cigarette smoking and bronchogenic carcinoma is also statistical but of an infinitely greater probability.

That this is not a matter of mere legal sophistry will be confirmed by most general practitioners, who are dealing with increasing frequency with features of anxiety and guilt in women on the pill (and their husbands) produced by the prominence given to these cases by the press. I suggest that requiring a much higher degree of proof linking the pill directly with the cause of death in each individual case would both serve the ends of justice and ensure the peace of mind of many of our patients who are much less at risk from the pill than from smoking cigarettes.

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Self-mutilation in severely retarded children

SIR,—May I point out to Minerva (25 March, p 794) that many of the self-mutilating severely retarded children on whom she reports are possibly psychotic rather than simply stimulus seeking. Some may, indeed, be in a chronic state of hyperarousal so that supernormal stimuli may only serve to irritate them further. The attention-seeking cliché is so overdone in the mentally handicapped field as to have lost explanatory power.

It is well known that the diagnosis of mental illness is often exceedingly difficult in a setting of subnormality as the patient usually presents merely with persistent, non-specific behavioural upset. All mentally handicapped children should be given the chance of drug treatment (with phenothiazines, lithium, amphetamine, etc) if they show bizarre or troublesome behaviour, whether continuous or phasic. Otherwise any underlying mental illness may interfere with the learning process so that their other handicaps are compounded by educational backwardness as well.

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Oesophageal bolus extraction by balloon catheter

SIR,—The technique described by Mr Peter A Jones (1 April, p 819) seems a useful therapeutic trick for the relief of oesophageal bolus obstruction when skilled help is not immediately available. I would, however, take issue with his statement that if this technique fails rigid oesophagoscopy under general anaesthesia is indicated. If the fiberoptic endoscope is used bolus extraction can easily be done under local anaesthesia and sedation. This also allows immediate biopsy and dilatation of any stricture present using Eder-Puestow dilators. This should be regarded as the procedure of choice if the instruments are available.

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SIR,—May I add a comment to the laudable article "Oesophageal bolus extraction by balloon catheter" (1 April, p 819) by Mr P A Jones?

Sometimes it is advisable to screen the removal of the foreign body with an image intensifier, and so to put Hypaque or a similar contrast medium into the balloon of the Foley catheter instead of air. Anyway, a fluid is better than air, because it is non-compressible. A catheter smaller than 26 F can be inserted more easily and I would recommend filling the balloon with 20 ml rather than the 8 ml suggested by the author.

This method is suitable for removing soft or rounded objects—for example, meat and coins—but it is not advisable for hard, irregular objects—these should be removed via oesophagoscopy. A point to be noted is that some modern dental plates do not contain any radiopaque material (as this material weakens them), so may not be visible on plain x-ray. As with any radiotranslucent object suspected of obstructing the oesophagus, give a dilute barium swallow, or a cotton wool ball soaked in barium. Even if the cotton wool passes the object, it will leave a few strands stuck to it. Before using this balloon catheter technique, it is safer to make efforts to locate and identify the obstruction.

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Schumann's hand injury

SIR,—In their recent article on Schumann's hand injury (8 April, p 900), Dr R A Henson and Professor H Urich have suggested that Robert Schumann's "hand disability" may have been due to "damage to the posterior interosseous nerve . . . for the clinical picture is more in accord with a lesion here than at any other point in the nervous system." Yet they have not been able to find a single report of posterior interosseous palsy occurring in the really enormous body of professional pianists, and they also express their own reservation about such a diagnosis.

I remember, as a medical student, attending one of the late Mr A Dickson Wright's outpatient clinics at St Mary's—it must have been in 1940 or 1941—when one of my colleagues, a keen amateur fiddler, sought his advice about difficulties he was having (with his left hand) in playing rapid passages. Whereupon "Dicky" expressed the view that his problem was probably due to the same anatomical limitation as Schumann had experienced with his right hand (which is responsible for most of the "velocity" in piano playing), a limitation that can be easily demonstrated.

Place the outstretched hand—either hand—on a flat surface (like a table top), with the fingers slightly flexed, in the position they would adopt on a keyboard; now raise each digit, singly and separately, as high as possible above the table. The thumb, index finger, and little finger can be raised quite freely, the middle finger less freely, and the ring finger least of all. This limitation of extension of the ring finger is caused by the restriction imposed on its extensor tendon by the oblique cross-connections which join it to its fellows of the middle and little fingers. According to "Dicky," it was Schumann's right ring finger that troubled him most, and his frustration with this anatomical "handicap" that caused him to use the mechanical device that led to permanent stiffness and the abandonment of his career as a performer. Furthermore, he

(ADW) had divided these cross-tendons in an amateur pianist, who had subsequently assessed the benefits of his operation as the equivalent of two years of hard practising!

