fore be used when a beta-blocking agent is required in diabetics prone to hypoglycaemia. However, with these drugs also patients should be informed that institution of treatment may modify the normal hypoglycaemic symptoms. Additionally, until further experience has been gained we think that special care should be exercised with any of these drugs in diabetics with clear autonomic neuropathy, where both symptoms and recovery may be further compromised.

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Anorexia nervosa in diabetes mellitus

SIR,—Further to the reports of anorexia nervosa in diabetics by Drs C G Fairburn and J M Steel (10 May p 1167) and Dr Joan R Gomez (5 July, p 61) I submit the case of a 20-year-old girl.

Insulin-dependant diabetes was diagnosed in 1973 at 13½ years. She menstruated regularly from 14 years, when her weight was 44½ kg. In 1976 frequent ketonuria was noted and she admitted to reducing her insulin to control her weight. In February 1978 she was started on phenytoin 100 mg for symptomatic nocturnal epilepsy. In January 1979 her weight had fallen to 38.5 kg (expected weight 52 kg). She admitted that this was due to dieting and adamantly refused admission as her skeletal appearance was "about right." She had last menstruated in May 1978, when her weight was 51 kg. In April 1979 she was admitted in severe ketoacidosis. The diagnosis of anorexia nervosa was guarded because of the diabetes and "epilepsy." She was managed with a high-dose insulin regimen but not confined to bed. Initially frequent hypoglycaemic attacks occurred and it was noticed that she disappeared into the toilets immediately after meals "to test her urine for sugar." She was discharged with no recorded weight gain. A further four episodes of ketoacidosis occurred in 1979, each seeming to follow a record of weight gain in the clinic. She complains of

frequent hypoglycaemia, which she confirms with Dextrostix. Reductions in insulin dosage have therefore been condoned despite clinic Dextrostix readings in excess of 22 mmol/l (400 mg/100 ml). HbA_{1c} ranges from 10.1% to 15%. Her urine contains little sugar and she is suspected of diluting the samples. She remains underweight at 46 kg and amenorrhoeic (see figure), is single, and lives with her parents, but does have a boyfriend.

Reluctance to diagnose anorexia nervosa in the notoriously difficult young female diabetic may contribute to the infrequent reports.

I thank Dr R de Mowbray for permission to report this case.

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Site of action of intrathecal morphine

SIR,—May I somewhat tardily comment on your correspondents' responses (27 September, p 870) to my previous letter (6 September, p 680)? Dr P J W Knell's suggestion that the hyperbaric solution of morphine which we injected intrathecally did not reach the target sites in the spinal cord is reasonable, although I would have anticipated that the lower sacral segments would have been blocked; yet this was not the case. Anticipating Dr Knell's idea, in our own investigation (report awaiting publication) we injected morphine (2 mg in 10 ml) extradurally via a cannula inserted through the T10/11 interspace, yet still failed totally to relieve the pain of labour.

Dr Jacobson's letter reiterates one of the more pressing arguments favouring the spinal cord as the site of action of intrathecal morphine—namely, that opiate receptors have been identified in the spinal cord. This has never seemed to me to be a very convincing argument, as it assumes that narcotics, when attached to these receptors, necessarily effect a classical "opiate" activity. The suggestion becomes even more tenuous in the light of recent publications. It has been demonstrated¹ that there are receptors to opiates and opioid substances (including naloxone) in the placenta and in the hypophyseal-hypothalamic region,² and indeed that the placenta synthesises endorphins.³ It is beginning to look as though there are cell membranes which contain specific receptors for narcotics scattered throughout the body. Possibly it will emerge

that endorphins are analogous to substances like the prostaglandins, having a multitude of functions depending on the exact configuration of the molecule and on the identity of the target cell. If such is the case, opiates—the analogues of endorphins—will act in accordance with the local situation, and in the case of the spinal cord they might well not be acting as depressants of pain impulses. The onus remains with others to confirm that intrathecal (or extradural) morphine exerts analgesic activity at spinal cord level rather than in brain.

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Community medicine—a second chance?

SIR,—Your leading article (27 September, p 826) raises a number of important points and I hope that, together with the recent report of the joint working party, it may stimulate some necessary change.

I believe that there are two key issues in community medicine today: firstly, the question of administrative and technical support and, secondly, the danger of professional isolation of those working in community medicine. Given adequate recourse to a good information unit and to the general administrative system much can be achieved, but these things are not adequate on their own. Community medicine specialists need to have secretarial, administrative, and research services accountable and responsible to them and not to anybody else. The total resources do not need to be great but they do need to exist. Without them the practice of the specialty will become ineffective and this will inevitably result in low morale and an inadequate advertisement of the subject to clinical colleagues and to other professionals in the Health Service. Would-be entrants to the specialty could scarcely be blamed if they did not wish to continue their studies in a specialty which achieved little and offered less. Professional isolation can be overcome provided the danger is recognised. Community medicine specialists need the stimulus and even the irritation of professional conversation with colleagues in the same specialty. The formation of departments of community medicine, providing they are adequately serviced and supported, and provided they can be motivated not to self-destruct, will do much to improve the situation.

Outside the specialty, two bodies could help to improve the situation. Regional health authorities should provide the stimulus and opportunity for regional meetings of community medicine specialists, to be held on a routine basis, and indicate that it is expected that such meetings are supported. The British Medical Association should publicise those health authorities that decline to provide adequate support for community medicine, and if this has no effect use the mechanism of the "important notice" procedure in the advertisement section of the journal.

Consideration could also be given to more firmly establishing district community physicians as the physicians with overall

Patient's clinic record.

Conversion: SI to traditional units—Glucose: 1 mmol/l = 18 mg/100 ml.