was 10 to 1. This is the same figure as is found in our hospital.

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¹ Russell, J G B, *Radiology in Obstetrics and Antenatal Paediatrics*, p 35. London, Butterworths, 1973.

Non-autoclavable lignocaine laryngeal sprays

SIR,—We were surprised, but gladdened, to read (11 February, p 369) that Penlon Ltd in conjunction with Professor A C Forrester had in fact anticipated by some years our suggestions (10 September, p 680) for the modification of Forrester laryngeal sprays.

However, it should be noted that other manufacturers—for example, British Oxygen Company Ltd, Medishield—still distribute non-autoclavable laryngeal sprays which may well constitute the infection hazard described in our original paper.

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Sarcoid heart disease

SIR,—In 1973¹ you were kind enough to publish a letter from me reporting my interest in collecting cases of suspected cardiac sarcoidosis. As a result of this and other efforts a report² was made of 50 cases. The collection of cases has continued and all surviving patients are followed up by an annual inquiry. It is felt that by this means it may be possible to gain a better knowledge of the natural history of this uncommon and often bizarre form of cardiac disease.

I would like to appeal for further cases to be reported to me. To date a total of over 150 cases have been collected. The diagnosis is certain in over 50, almost certain in another 35. There is necropsy confirmation in 37. It should be emphasised that the diagnosis is to be suspected in any bizarre form of heart disease, especially with difficult and changing dysrhythmias or congestive cardiomyopathy. Florid clinical sarcoidosis in other organs is frequently absent, but some histological evidence of sarcoidosis is essential to the diagnosis.

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¹ Fleming, H A, *British Medical Journal*, 1973, **1**, 174.
² Fleming, H A, *British Heart Journal*, 1974, **36**, 54.

Rubella vaccination and pregnancy

SIR,—We are concerned about the unthinking administration of vaccine to women who wish to be immunised against rubella before they become pregnant. From time to time patients are referred for consideration of termination of pregnancy because of inadvertent administration of vaccine in the second part of the menstrual cycle when, unknowingly, they are pregnant. The decision is always difficult for the gynaecologist because of the relatively slight risk of the fetus being affected. Giles¹ reported that, in 83 women given rubella

vaccine before planned termination of pregnancy, the virus was isolated in three of the fetuses and ten of the placentas. If one assumes that 85% of women are seropositive anyway, and therefore immune, the risk of fetal infection is slight. However, for the woman who finds she is pregnant and knows that the vaccine was given shortly after conception it is impossible to view the matter so objectively, and nearly always she persists in her request for termination.

We would like to make a plea that the immune status of the patient is determined before rubella vaccine is given. If she is seronegative the vaccine should only be given if it is certain that pregnancy can be avoided by adequate contraception for at least two months.² Gringras *et al*³ have shown that this system is feasible in general practice.

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¹ Giles, P F H, Mackay-Scollaye, E M, Christiansen, K, *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 1973, **13**, 65.

² Department of Health and Social Security, *Rubella Vaccination*, CMO 76/4. London, DHSS, 1976.

³ Gringras, M, *et al*, *British Medical Journal*, 1977, **2**, 245.

Herpes simplex virus excretion in febrile immunosuppressed patients

SIR,—Herpes simplex virus (HSV) as well as other herpes viruses, such as cytomegalovirus (CMV) and varicella-zoster virus, are known to cause serious infections in the immunosuppressed host. Moreover, asymptomatic excretion of CMV and of another herpes virus, the Epstein-Barr virus, is more frequent in these patients than in patients without an immune deficiency. We have found that this may also be true of HSV.

We cultured urine and saliva on human diploid fibroblasts searching for CMV in 60 patients with unexplained fever. Of these 18 were considered to be immunosuppressed (14 kidney transplant recipients, 2 patients with treated systemic lupus erythematosus, and 1 each with lymphoma and chronic lymphatic leukaemia). Their mean age was 37.5 years. The remaining 42 patients, with a mean age of 35.8 years, did not have a history suggesting an immune deficiency. CMV was isolated in 6 immunosuppressed and in 10 non-immunosuppressed patients. To our surprise HSV was isolated in 7 (39%) of the former and in 2 (5%) of the latter ($\chi^2=45$, $P<0.001$) (see table). Seven of 15 (47%) saliva specimens of the immunosuppressed patients were positive. All these isolates were identified as HSV-1 by microneutralisation using specific antisera, except for one HSV-2. None of these patients had oral lesions.

Asymptomatic HSV excretion has been described in the same proportion (5%) of non-immunosuppressed patients with respiratory infections as of our patients with

unexplained fever.¹ Isolation of HSV in the immunosuppressed is probably much more frequent but has in general been associated with herpetic lesions.^{2,3} However, the high recovery rate of HSV in our febrile immunosuppressed patients without orolabial lesions was unexpected.

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¹ Lindgren, K M, Douglas, R G, Jun, and Couch, R B, *New England Journal of Medicine*, 1968, **278**, 517.

² Ruffault, A, and Fauconnier, B, *Pathologie et biologie* (Paris), 1976, **24**, 37.

³ Aston, D L, Cohen, A, and Spindler, M A, *British Medical Journal*, 1972, **4**, 462.

Parenteral nutrition

SIR,—After many years of development and evaluation of total parenteral nutrition most clinicians in this country now accept that intravenous 5% dextrose is a completely inadequate source of energy. Even our medical students appreciate that 2 litres of 5% dextrose per day only provide about 1.7 MJ (400 kcal), whereas the daily energy requirements are at least 6.3–8.4 MJ (1500–2000 kcal) with considerably increased requirements in seriously ill catabolic patients.¹ It was therefore with more than a little concern that we read, in the middle of the otherwise excellent article by Mr M E J Beard and his colleagues on acute marrow folate deficiency during intensive care (11 March, p 624), that for 10 days the patient's "energy intake was maintained [our italics] with 5% dextrose; he took no food by mouth." That this kind of thinking still exists in authors (as well as in referees) demonstrates the requirement for further education in nutritional requirements of seriously ill patients. Paradoxically, this report was printed next to an article on central venous catheterisation to permit infusion of hypertonic nutrient solutions.

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¹ Lee, H A, *Parenteral Nutrition in Acute Metabolic Illness*. New York, Academic Press, 1975.

Skateboard injuries

SIR,—There is considerable interest in the "dangerous sport" of skateboarding and, while not wishing to minimise the problems of epiphyseal injury, etc, there appears to be an overemphasis on the dangers.

This accident and emergency department has a population at risk of 350 000 and in the nine-month period 1 June 1977–28 February 1978 there were 43 777 new patients, of whom 116 had sustained skateboard injuries. Fractures constituted 33.6% of the skateboard injuries; 23 of these 39 fractures involved the

Isolation of herpes simplex virus in febrile patients with and without immune deficiency

	No (%) of patients					
	Immunosuppressed			Non-immunosuppressed		
	Total	No with saliva culture	No with urine culture	Total	No with saliva culture	No with urine culture
No who had cultures ..	18	15	16	42	39	41
CMV positive ..	6 (33)	4 (27)	5 (31)	10 (24)	7 (18)	8 (20)
HSV negative ..	7 (39)	7 (47)	0 (0)	2 (5)	2 (5)	0 (0)