often quick to ascribe to the phenomenon all their ails, from asthma to zoster. Although most general practitioners would support their patients' claims, if only on aesthetic grounds, scientifically based evidence on the adverse effects of damp housing on health is hard to come by.[1]

## 'Bad' smells

The dirty-smelling house, with odours from different sources such as sweat, stale cooking and decaying food, may be of medical significance in several ways. Some general practitioners include these malodours in an index of their patients' inability to cope—an important consideration for example in interpreting the urgency of a house call, and in making management decisions regarding the prescribing of drugs or continuing to look after an ill patient at home.

The presence of children of preschool ages may add a contribution, and with windows tightly closed against the night air the atmosphere soon becomes fetid. Its impact is unforgettable and to the doctor, making an out-of-hours call for a minor malady, has added significance.

The odour of incontinence of urine has a sweetish component which differs from the more offensive malodour of urinary tract infection. These smells, usually more directly related to individuals and their clothing, may permeate a house. Once a distressing feature of institutions for the care of the elderly; nowadays they have been rendered less obtrusive.

The truly impoverished household may be characterized by odours from other sources, including various infestations such as bed-bugs, fleas and lice.[2] Such a combination of smells is remarkable in two respects. Though the smell may be overpowering at first, one quickly becomes acclimatized: after initial contact, the smell may cling to one's clothes for several days.

The malodours described above may be of significance in themselves—and so may be a *change* in the household smell. Detecting malodour for the first time in a house previously known to be odour-free may provide the doctor with additional evidence to corroborate suspicions of incipient senile dementia or depressive illness.

Health hazards associated with urea formaldehyde insulation have recently been in the news. Under certain conditions the chemical may give off an unpleasant odour. Whether this may cause illness is still open to question.

Household pets may add their contribution and the sense of smell might prompt the doctor to consider the possibility of one of the zoonoses in appropriate circumstances. Such a smell may also indicate poverty or possibly diminished social responsibility, for example in the household with the peculiarly pungent smell of a tomcat which has not been taken to the vet to be neutered.

On the other hand, a spick-and-span household fragrant with furniture polish and perhaps with a hint of antiseptic may betoken more than just the houseproud: is there a possible obsessional neurosis in the offing?

## Conclusion

Cleanliness, it may be, is next to godliness. At the same time, perhaps our society's preoccupation with BO, HO and deodorants contains a denial of individuality. Life would be a lot duller without smells, good and bad, and as doctors we would be the poorer. An assault on the nostrils can open the eyes!

**References**

1. Gray JAM. Housing, health and illness. *Br Med J* 1978; **2,** 100-101.
2. Cotterill JA. (1983). Nose in diagnosis. *Lancet* 1983; **1,** 293.

# LETTERS

## Measles Vaccine

Sir,

I refer to Dr A. P. Bennett's letter on the efficacy of measles vaccine (December *Journal,* p. 781). No real comment can be made on the efficacy of the vaccine on the figures presented and certainly the conclusions drawn about 'patchy success rates' are just not possible unless a comparison of the attack *rates* in the immunized and non-immunized groups is made in those exposed to the infection. The comparison of numerators without their accompanying denominators is not helpful and all too common. Attack rates are best demonstrated within schools, or even streets, exposed and containing immunized and nonimmunized children.

The campaign for the elimination of *indigenous* measles in the United States demonstrates dramatically the efficacy of efficient measles immunization. Immunization rates are now 97 per cent for children entering kindergarten or first grade. The number of measles cases in the USA in the first 37 weeks of 1982 was 1,230 compared with 12,843 in 1980 and 53,023 in 1977. The number of US counties reporting measles in the same period in 1982 was 165; 714 in 1980 and 1,429 in 1977. Such a policy will, of course, necessitate the continuation of high immunization levels and effective surveillance systems and responses to the occurrence of suspected cases, since the importation of measles from outside the USA will continue unchanged.

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**Reference**

Centres for Disease Control. *Morbidity and Mortality Weekly Report* 1982; **31,** No. 38.

## Teams for the Year 2000

Sir,

David Brookes raises an extremely important point (February *Journal,* p. 67) when he says that the primary health care team needs to encompass those people who used to work for and from the hospitals, and who have been considered to be ancillary workers in the past. These are nurses of various genres, technicians and the like, whom he strongly recommends to be drawn into the primary care team concept and management to the degree of total involvement. This is correct and praiseworthy, though probably impractical in the light of current medical politics.

However, his closing remarks worry me. He concurs with David Metcalfe's published opinion that 'hospital services are not geared to cope with the primary health care needs of the community and are bound to perform badly because they function best at finding and rectifying pathophysiologi-