seem to be completely unaware that the caravans they tow are wider than their car. I certainly have missed catastrophe by inches from towed caravans.

I would make a special plea for the separation of cyclists from motor traffic by special cycle routes or tracks in towns. Your correspondent says that the entrance and exit of cycle tracks may be awkward, but these could be controlled by traffic lights.

I do not think that a cycling proficiency test for any adult cycling on a main road should be mandatory, but all children who cycle should certainly take a school or similar cycling test. The wearing of helmets by cyclists should be encouraged, but it could be enforced legally only with difficulty. It must be remembered that the beauty of cycling, apart from exploring the byways that many motorists have forgotten, is the convenience for short journeys—no getting the car out of the garage, no difficulty with starting, no parking problem at the shops, etc.

May I suggest that your special correspondent might have got in touch with the Cyclists' Touring Club (69 Meadow, Godalming, Surrey), the cyclists' national body which runs an insurance scheme for cyclists and has the widest knowledge of the hazards of cycling, especially for adults. May I further suggest that anyone in later life taking up cycling for exercise and enjoyment would find the CTC most helpful in many ways quite apart from accidents, as I have done.

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No driving licences for alcoholics?

SIR,—With reference to your recent articles on road accidents and the unfit driver (25 November, p 1471) and on road accidents and driving behaviour (2 December, p 1551), I wonder how many doctors realise that all alcoholics are expected to notify their "disability" to the Driver and Vehicle Licensing Centre, Swansea, and are liable to a fine not exceeding £100 if they do not do so. Under present interpretation of the regulations it appears that they are likely to have their licences withdrawn unless or until they can claim or prove two years' total abstinence. I was astonished to learn that this was so when I was recently approached by the DVLC about a patient treated in this unit who had applied for routine renewal of his licence. (No offence had been committed, nor had the previous licence lapsed.) Only after I had reluctantly undertaken to notify the DVLC if this man took any drink, or failed to keep in touch with me every week, was a new (temporary) licence issued.

I am wholeheartedly in favour of road safety and I unreservedly condemn driving under the influence of alcohol; but it seems to me that the regulation is invidious, ineffectual, impractical, and likely to bring the law into disrepute. Alcoholics, when sober, are arguably no worse drivers than the rest of us, and many alcoholics are careful not to drive when drinking. Furthermore, very few alcoholics are likely to notify the centre and it is the more irresponsible and less insightful who will fail to do so.

How is the DVLC to be satisfied that two years' abstinence has in fact been reached? Are doctors to become big brothers for Swansea and lose the trust and co-operation of their patients? And what about the

(admittedly few) alcoholics who attempt to revert to social drinking or who have only an occasional lapse? The DVLC claims to have expert advice that "one year of complete abstinence should give rise to optimism, and two years to confidence in the provision of a driving licence." I wonder if the expert anticipated the results of his advice?

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Erythromycin in legionnaire's disease

SIR,—Your leading article on legionnaire's disease (11 November, p 1319) comments that "American enthusiasm for erythromycin was not justified by the British experience." We saw three patients with a confirmed diagnosis of legionnaire's disease last summer who were all treated with erythromycin. They all recovered, though one developed renal failure requiring temporary peritoneal dialysis.

A particularly dramatic clinical response to erythromycin was shown in the third case, that of a 34-year-old woman admitted five days after returning from holiday in Spain. She had been unwell for three days with cough, headache, and vomiting with some diarrhoea. She was ill with a temperature of 40.6°C and a dry cough but had no abnormal signs in the chest. Splenomegaly was present. Chest x-ray demonstrated pneumonic consolidation at the base of the right lung and the clinical diagnosis of legionnaire's disease was confirmed by a titre of 1/32 rising to 1/1024 after a week. Erythromycin was started on admission, resulting in defervescence and rapid improvement within 24 h. The response was directly associated with the use of erythromycin and this was the only antibiotic used. In a disease which carries an appreciable mortality erythromycin should be administered promptly in any case of suspected legionnaire's disease. Response may be unsatisfactory in some patients but may be dramatic and life-saving in others.

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Smear campaign

SIR,—I read with interest the letters from Mr T R Cullinan and Dr Leslie Ellis (16 December, p 1711) and am in full agreement with their thoughts on this subject. As one who has had more than 25 years' experience in vaginal cytology, may I explain some of the points they raise?

Firstly, the form of which Dr Cullinan so aptly comments. Having myself been many years in advance of the Department of Health and Social Security I had to design my own form and I soon learnt that the more items you put on it the less likely you are to get any worthwhile answers. My form required 11 pieces of information which I considered necessary to the correct interpretation of the smear. Over many years I found I was lucky if I got 75% of these facts filled in. I was concerned at national level over the setting up of the present form. My role was to prevent it ever seeing the light of day, but, alas, in this object I was singularly unsuccessful. Among

its main disadvantages are its length and complexity and the fourth carbon copy never seems to come out. It does not fit easily into any known filing cabinet and in its present form it is unsuitable for computerisation. These things I discovered by using it in conjunction with my colleagues both in hospital and in general practice.

Both Mr Cullinan and Dr Ellis ask for information on the timing of resmearing, and the answer to this is easy. In the first instance, the resmear should be in one year (a small percentage of first smears are false-negatives) and thereafter at five-year intervals until the age of 60, when it can be discontinued.

Dr Ellis quotes the mystical figure of age 35 as the time of taking the first smear and I can tell him how this was arrived at. Many years ago the late Dr Joe Bamforth was asked by the Department at what age smearing should commence. Not being a clinician he consulted a senior gynaecological colleague (who, incidentally, was not known for his interest in cervical cancer), who replied that he had never seen the disease before the age of 35. Thus this figure stuck and of course anything which sticks at the Department can only be removed by revolution or explosion. It is many years since Dr Bamforth told me these facts, but, despite the arguments of many of us, this mystical and mythical figure is largely adhered to. The fact is that ideally the first smear should be taken as soon as possible after the first act of intercourse, however young that may be.

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Comparison between communities

SIR,—The series "Epidemiology for the Uninitiated" by Professor Geoffrey Rose and Dr D J P Barker makes fascinating reading to those interested in the epidemiology of diseases in developing populations.

In their recent article on "Aetiology-comparison between communities" (25 November, p 1483), we were taken aback by the view that the reported low incidences or prevalences of certain diseases in developing populations—for example, in Africa—may be more apparent than real, depending on how hard one looks. However, not all observations are made at small, isolated, rural mission hospitals: some are made at large, well-equipped city hospitals, of which there are several on this continent.

The authors refer to appendicitis. Locally (1) from records of operations in hospital, (2) from prevalences of operations in school pupils, and (3) from prevalences of operations in the huge number of labourers in the mines (whose medical facilities are excellent) we know that the low prevalence of appendicectomies in blacks is entirely real and not apparent. In large centres of population patients are assuredly not "more likely to die before they reach hospital."

Uncertainties due to variations in diagnostic practice are mentioned. In numerous fields there are differences in standards or in diagnostic criteria—growth, blood pressure, rickets, diabetes, coronary heart disease, etc. Accordingly the problem of determining whether ulcerative colitis (cited by the writers) is or is not rare is appreciated. However, the very much lower occurrence of the disease in urban South African blacks is undoubted.