The extent of swelling is variable. If the joint is distended with blood there can be no complete capsular tear. Conversely, with a complete rupture there may be little joint fluid because it has escaped. Visible bruising is uncommon with simple meniscal tears and indicate capsular damage.

MINOR LIGAMENT SPRAINS

Minor ligament sprains can be treated conservatively but the position of immobilisation is important. The medial and lateral ligaments are taut in extension and relaxed in flexion: therefore the correct position for immobilisation is in about 30° of flexion. Ligaments will heal if immobilised in extension but with inevitable lengthening and hence some degree of instability.

Sometimes people are concerned because of the length of time for recovery of full knee movement after ligament injuries treated surgically or conservatively. It is best that recovery is slow, for rapid recovery means repair with lengthening. We forget that a ligament glides over bony surfaces near their attachment, and this cannot take place until full healing.

INSTABILITY

Late cases of instability are common. In some of these the injuries have been missed. In others primary repair has achieved only limited stability. Not all of these need surgical treatment, and building up the thigh muscles with physiotherapy may suffice. Considerable interest and ingenuity have been used in attempts at surgical correction of this problem. Repair procedures are undertaken according to the type of instability rather than for a named ligament rupture. It may be stated with some confidence that late anteromedial and anterolateral instability are correctable, but late cases of posterior cruciate and pure lateral ligament instability cannot be repaired with confidence.

Before any consideration of late ligament repair possible meniscal damage must be investigated and treated. The commonest cause of knee instability is a torn cartilage, and once this is removed sometimes the dynamic stabilisers control a knee sufficiently for the patient's needs.

A joint that is unstable for a long time will develop degenerative changes. Recurring abnormal movement and abnormal pressure from deformity cause articular cartilage damage. Ligamentous knee joint injuries are serious, and the more severe injuries cannot be repaired to give more than a good result. Many of them can be described only as fair. Inevitably this raises the question of the relative merits of conservative treatment for all cases and surgical treatment for all complete ruptures. The balance strongly favours surgery improving a result when complete rupture has been diagnosed correctly and the surgical repair has been thorough.

Medicine in Society

Self-help society for eczema sufferers and their families

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It is easy to see why self-help societies for the chronically ill and their relatives have grown up in Britain. One guide[1] lists over 50—for diabetes, spina bifida, Friedreich's ataxia, migraine, and almost any disease you can name. As acute illness has been treated more successfully and the complications of chronic illness reduced, patients have taken more notice of the problems that arise from their trying to lead normal lives. Fellow sufferers may often understand these problems better than a doctor. At the same time articulate patients and the parents of sick children have become less passive, more concerned to understand their illnesses, to participate in treatment. Mass communication has given them opportunities to contact others. How, then, are these self-help societies formed and how do they work? The history of the eczema society may not be typical, but it sheds light on many aspects of the relation between self-help societies and health professionals.

The National Eczema Society

Eczema affects about 4% of the population and accounts for most of the 10 million prescriptions written in England each year for topical steroids. It attacks mostly (and most severely) very young children. Typically, a young mother has to organise special clothing, feeding, playing, house-cleaning, and bathing, as well as the treatment the doctor may order.

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Christine Orton, whose 8-year-old son had suffered from eczema since infancy, wrote about him in the *Guardian* in May 1975. (A newspaper's help is important for a self-help group, and credit should go to one that gives it; some popular dailies later refused to write about eczema.) In passing, Mrs Orton wrote, "Perhaps we should form a society for sufferers and their relatives." This sentence provoked hundreds of letters from patients, parents, nurses, doctors, and a dermatologist who ran regular family therapy groups. Drug manufacturers wrote to her about steroids. The National Council of Social Services (NCSS), a government-financed organisation experienced in getting charities and self-help groups off the ground, sent an offer of advice and facilities. So in July last year a group of 55 people met at the NCSS in London. They formed local groups to plan recruitment, appointed a steering committee to organise the National Eczema Society, and donated £70 towards it.

ISOLATION AND EMBARRASSMENT

It was a relief to see how few the cranks and inveterate doctor-bashers were. A few stood up at the first meeting to extol vitamin X or litigation against dermatologists, but most wanted to co-operate with doctors and drug companies. What became

apparent was the isolation that families felt. Sufferers found for the first time how similar their problems were: the unremitting irritation to the patient and everyone around him, the guilt of parents who could do nothing to control the disease, the insomnia, the distress caused by the sight of a suffering child, the pain caused by contact with many household objects, and the physical restraints that tight and dry skin imposed.

Many of these observations are commonplace to doctors, yet patients and relatives found reassurance in being able to share them. Social problems were shared, too. For example, teachers sometimes segregate children as if eczema were infectious. Adult sufferers have difficulties in occupations such as catering and modelling, and they may not take holidays because treatments can mess up bedclothes or because swimming costumes may expose affected skin that is usually concealed. Boyfriends, girlfriends, husbands, and wives are often embarrassed by eczema, and this may lead to sexual problems.

