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