Is it not possible that the oversensitive artist was looking for a "therapeutic" solution to his own technical shortcomings? And is it necessary to invoke a neurological lesion—or, indeed, any lesion—to account for them?

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Anaesthetists' Joint Working Party on Hospital Building Programme

SIR,—This Joint Working Party has been established by the Faculty of Anaesthetists of the Royal College of Surgeons of England and the Association of Anaesthetists of Great Britain and Ireland with the objective of "ensuring that anaesthetic requirements are taken into consideration in proposed hospital building programmes related to the Department of Health and Social Security (DHSS)." The composition of the working party is: Dr T B Boulton (chairman), Professor A R Hunter, and Dr H T Davenport (representing the faculty); Dr E B Lewis and Dr J M B Burn (representing the association); and Dr A Hind (co-opted to represent the DHSS).

The working party is currently establishing itself as the channel by which the interests of anaesthetists in the field of hospital building can be represented and supported at all levels in the National Health Service. It is preparing recommendations for the revision of the 1971 Design Guide *Anaesthetic Services in District Hospitals* (DHSS JH48/83) and is urging its universal application in future planning. It has been established that Design Guides now have the same authority as the Building Notes which preceded them, though some authorities seem reluctant to accept this interpretation of central DHSS regulations. The working party also intends to review all Building Notes and Design Guides relating to operating theatre suites, recovery rooms, intensive care areas, etc, and would welcome constructive suggestions.

The chairman and members of the working party would be pleased to advise and lend their support to individual departments of anaesthesia concerned with ensuring that the interests of anaesthetists are fully served in planning and constructing new buildings or reconstructing old ones.

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Mobility and the disabled

SIR,—As a disabled driver (RAF war pensioner) who has been involved in a variety of campaigns and investigations concerning mobility for disabled persons I write to say that I am appalled at some comments regarding "outdoor transport" in your leading article "Mobility and the disabled" (18 March, p 672).

At a time when practically all organisations (including the newly formed Motability Organisation) representing disabled drivers agree that the vital vehicle requirement is a four-wheel two- to four-seater car it is most

regrettable that the medical profession's journal should publish a leading article containing comments which are bound to give encouragement to that body of 19th-century opinion in the Department of Health and Social Security prepared to condemn disabled persons, able to drive, to be second-class citizens with their isolation still further confirmed by restricting their mobility to a "solo vehicle" that is cheap; while your repeated reference to a "motorised wheelchair"—in other words, great-grandfather's Bath chair with some form of power—is an insult to disabled drivers at the close of the 20th century when all the wonders of electronics are available to Government to produce a four-wheel car that at the very least is a two-seater. As for your comment on the need for something cheap to ensure its appeal to the DHSS, this makes sorry reading for disabled pensioners who see the Treasury able to afford huge sums to help subsidise ventures in various Marxist countries in direct competition with Britain's economic interest.

Your article gives rightful prominence to the need for recognition by local authorities for house adaptations to suit the disabled, but, although stressing the need for such changes to be "high on any list of sociomedical priorities," it makes no mention of the rights of disabled persons to have the validity of their opinion acknowledged at governmental and local authority levels.

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*A four-wheeled two- or four-seater car might be ideal for some disabled drivers, but there is also a need for a form of solo vehicle for people to get about in their immediate neighbourhood. Not everyone is capable of driving a car, and a slower, safer, more stable vehicle would fulfil an undoubted need. Furthermore, there is no possibility of providing expensive and advanced equipment on demand for large numbers of disabled people; cheapness does not imply second rate, but it does mean that the vehicle can be made available to all who need it.—ED, *BMJ*.

Cervical "erosion"

SIR,—Dr M J Goldacre and his colleagues (25 March, p 748) have by careful study confirmed what many gynaecologists have long taken for granted, that the common cervical erosion is not a lesion. The term is also, as they said, misleading and I wish they had gone further and suggested an alternative—what about "mucosal ectopy"? The only things to be said for "erosion" are that it is established by usage and there seems to be no alternative as brief. Unfortunately, prolonged usage has not altered the common meaning of the word for patients, nor indeed for many doctors. Thus patients are frightened by what sounds like an ulcer (and some are aware of the euphemistic use of *that* term) and doctors still frequently refer women without relevant or even any symptoms to gynaecologists because of cervical "erosion."

