talking my way back *out* of Immigration and Customs against the one-way flow proved to be an interesting and slightly schizophrenic test of initiative.

But was I legally entitled to practise medicine over international waters in an American aircraft? And, Good Samaritan laws notwithstanding, was I protected by my defence society from allegation of malpractice? Could not the purser of a jumbo have a sealed medical pack on his inventory of stores, along with the bonded items of liquor, etc, that are also liable to theft?

Perhaps airlines might offer doctors a staff discount on their tickets if they were prepared to be available during the flight. Saving just one costly fuel jettison and aircraft diversion would pay for that.

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Problems of community services for the mentally handicapped

SIR,—In recent years there has been an increase of training centres and hostels for the mentally handicapped in the community. This provision has generally been so welcome and desirable that the mechanism of its operation has received little scrutiny. Of concern to many consultants serving the mentally handicapped is the growing number of mentally handicapped people referred to them with the complaint that they are presenting problems of behaviour in new training centres and hostels. Often there is pressure for the transfer of a mentally handicapped person from the community facilities to hospital. At first such cases were accepted at their face value, but often human relationships have emerged as a major factor and prompt questions about the attitudes of staff and the aims and objectives of training centres and hostels.

New facilities for the mentally retarded have frequently been developed by social services departments after little consultation with the health authorities or specialists in mental handicap who were already providing a considerable proportion of the residential and therapeutic services for the mentally handicapped. The selection of residents for hostels is sometimes done by panels of social workers operating almost in secret, and the residents appear to have had little psychological or psychiatric appraisal. Hostels and training centres often tend not to ask for medical advice about clients until a crisis is reached. Then

exclusion of the offending person is sought. Some community facilities for the mentally handicapped appear to compete with rather than to complement hospital services. Medical and psychiatric help to the mentally handicapped in training centres and hostels may be less readily available today compared with the days when these services were run by the Health Departments. Hence a number of questions need to be answered in the provision of community services for the mentally handicapped.

(1) What are the aims and objectives of the training centres for the mentally handicapped? In most cases this means the severely mentally handicapped. These centres have broadened their curricula, but occupation is still a pre-dominating function although they are called training centres. "Training" for what? There is a lobby of opinion among parents of the mentally retarded that these centres would be better operated by departments of education than by the social services.

(2) What are the aims and objectives of community hostels for the mentally handicapped? At present mentally handicapped people who might well be in hospital are taken into hostels while patients in hospital await hostel placement.

(3) Are the qualifications, training, and preparation of staff for training centres and hostels appropriate? Staff with a nursing background often appear to be the most successful in managing the severely mentally handicapped. Some special care units in the community already employ nurses.

The command paper "Better Services for the Mentally Handicapped"¹ gives details of the provision required for the mentally handicapped in terms of the quantity of facilities needed. Some local authorities have made progress towards reaching the targets set. Buildings are only the first essential in a service for the mentally handicapped. Their provision alone does not solve the problems of this group of people, whose happiness and success are dependent largely on the quality of life and the human relationships that facilities for the mentally retarded create.

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¹ Department of Health and Social Security, *Better Services for the Mentally Handicapped*, Cmnd 4683, London, HMSO, 1971.

Form E111

SIR,—Minerva (23 July, p 271) questions the need for Britons holidaying abroad within the EEC to acquire a form E111.

Arrangements for providing travellers with medical treatment under the sickness insurance schemes of our Community partners are made under EEC regulations. These regulations, which were made before UK accession, provide for the cost of treatment to be reimbursed by the institution of the patient's own country. The arrangements do not apply to everyone in the Community—for example, not all self-employed or non-employed persons are covered. It is therefore necessary for travellers to be able to produce evidence of entitlement to medical treatment in most other EEC countries by means of the Community form E111, and this is necessary each time a visit is made because a person may change his status under the regulations between visits.

Since accession the UK Government has

been pressing for the regulations to be extended to cover all citizens of the Community and this proposal is under consideration in Brussels. If this is done it may be possible to simplify the procedure considerably. Already some countries—that is, Denmark and the Irish Republic—do not require form E111 from British travellers. Full details of the procedure for obtaining form E111 and of the treatment which can be obtained in each country are given in leaflet SA28, which travellers are urged to obtain from their local social security office before departure. The leaflet points out that if you make frequent trips you should tell the office and a certificate covering a longer period will be issued.

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Poisoning with antidepressants

SIR,—Dr C L Brewer's letter (20 August, p 523), in which he likens the prescribing of tricyclic antidepressants to that of chloramphenicol, is naive in its reasoning and misleading. He suggests that since tricyclic antidepressant drugs in large overdosage have been associated with numerous deaths two comparatively untried compounds should be used in their stead. Depression is a ubiquitous term, embracing a huge range of conditions and states of mind from minor upsets to severe psychotic illness. It would be extraordinary if widely differing types of drug should be of equal therapeutic value across the spectrum.

The original antidepressant drugs, imipramine and iproniazid, the prototypes of the tricyclic antidepressants and the monoamine oxidase inhibitors respectively, were discovered by chance 20 years ago. They are still, on the whole, among the most effective drugs available for severe depression. There is no convincing evidence that mianserin and flupenthixol are in any way comparable to them or to their analogues, such as amitriptyline and tranylcypromine, in such cases. These are potent drugs, dangerous in big overdosage. But no one would, or should, give such drugs to patients whose depression stems from a disordered personality, prone to suicidal gestures, or to a potentially suicidal depressed patient without first ensuring his safety by admission to hospital or his own promise not to take an overdose until the next appointment. (Almost no seriously depressed patient lies to his therapist.) Dr Brewer states that tricyclics are often inappropriately prescribed; why is he not critical of unnecessary or unthinking prescribing for patients liable to use their medication for self-harm rather than condemning a range of drugs whose usefulness in the right case is beyond doubt?

Surely it is time that some degree of common sense crept back into the evaluation of treatment in psychiatry. For instance, the results of many of the so-called double-blind trials should be recognised as largely meaningless, dependent as they are upon a rigid format which allows no scope for original clinical observation and the assessment of the real value of a particular drug. To imply, quoting two such trials, that mianserin and flupenthixol are therapeutically equivalent to each other and to the range of tricyclic drugs seems