THE SOCIETY'S AIMS

A self-help society has to develop both as a central organisation and at the grass roots. A steering group can formulate policy while local groups keep supporters in touch in the early months. By November 1975 a second meeting was able to adopt a constitution, drawn up with the help of the NCSS and the Psoriasis Association. The new society's aims were spelt out: to speak on behalf of sufferers and their families, to dispel ignorance by talking to government bodies, clubs, charities, health authorities, colleges of education, and through the mass media to the public; to support and suggest research and raise money for it; to collate and co-ordinate patients' experiences and medical views; to disseminate information on practical and emotional problems; to press for reforms such as free prescriptions for adult chronic sufferers; and "to give solace and relieve isolation."

Professional support

Professional support is essential for such a group. Consultants attended the November meeting, and, at a day conference in May 1976 to celebrate registration with the Charity Commissioners, lectures were given by a dermatologist—Dr K Sanderson, of St George's Hospital, London—and an immunologist—Dr J Brostoff, of the Middlesex Hospital. Dr C Vickers, of Liverpool University, will speak at the next conference in Manchester this November. Consultants helped to prepare a pamphlet, *What is Eczema?*, and contributed to the Society's quarterly magazine *Exchange*, which members receive as part of the service provided for the annual subscription of £3.

The National Eczema Society now has many hundreds of members. People have been referred by doctors or collected through publicity in the *Guardian*; other national, local, and even foreign newspapers; women's magazines; and programmes on both television channels and several radio stations. Members automatically belong to one of the 25 local groups, covering much of the British Isles. New groups are being set up about once a fortnight. Their activities depend on the members. Some find that simply exhanging problems can become demoralising, so most meetings now have a talk from a dermatologist, a general practitioner, a pharmacist, or a speaker from another interested profession, followed by questions and a discussion. Some, however, still like to be able to talk about the recurring crises in health. A few have arranged information sheets about local shops selling non-allergenic goods and even provide babysitting services.

The relationship between the National Eczema Society and doctors is excellent. Some clinics and general practitioners routinely refer patients to their local groups for support. This overcomes the social and geographical bias inevitable if publicity is occasional and selective. The society make it clear that it cannot offer individual medical advice, but doctors are finding that the groups can manage social problems satisfactorily. For example, one group improved relations between a boy's parents and his teachers and avoided his imminent referral to a special school.

Pressure group

Nevertheless, no self-help society can remain ignorant of the darker side of medical practice. The national secretary receives 100 letters in an average week, and half report what seems to be a justifiable cause for dissatisfaction. The most common complaint is that doctors treat the skin but are reluctant to talk about social and emotional difficulties—out of insensitivity or the well-meaning belief that it is therapeutic to play these down, or because the high rate of spontaneous remission makes eczema seem trivial. Some general practitioners refuse to refer patients to hospital, even though many dermatologists believe that all chronic cases should be managed with consultant help. There is widespread medical ignorance about safe doses and steroid-sensitive areas like the face and eyes, and the manufacturers' leaflets are lacking in this respect, too. By distributing information about the best medical care any self-help society inevitably increases dissatisfaction with some doctors. Members will want to act as a pressure group where harm or insensitivity is found. But, if the experience of the National Eczema Society is representative, they will do it with the support of doctors and other health workers who are pressing for a rise in standards. By attracting the interest of those most affected, they can raise money and mobilise research to make advances against the disease itself.

Information is available from Jill Westgarth, honorary secretary, the National Eczema Society, 27 Doyle Gardens, London NW10 3DB. She asks doctors to send a 10p stamp with their inquiries. I want to thank the officers of the National Eczema Society for their help, especially Ann Oree (group co-ordinator) and Christine Orton (press officer).

Reference

[1] *Health Education Index and Guide to Voluntary Social Welfare Organisations*. London, Edsall, 1976.

Have any tests been made on the possible carcinogenicity of sodium cromoglycate?

Formal carcinogenicity studies on sodium cromoglycate (SCG) with exposure by the appropriate (inhalation) route have not been carried out. Carcinogenicity tests in hamsters and mice with administration via the intraperitoneal route have been briefly reported[1] as showing SCG to be free of carcinogenic potential. SCG given by this route is known to be distributed to the lung, from which it is rapidly cleared in the plasma. In so far as some carcinogens are also teratogens, teratogenicity tests in rats and rabbits gave negative results. Also since carcinogens tend to be mutagens it is significant that no mutagenic effects were found in a range of tests with yeasts, bacteria, and human peripheral lymphocytes. The results of studies lasting up to one year in squirrel monkeys[2] caused no concern as to possible carcinogenicity, but in rats renal tubular lesions at high-dose levels have been studied further. No suspicious effects were seen in 82 children aged 6-18 years treated with the drug for three or more years.[3] Also, since only a little of the inhaled dose reaches the lung, from which the drug is rapidly cleared unmetabolised, there is small opportunity and little likelihood of accumulation in that organ. It seems, therefore, unlikely that treatment with SCG entails any hazard of carcinogenicity.

[1] *Intal*®—*Cromolyn Sodium*, p 78. USA, Fison's Corporation, 1974.
[2] Procter, B G, *et al*, *Toxicology and Applied Pharmacology*, 1973, **25**, 479.
[3] Smith, J M, and Pizarro, Y A, *Clinical Allergy*, 1972, **2**, 143.