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