whose ostensible aim is to promote "responsibility."

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Housing, health, and illness

SIR,—The data from Mr H F Thomas and Dr J W G Yarnell (29 July, p 358) suggest that medical intervention in housing in Oxford (8 July, p 100) is comparatively ineffective and, presumably, inefficient. Before raising the question of the extent to which housing should be medicalised, I would like to comment on the possible meanings of the data presented. In Oxford, medical points account for about 5% of the points level of the qualifying threshold for housing from the waiting list, whereas they account for over half the level of the qualifying threshold in some of the Welsh authorities cited. It is possible that this is due not to any lesser respect for medical opinion in Oxford but to the fact that the city of Oxford is politically evenly balanced. Neither party predominates and, in my opinion, because of this a system has evolved in which the housing need of applicants is considered principally on falsifiable criteria—for example, the size of the rooms they occupy and the number and age of their children. There is little scope for discretionary assessment of need or "merit" for housing by individual councillors, housing managers, and medical advisers. The time which will elapse before an applicant is rehoused is therefore determined mainly by criteria which have been debated and agreed by both political parties and published for all applicants to consult. Could it be that those authorities in which the power of medical discretion was great were one-party councils in which there is greater discretion of all sorts?

The cases taken to committee can be regarded as those in which medical points accounted for 100% of the number required to qualify for housing. The opportunity to bypass the points system completely is useful not only because some cases occur which required immediate action, but also because it gives me a valuable chance each month to discuss cases, policies, and principles with councillors.

The points raised by Dr F J G Lishman (5 August, p 431) are valid, but I still do not think that I could grade "urgency" with confidence after a single home visit. The family knowledge that their chance of rehousing was a function of the degree of urgency they presented to a visitor means that such knowledge could never be objective. In my opinion such visits introduce other personal relationships and therefore other biases into the assessment.

That my observations are inferences and limited, as Drs D S Pickup and S Moolerjee suggest (5 August, p 431), is correct, but I hope they are valid, for all inferences are limited. The number of mental health cases dealt with has decreased over the years as the social services department now has the right to bring cases to committee, a progressive move by the city of Oxford which has demedicalised one aspect of housing need. It is interesting that the proportions of cases helped in Liverpool and Oxford are so similar, perhaps because of the equal political balance in both cities.

Would I not like more power? Should I not be using all the Aesculapian authority I can command to advance those cases referred to me as vigorously as I can? I think my answer to both questions is no. One reason is that even the system of self-referral employed in Oxford does not ensure that all the applicants with medical problems are known to me. No individual can identify all the possible need in his catchment area, but rather than devote more energy to the promotion of those cases known to me, which may be strong cases or may be cases with strong advocates, I am trying to identify more of those in need. Some applicants have no advocates at all. There are families in every city centre who are neither registered with a general practitioner nor literate. Also, I believe further medicalisation of housing is inappropriate in the city of Oxford. Housing need is not an illness; it is a human predicament which can be assessed as well by elected representatives and housing managers as by someone who has had a medical training. There is a continuing need for medical influence on cases and policy, but the form of that influence should be a function not only of possible relationships between housing conditions and the development of illness, but of the particular social and political context in which a community physician is working.

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Prevalence of anorexia nervosa

SIR,—In your Parliamentary news (15 July, p 213) you quote statistics concerning the prevalence and recorded mortality of anorexia nervosa. You report that "the prevalence of anorexia nervosa is about 1 per 100 of 16 to 18-year-old girls" and list the recorded deaths as ranging between 21 and 26 per annum in the past five years. These figures were produced by the Health Minister, Mr Roland Moyle, in reply to questions following a statement made in the House of Commons in which concern was expressed at the apparent increased incidence of the condition in recent years and the inadequacy of treatment facilities. The Health Minister apparently advanced the mortality statistics as evidence that there was no such increase.

I think it likely that the stated prevalence statistics derive from our own study,¹ which in fact revealed that the prevalence among 16 to 18-year-old schoolgirls was 1 per 200. It was 1 per 100 for those in the independent sector of education and 1 per 330 in the comprehensive sector.

The recorded mortality figures are misleading. Firstly, deaths from anorexia nervosa usually occur after five or more years of illness. A recent increase in incidence would therefore not yet be reflected in an increased mortality. Secondly, deaths in people with anorexia nervosa are not often recorded as caused by anorexia nervosa. Such people may have successfully concealed their condition to the last. Even if it is evident, then death may still be recorded as occurring only from suicide (the common cause of death in people with anorexia nervosa) or from one of the physical complications of the condition.^{2,3} Two patients with severe anorexia nervosa attending our clinic have died within the past few weeks. In the first death was recorded as

due to carbon monoxide poisoning. In the second it is likely that a similar cause will be recorded.

In the past few years this unit has received between 12 and 20 new requests per week to see patients thought to have anorexia nervosa. In the event we can take on one new such patient and her or his family per week, bearing in mind the intense and protracted treatment programme that usually stems from such consultations. Many people now hold the view that anorexia nervosa is becoming more common.

About four years ago two of us approached the Department of Health with a proposal that more extensive specialised services were needed for the treatment and management of this condition, but to no effect. People with anorexia nervosa, reluctant patients at the best of times, often continue, like alcoholics, to ricochet around the general medical and psychiatric services as and when they experience crises in their condition. In my view the problem has become much greater in the last few years because of the increased incidence, and the Health Minister would be well advised to reconsider the matter.

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¹ Crisp, A H, Palmer, R L, and Kalucy, R S, *British Journal of Psychiatry*, 1976, **128**, 549.

² Crisp, A H, *Proceedings of the Royal Society of Medicine*, 1977, **70**, 464.

³ Crisp, A H, *Proceedings of the Royal Society of Medicine*, 1977, **70**, 686.

Disodium cromoglycate ointment in atopic eczema

SIR,—Disodium cromoglycate (DSCG) is an effective inhibitor of IgE-mediated hypersensitivity reactions and has been used with success in patients with respiratory hypersensitivity of the type III as well as type I category.¹ More recently the use of topical 10% DSCG ointment in atopic eczema has been proposed, and a randomised double-blind trial of this treatment in 21 children with atopic eczema revealed a significant suppression of pruritus in patients receiving the active preparation, which was followed by improvement of the eczema.² However, the children studied in this trial had changes mainly confined to the skin of the limbs, with little or no involvement of the face and trunk. The response of more severe forms of atopic eczema of the type routinely referred to a dermatological clinic was therefore of interest.

Eleven patients (eight male) ranging in age from 13 to 38 (mean 20) years were studied. Only inpatients with eczema of moderate or severe degree who had given informed consent were admitted to the study. Six of the patients had associated asthma and had benefited from DSCG inhalation for this complaint. Each patient was allocated two outwardly identical tubes of ointment (white soft paraffin with 10% w/w DSCG or white soft paraffin alone), one marked for the left side and one for the right side, to be applied to affected areas twice daily for four weeks. The application was randomised so that some patients treated their left and some their right sides with the active ointment. The contents of the tubes were unknown to either the patient or the clinician. During and after a run-in period of five days, during which all previous topical therapy was stopped, the patient kept a diary of itching on both sides of the body and the clinical responses of the two sides were assessed weekly by the clinician and by the patient.