

from pedal top to saddle top should be 109% of the inside length of the lower extremity, measured from groin to floor (*American Cycling*, June 1967, p 12). For safety, at least 2 in of seat post should be left inside the tube.

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Hazards From Bicycles

To the Editor.—The illustrations in the article by Dr David Furnas entitled "Ten Speed Bicycles and Shoulder Bags" (236:2318, 1976) shows another danger. There are no lights, front or back, on the bicycle shown.

With the medical profession encouraging daily exercise by older people, bike riding after work and therefore after sundown is on the increase. To prevent accidents, why aren't manufacturers required to paint bicycles with fluorescent paint or to have lights or reflectors at the front, back, and sides?

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To the Editor.—The accident described by Dr Furnas can also be caused by a rider carelessly driving over a piece of wood, which can get thrown into the spokes of the front wheel with potentially disastrous results. I was personally involved on the bottom of a four-bicycle pileup as a result of this. It was only by the greatest good fortune that the whole pile of us was not run over by automobiles.

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Adhesion of Malignant Cells to Capillary Endothelium

To the Editor.—In a recent clinical report (235:2825, 1976), Li and Ross indicate that cells from solid tumors that escape into the general circulation either perish or remain dormant until they have achieved attachment to the endothelium of the capillary wall with the assistance of a fibrin clot. Our laboratory studies indicate this observation to be correct but incomplete.

The known adhesive properties of fibrin and its continuous presence in the blood make it a logical agent to bind the malignant cells to the endothelium walls. However, it is important to point out that the adhesiveness of fibrin is a function of its surface-active properties. Thus, we

have observed that a number of endogenous surface-active molecules (such as lecithin), as well as macromolecules (such as the mucopolysaccharides and albumin), are also capable of adsorbing onto cell surfaces and forming films that adhere readily to adjacent surfaces. These surfaces can be the surfaces of other cells or the surface of the endothelium.^{1,2}

A critical step in the metastatic process is the adhesion of the malignant cell to the capillary surface. While fibrin can accomplish this step, high concentrations of any macromolecule or surface-active agent can also initiate and maintain the process of adhesion. This fact may have important implications for the process of metastasis, given the evidence that membranes of cancer cells have been reported to contain high concentrations of molecules that have surface-active properties.¹⁻³

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1. Riley V: Breast cancer patients: Substance in blood causing acceleration of erythrocyte sedimentation rate. *Science* 19:86-87, 1976.

2. Ecanow B, Gold B: Erythrocyte sedimentation rates and malignancy: Role of age and erythrocyte aggregation. *Science* 193:919-920, 1976.

3. Nicolson G, Poste G: The cancer cell: Dynamic aspects and modifications in cell surface organization. *N Engl J Med* 295:197-203, 253-258, 1976.

Allergy to Mace

To the Editor.—Dr Frazier's article (236:2526, 1976) is not the second reported instance of allergic contact dermatitis to chemical mace. In 1969, we reported several cases of allergic contact dermatitis to chloroacetophenone, the active ingredient in chemical mace.¹ Furthermore, we evaluated the sensitizing potential of this compound and studied cross-reactivities to related chemical compounds. We agree with Dr Frazier's conclusions that physicians should be aware of this undesirable complication which may be associated with the use of chemical mace.

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1. Penneys NS, Israel RM, Indgin SM: Contact dermatitis due to 1-chloroacetophenone and chemical mace. *N Engl J Med* 281:413-415, 1969.

To the Editor.—The brief report by Dr Frazier was an interesting description of an unusual contact dermatitis. However, it was not the second recorded case, as was suggested. Sev-

eral similar cases have been described. Although I have not attempted a detailed search of the literature, I am aware of the following three references which Dr Frazier might find interesting:

1. Penneys N, Israel RM, Indgin SM: Contact dermatitis due to 1-chloroacetophenone and chemical mace. *N Engl J Med* 281:413-415, 1969.

2. Penneys N: Contact dermatitis to chloroacetophenone. *Fed Proc* 30:96-99, 1971.

3. Maibach H, Marzulli F: Allergic sensitization potential of riot-control lacrimants: Human draize test. *Contact Dermatitis Newsletter* 9:209, 1971.

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Let's Do Away With CVA

To the Editor.—I read the suggestion of Dr Lester Adelson, "Let's Do Away with CVA" (236:2390, 1976). I am in full agreement that the actual semantics of the terminology is indeed bad: the anatomical lesion should be described in the nomenclature.

However, worse than the semantics of the problem is the medical implication. This usually is an "end-all" to further diagnostic procedures and therapy. It has been pointed out in several publications that the terms "stroke" or "CVA" are cover-ups for lesions that are amenable to current techniques of surgical therapy. In a random review of 276 hospital admissions, 46% of patients with this initial diagnosis were found to have surgical lesions.¹

I think this needs to be pointed out again and again so that cases of patients with abrupt onset of neurologic deficit will be investigated thoroughly and managed adequately.

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1. Raskind R, Weiss SR: Pathologic diagnosis of stroke. *Angiology* 20:224-235, 1969.

CORRECTION

Living Physician.—The report of death on Padma Vaidyanathan was incorrect in the Jan 3 OBITUARIES (237:70, 1977). Dr Vaidyanathan is alive and lives in Richmond, Va.