transfusion centres screen all donations in a search for carriers before issuing blood to hospitals. We now simply reject donors known to be carriers and those with a history of hepatitis (jaundice) *within the previous 12 months*. Donors should not have been in close contact with a case of hepatitis during the previous six months. The decision whether to accept the donor is based on the history taken at the bedside during a donor session.

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Giving RSV vaccine intranasally

SIR,—I was interested in the reports of failure of immunisation to protect young children from respiratory syncytial virus (RSV) infections (leading article 25 August, p 457). In the studies quoted, a rise in serum antibody against RSV is often observed following systemic vaccine inoculation, but no mention is made of attempts at intranasal administration. The beneficial effects of local cellular and humoral immunity in the lung in response to local attenuated virus vaccines have been well documented.¹ Preliminary work suggests that immunity against rotavirus gastroenteritis may be related to local rather than systemic antibody and that the oral route of vaccine administration may be more protective than the systemic.² It would be interesting, therefore, to observe if intranasally administered RSV vaccine would be more protective than its systemic counterpart.

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¹ Newhouse, M, Sandins, J, and Bienenstock, J, *New England Journal of Medicine*, 1976, **295**, 1045.

² Chanock, R M, Wyatt, R G, and Kapikian, A Z, *Journal of the American Medical Veterinary Association*, 1978, **173**, 570.

Rubella vaccination

SIR,—While it is true that Dr Max Gringras (13 October, p 933) found high acceptance rates for rubella serotesting, he ignores the point that this was in general practice and not in area health authority family planning clinics. There are several reasons for the differences in acceptability—different client groups, the relationship with the doctor—all of which will effect compliance.

Under the present system, we are ethically prepared to risk causing terminations in seronegative women and ethically prepared to accept our impotence in preventing much larger numbers of terminations in unprotected women exposed to natural infection. Surely, by definition, our ethics should be consistent.

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Hypertension and general practice

SIR,—I am delighted to know that Dr D G Beevers (3 November, p 1137) is not responsible for the disgracefully low level of

diagnosis and treatment of hypertension in Great Britain, but that that old whipping boy the general practitioner can confidently be blamed for it.

If he were to spend one week in general practice he would realise that the average time available for a consultation is five minutes, give or take a few minutes. This is also the time it takes to measure the blood pressure properly. Which would he have? Although the number of doctors in hospital practice has increased enormously in recent years, there has been no parallel increase in the number of GPs.

What we need is more doctors in general practice to ease the very considerable burdens in that specialty, and perhaps this is the problem which Dr Beevers should take up in his next confrontation with the television cameras.

The considerable number of GPs currently running the Medical Research Council's mild-to-moderate hypertension trial, those in hypertension units all over the country, and the many others who are increasingly aware of the problem of hypertension must find the comments of Dr Beevers at the very least disheartening.

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Blood pressure measurements

SIR,—I, like Dr Eoin O'Brien and Professor Kevin O'Malley (3 November, p 1126), believe that selected hypertensive patients should be encouraged to measure their own blood pressures. However, I would suggest that for greater simplicity in self-recording the stethoscope should be discarded by the patient. With the aneroid or mercury manometer a satisfactory estimate can be made of the systolic blood pressure when the "knocking" sensation of the Korotkoff sound is felt in the brachial artery. The diastolic level can be reasonably accurately measured by the rather abrupt diminution or disappearance of the "knocking" sensation as the pressure in the cuff is reduced. The accuracy of measurement is certainly adequate for the efficient day-to-day management of high blood pressure.

Changes in the magnitude of oscillation of the aneroid stylus also occur at systolic and diastolic levels but they are more difficult to identify than the changing sensations in the brachial arteries.

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Pulmonary impairment and disability

SIR,—While it is always nice to be quoted by Minerva (29 September, p 801), it is nicer still to be quoted accurately. Only the neophyte would suggest that pulmonary function tests are an objective measurement of respiratory disability; in reality they measure pulmonary impairment, and the distinction between impairment and disability is crucial.¹

Minerva's second comment on my paper is also a trifle misleading. She implies that I said, "The effect of breathlessness on employment seems to depend most on the gap between earnings and sick pay and whether or not the work is interesting." While it is true that those

persons who are well paid and who have a job that they find interesting are more likely to continue working despite significant pulmonary impairment than those who have tedious, less well-paid jobs, I am not sure whether the decision to return to work depends all that much on whether the subject complains of shortness of breath. The same factors seem to operate in regard to the time off work following an acute illness or an operation, such as a myocardial infarction or lobectomy.

In questioning Minerva I trust I shall not suffer the fate of Arachne and be turned into a spider.

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¹ Morgan, K, *Chest*, 1979, **75**, 712.

George Gershwin

SIR,—Minerva's paragraph (20 October, p 1007) brings to mind information which came my way in America about 15 years ago, which throws light on at least the first referral of this neurosurgical case to a psychoanalyst.

The initial symptoms occurred when Gershwin, then 38, was performing his gorgeous piano concerto in one of the Californian cities. At one point he unaccountably seemed to pause and then jump four bars. The conductor pulled them together, and in conversation with the soloist afterwards it turned out that Gershwin had little recollection of the incident, but mentioned a momentary giddiness and a smell of burning rubber. The headaches began a day or two later.

At this time, George's brother, Ira, had been in touch with an analyst, in whom he had developed great confidence; so on hearing about the headaches he persuaded, or over-persuaded, his brother to consult this analyst. From then on Gershwin had no lack of well-wishers and their advice. As a result, he consulted at least three neurosurgeons or neuropsychiatrists in New York, Florida, and California, making tedious flights that in those presumably unpressurised conditions must have been hazardous for a brain tumour. In the outcome, neither localising nor even lateralising signs were elicited and the inference was that no surgeon, faced with such an illustrious patient, would take the risk of opening up first the wrong temporal lobe.

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Possible treatment for cold sores

SIR,—I have noted the letters on possible treatment for cold sores about using borates and the plea for ice (3 November, p 1150). If there is a helpful pharmaceutical service available Miller¹ describes how active herpes-virus infection could be treated using influenza virus vaccine intradermally as mentioned by Lee in 1961.

I have used the diluted vaccine on cases of mild herpes with healing of eruptions in a couple of days; I have not yet had any cases with severe symptoms to see if his report of symptoms clearing in 30 minutes holds for patients on this side of the Atlantic. But the