Some may argue that they would not want their alertness to the possibility of cervical carcinoma dulled by complacency towards any apparent lesion. However, even if they feel the need for a specialist opinion there is no need to frighten their patients by spurious terminology. In any case, in the absence of

bleeding and given normal cytology the possibility of cervical carcinoma can be ignored.

Although endocervical mucosa is exposed owing to ectropion, it is much more commonly exposed owing to differential growth of the underlying parenchyma, which effectively rolls the epithelium outwards from the external os. This is presumably hormone mediated, being commonest and most florid in pregnancy, and also common during oral contraception, as Dr Goldacre and his colleagues showed. "Mucosal ectopy" would seem an appropriate term to describe this condition, but perhaps someone could suggest a better and simpler alternative.

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Complications of radiculography

SIR,—We were interested to read the report by Dr J B Eastwood and his colleagues of bilateral central fracture dislocation of the hips following radiculography using meglumine iocarmate (Dimer-X) (18 March, p 692). Although we have never seen such a dramatic complication as this, the very high percentage of minor but distressing complications, in particular persistent headache, has led us largely to abandon the procedure in favour of ascending lumbar venography.¹ This is a simple and reliable technique which does not involve thecal puncture and which can be used on outpatients. It also gives information about lesions that are some distance from the dura and will, for instance, help in the diagnosis of lateral disc protrusions as well as deciding whether an observed congenital or traumatic abnormality is, in fact, responsible for the symptoms.

The major drawback is gaining familiarity with the radiological appearance, but this can be rapidly achieved, especially as it is not necessary to admit the patient and hence can be contemplated earlier in the management of patients with back pain.

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¹ Clarke, A K, *et al*, *Rheumatology and Rehabilitation*, 1977, 16, 83.

Do people smoke for nicotine?

SIR,—Mr R Stepney (8 April, p 922) should beware of trying to use secular changes in cigarette consumption to give information about changes in individual smoking habits. The annual consumption per adult smoker over the 25 years 1950-75 does not describe changes in smoking habits in the same smokers but just a composite effect of all sorts of changes in a radically altering population of smokers. During this period older female smokers were dying off and being replaced by younger, heavier smoking women. At the same time many men were stopping smoking, but these tended to be lighter smokers. Thus the average consumption per smoker inevitably increased, regardless of whether or not the

persisting heavier smokers increased their consumption. Maybe they did. We just don't know.

Observation of small numbers of smokers exposed without their knowledge to changes in nicotine intake does show that abrupt, large reductions of nicotine are followed by an increased consumption, but smaller changes, as from 1.4 mg to 1.0 mg of nicotine per cigarette, are not.¹

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¹ Freedman, S, and Fletcher, C M, *British Medical Journal*, 1976, 1, 1427.

Hazard of chemical sympathectomy

SIR,—We feel it would be unfortunate if those who wished to perform chemical sympathectomies were led to believe that the procedure should only be done under radiological control, as suggested by Drs A P Rubin and B R Master (25 March, p 790). Not only is it frequently difficult to organise the use of an image intensifier, but we feel it is unnecessary. Using a method similar to that described by Mehta¹ we have done 287 cases and have not so far encountered any significant sequelae apart from two patients who developed neuritis of the thigh. Whatever technique is employed, it is important for the needle to be deep enough to avoid injecting near somatic nerves or into the substance of the psoas muscle.

Employing Mehta's technique it is virtually impossible to be sufficiently posterior to enter the intervertebral foramen or puncture the dural cuff. Even if one is doubtful about the position of the needle tip many radiologists would feel that Conray 280 is not without hazard if injected into the subarachnoid space.

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¹ Mehta, M, *Intractable Pain*, p 213. Philadelphia, Saunders, 1973.

Place of ultrasound and radiography in obstetrics

SIR,—I am afraid that Dr H B Meire and his colleagues (8 April, p 882) are not getting the proper benefit from radiographing fetuses if they merely look on the result as a means of measuring the conceptional age of the fetus.

Ultrasonic and radiographic fetal maturity assessments are measuring different aspects of the baby's development, one the body or head size, and the other the bone age. The relationship of these parameters of gestation to each other and to the other parameters has been discussed; the variations in their relationship to each other is an important indication of the presence and severity of fetal disease.¹ Indeed a considerable portion of antenatal care is given over to searching for differences in the various assessments of fetal age. Merely because they are measured in the same units—weeks of gestation—does not indicate that they are measuring the same entity. Radiological and ultrasonic assessments are therefore complementary to each other, and should not be regarded as supplementary.

It was interesting to note that the ratio of ultrasonic scans to radiography in this series