fining of the flour. But the fact that so much fibre is lost in the former does not lessen the serious consequences of that also lost in the latter, as readily perceived in the present widespread therapeutic use of the unprocessed bran removed.—I am, etc.,

T. L. CLEAVE

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1 Cleave, T. L., *The Saccharine Disease*. Bristol, Wright, 1975.

Psittacosis and Disseminated Intravascular Coagulation

SIR,—We have read with interest the report by Dr. D. V. Hamilton (17 May, p. 370) and wish to record a similar case.

A 28-year-old woman was admitted gravely ill with fever and signs of bilateral pulmonary consolidation. Chest *x*-ray confirmed extensive alveolar consolidation throughout the right lung and left lobe, sparing the apex of the left upper lobe. Arterial blood gases showed severe hypoxaemia. A provisional diagnosis of staphylococcal or viral pneumonia was made and treatment started with physiotherapy and intravenous ampicillin, cloxacillin, and fucidin. She was transferred to the intensive therapy unit where the trachea was aspirated and positive pressure ventilation instituted. It was not until 48 hours later that we were able to interview relatives and learnt that there were three parrots and two cockatoos in the home. We immediately suspected psittacosis and substituted tetracycline for the previous antibiotics. There was no improvement in the clinical state and tracheostomy was carried out. On the fourth day after admission bruising was noted on the arms where the sphygmomanometer cuff was placed. Coagulation studies produced the following results: fibrin degradation products 160 mg/l, fibrinogen titre 1/8, thrombin time 19 s (control 10 s), prothrombin time 19 s (control 15 s), kaolin-cephalin coagulation time 33 s (control 32 s), platelet count $11{\cdot}0\times10^9$/l (11 000/mm^3). A diagnosis of consumption coagulopathy was made, anticoagulation was commenced with intravenous heparin, and fresh blood was transfused.

This complication was treated successfully but the patient's respiratory condition showed little improvement and on the eighth day after admission she died. At post-mortem there was consolidation of the whole of the right lung and of the left lower lobe, while approximately one-third of the left upper lobe showed haemorrhagic oedema. Antemortem blood clot was removed from the pelvic veins, pulmonary arteries, and mitral valve cusps; the heart was otherwise normal. The kidneys showed areas of infarction. Subsequently paired sera for complement fixation tests confirmed psittacosis.

Five other members of the immediate family had respiratory infections at approximately the same time and in three there was clinical and radiological evidence of pneumonia and serological confirmation of psittacosis. Yet another case has recently been confirmed in our ward; he had visited the same premises from which our other patients had been supplied with a bird. In none of the four other cases we studied were coagulation defects detected.—We are, etc.,

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Vagotomy for Duodenal Ulcer

SIR,—Mr. D. Johnston and others (29 March, p. 716) claim a good correlation between positivity soon after vagotomy and subsequent recurrent ulceration. A significant relationship has been found between recurrent ulceration within six to eight years after truncal vagotomy and drainage and insulin positivity at the tenth day.[1] However, the predictive value of a positive Hollander response was only 26% and the sensitivity 45%. The corresponding figures three to four years later were 19 and 72% respectively. Our study[2] included 500 patients with duodenal ulcer being operated upon consecutively by truncal vagotomy and drainage, while the studies mentioned by Johnston *et al.* included only small and selected groups.

It is surprising that Johnston *et al.* do not comment on their own high frequency of insulin positivity one year after H.S.V.[3] amounting to 51%, which is a higher figure than that three to four years after truncal vagotomy. Our frequency of 58% 10 days after H.S.V. was associated with the same reduction in maximal acid secretion as that of Johnston *et al.*, but 11 recurrences were seen among 50 patients within four years. The recurrent ulcer healed in three, resulting in a final recurrence rate of 16%. Johnston *et al.* found no relation between recurrent ulcer and acid secretion in patients with H.S.V. This is not very surprising, since no more than two recurrences were found among 300 patients. However, our acid secretion figures revealed no relationship between the completeness of H.S.V. according to multiple criteria and recurrent ulceration.

