A lively dialectic between proponents of bacterial and viral aetiologies may generate useful hypotheses to be criticised and tested during the next exciting years of research into diarrhoeal diseases.

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Multicentre trial of prednisolone in the Guillain-Barré syndrome

SIR,—The Guillain-Barré syndrome, discussed in your leading article (26 July, p 190), has a misleading reputation as a benign condition. Severe weakness lasts for at least three months in most patients and respiratory failure necessitates artificial ventilation in about 20%. Despite intensive care mortality rates of 5 to 10% are still found in most modern series and recovery is incomplete in a further 5 to 10%.[1-3] Accordingly the potential benefits of an agent such as prednisolone are worth investigating.

Sadly, after quarter of a century of uncontrolled trials the role of corticosteroids in the treatment of Guillain-Barré syndrome remains controversial.[3-5] We are therefore engaged in a multicentre controlled trial in which the results of randomly allocated treatment with or without a course of prednisolone are being assessed by "blind" observers. The trial is now in its second year and 20 patients have entered. Preliminary statistical analysis of our results by Professor P Armitage does not reveal an advantage to either group. We estimate that 50 patients will be required to show a clinically worthwhile change due to treatment. Patients from any hospital in London or its immediate neighbourhood are eligible for entry to the trial, and further details can be obtained from us.

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SI units

SIR,—Since my letter (19 July, p 159) on the subject of SI units, I noted that there was no further correspondence from any clinician who could point to any advantage resulting from their use.

At the insistence of my medical colleagues, I carried out a survey of all the medical staff in our health district, and the results indicate that, out of a possible 150 ballot papers, there were 90 signed objections to the introduction of SI. There was one dissenting colleague.

As I mentioned in my previous letter, I would be extremely foolish to force a system of clinical reporting on my colleagues who did not desire it, and I must say that the dilemma remains unresolved, especially in the light of Ministry "advice."

I find none of the arguments advanced in favour of SI as being convincing, and I know that medical staff and others make frequent use of literature derived from America and other foreign sources, which so far will continue to report in "proper metricated" units. It is easy to say that "everybody else is out of step but me," but in this instance everybody else—that is, the world—will be in step while the United Kingdom, by virtue of SI adoption, will be talking a curious scientific jargon almost singular in world clinical medicine.

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SIR,—The King's Lynn District Hospital Medical Staff Committee approved on 23 October the following motion: "That we do not intend to introduce SI units on 31 December 1975."

The staff suspected that support for the change is rather less strong than advocates of the new régime would have us believe.

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Influenza vaccination

SIR,—I read with great interest your leading article on influenza vaccination (18 October, p 125) and would like to make some comments supported by evidence which may not have been in your possession.

It is stated that field evidence of the protective effect of a live attenuated influenza vaccine given intranasally is still lacking. As this is a product very recently introduced into the UK this is so of this country, but a considerable amount of such work has been done on the Continent and in the USA.

To the best of our knowledge there is no field evidence of the protective effect of any updated inactivated vaccines against the A/Scotland strain. The killed vaccine has been shown to produce a better antibody response in general, but there is often a poor correlation between serum antibody response and the protection afforded an individual against influenza following vaccination. Protection of between 70 and 80% with reasonable certainty is claimed in your article for inactivated vaccine. However, a recent study has shown over 80% protection against natural challenge with A/Port Chalmers using a live vaccine.[1] Response to the A/Scotland virus is stated to be unlikely to be as good in the case of a live vaccine as that provoked by a killed vaccine, but again recent work has shown a serum conversion rate of 84% to this virus using a live vaccine.[2] Postvaccination titres were as high to A/Scotland as to A/Port Chalmers and the homologous strain.

A small point of correction is that the work by Lauteria *et al* referred to in your article involved an early strain of live attenuated virus "Ann," not the one currently available ("Alice").

The slight adverse effect on small-airway function observed in healthy volunteers[3] has not been confirmed in a further study in the USA in which changes in pulmonary function (using flow volume curves with air and helium mixture) have been used in both asthmatics and a control group. No changes in pulmonary function were demonstrated, no significant symptoms were reported, and a fourfold rise in antibody titre was found in [illegible]sons with low titres.[4]

In conclusion, it is submitted that live attenuated influenza vaccine has been well tolerated by over 10 000 people during its development, subsequently by well over a quarter of a million in clinical usage, and significantly by 381 patients who took part in clinical trials and were suffering from bronchopulmonary disease—that is, the high-risk groups.

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1 Douglas, G, as reported by A Prinzie at a symposium at the Royal Society of Medicine. London, April 1975.
2 Kuwert, E, in Symposium on Viral Diseases, Vienna, September 1975.
3 Rosenzweig, D Y, *et al*, *American Review of Respiratory Diseases*, 1975, **111**, 399.
4 Storms, W W, *et al*. Submitted for publication.

*** We are familiar with published, and much unpublished, work on live attenuated influenza vaccine from both the Continent and the USA, including that presented at the London symposium to which Dr Jackson-Moore refers. We reaffirm our view that although "there are expectations that live vaccines will stimulate a more solid immunity than killed," so far there have been no unequivocal reports that the live A/England vaccine protects against clinical infection with homologous or related viruses.

We agree that there is no field evidence so far available of the protective effect of up-to-date inactivated vaccine against the A/Scotland strain of influenza A virus. At the same time most workers in the field, including manufacturers, would expect that inactivated A/Scotland vaccine should be as protective against the homologous virus as previous inactivated vaccines against their homologous viruses. This expectation underlies the regular updating of inactivated vaccines, a policy that has not yet been doubted.

It is encouraging that "Alice" live A/England vaccine may give a serum conversion rate of 84% against the A/Scotland virus. Nevertheless, the serum conversion rate is only one criterion of the antibody response, and in the study to which Dr Jackson-Moore refers Professor Kuwert also reported that the serum HI antibody titres were lower after live virus vaccine than after inactivated vaccine. He further reported that the local HI antibody response was predominantly strain-specific.

That live vaccine may have an adverse effect on small-airway function is a possibility that it would be unwise entirely to disregard on the basis of the two negative reports. It is greatly hoped that live attenuated influenza vaccines will prove to be