The operative technique may not have been optimal in the beginning of our study and many surgeons were involved. The 11 recurrences could be referred to seven different surgeons. The recurrence rate in the following 200 patients has been less than 10%. It should be emphasized that antrectomy and truncal vagotomy was suggested in hypersecretors as an alternative to truncal vagotomy and pyloroplasty and not as an alternative to H.S.V.[3]—We are, etc.,

POVL MADSEN
OLE KRONBORG

Bispebjerg Hospital, Copenhagen

1 Kronborg, O., *Gut*, 1974, **15**, 714.
2 Kronborg, O., and Madsen, P., *Gut*, 1975, **16**, 268.
3 Johnston, D., *et al.*, *Gastroenterology*, 1973, **64**, 1.

Consultants' Fees for Dental Anaesthetics

SIR,—It seems most unfortunate that neither Dr. M. P. Coplans (24 May, p. 447) nor the Secretary in his comment following Dr. R. L. McMillan's letter (17 May, p. 395) has exposed the errors in Dr. McMillan's letter. He quotes the fees for anaesthetics administered by a general medical practitioner which apply to maternity and other work but not to dental work. He then compares this with fees paid to a consultant for dental anaesthetics. Both G.P.s and consultants are paid for items of dental treatment (as Dr. Coplans points out) and the fees are therefore identical and in my view derisory to both. Dr. McMillan goes on to add his suspicions that the G.P. has some illicit source for his materials, which of course is not the case (though one might be tempted to think that such a source could be more readily available to the consultant if one were as suspicious as Dr. McMillan).

Finally, Dr. McMillan thinks that this sort of treatment makes the consultant feel that the B.M.A. favours the G.P. I am sure that he realizes that the B.M.A. is not responsible for the level of remuneration in this field and is attempting to negotiate for improvements, but I do not think he helps the situation by drawing erroneous comparisons between the rates paid to the G.P. and the consultant.—I am, etc.,

C. D. LUND

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SIR,—My colleagues and I agree with Dr. R. L. McMillan (17 May, p. 395) that fees for dental anaesthesia are derisory and welcome Dr. M. P. Coplans's efforts (24 May, p. 447) to increase them. However, 20 years of waiting for the B.M.A. to do something has driven many anaesthetists to join the Hospital Consultants and Specialists Association. The President of the British Dental Council has recently condemned the operator/anaesthetist in dentistry in the strongest possible terms (24 May, p. 453). Many dentists who have done this will find that these derisory fees will not attract an anaesthetist; thus they will be forced to refer more patients to hospital dental departments. We find in this hospital that there is a constantly increasing and insatiable demand for more staff, more equipment, and more operating time from the dental department due to dentistry which could be done in dental practice being referred to the hospital. We estimate that the cost to the N.H.S. of having one tooth extracted under general anaesthesia is 5-10 times as much in this hospital as it is in general practice.—I am, etc.,

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Junior Hospital Staff Contract

SIR,—I find the fact that the Review Body has felt it necessary to have a survey on the hours worked and work done by junior staff somewhat disturbing. If its members are not already in possession of these facts, on what basis was the present contract priced? Furthermore, I wonder if I am being over-suspicious in scenting a return of the notorious "pool." Does the Review Body see its task in pricing the new contract as ensuring that junior staff receive a reasonable return for hours worked, work done, and responsibility undertaken when compared with other professional groups, or does it, as I suspect, see itself as sharing out a predetermined global sum "fairly" among them?

My misgivings about the fact of the survey, however, dwindled to nothing when set against those which I experienced when I read it. In the section on "stand-by" or "on-call" periods time spent on call at home and in the doctor's accommodation in the hospital is lumped together, presumably implying that it will be remunerated at one single rate. Compulsorily resident junior doctors who are married and who are not among the very small minority fortunate enough to have married accommodation within their hospitals will hardly need reminding of the vast difference between being on call at home and being resident in the hospital during "on-call" periods. In