ment of treatment of postherpetic neuralgia was 5.7 months for those initially treated with acyclovir and 29.3 months for those not treated with acyclovir. This implies that the patients who had been given acyclovir were assessed at a much earlier stage in their postherpetic neuralgia than the others. This is another factor that might seriously confound the results.

There appears to be a difference in the type of pain reported by the two groups of patients with postherpetic neuralgia. This difference may be due to a number of factors, including those outlined above. It is therefore misleading to state that the differences are due to initial treatment with acyclovir while ignoring other possibilities.

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Differential diagnosis of otitis media and externa

Sir,

I fear Dr Price's letter (August *Journal*, p.349) may cause some confusion in the diagnosis of otitis externa.

Otitis externa is a condition in which the patient complains of itching or soreness rather than pain, with or without discharge from the affected ear(s). Primary otitis externa is almost unheard of in children. Its presentation in adults is almost invariably linked to exposure to conditions of high temperature and/or humidity or else to a history of frequent swimming, previous episodes of dermatitis, and/or trauma, such as from cotton buds, an ill-fitting hearing aid mould or ear syringing. Secondary otitis externa, which is much more common in children than primary otitis externa, may be caused by the external auditory meatal skin becoming inflamed by being bathed in the pus and secretions of suppurative otitis media draining through a tympanic perforation.

Dr Price is correct in observing the fleeting nature of aural discharge in children, rapid resolution with appropriate treatment being the norm, but he is incorrect in asserting that hospital doctors do not see the condition. As a hospital consultant, I can assure him that we do: the young patient is usually referred urgently with a provisional diagnosis of mastoiditis.

Adopting Occam's razor, I would venture to suggest the following as an aide memoire: a history of upper respiratory tract infection followed by aural pain and discharge favours a diagnosis of otitis media with secondary otitis externa. A history of itching or soreness plus discharge favours a diagnosis of primary otitis externa, particularly if provoked by exposure to heat, humidity or trauma. Primary otitis externa tends to be bilateral while otitis media and secondary otitis externa tend to be unilateral. Children tend to suffer from secondary otitis externa while adults tend to suffer from primary otitis externa. It remains most illuminative to examine the normal ear first as a reference point from which to establish the condition of the affected ear.

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Social indicators of health needs

Sir,

The World Health Organization's 'health for all' strategy in 1981[1] ranked health inequalities linked to poverty as an important priority, which has unfortunately not been taken up as a target in the government's white paper *The health of the nation.*[2] Nonetheless, the concept of deprivation allowances for general practice in the 1990 contract for general practitioners is a major step in the right direction. The Jarman underprivileged area score, which is the basis for this, has been widely criticized in its construction, validation and application.[3-6] It was designed as a measure of workload and not deprivation, and it has not been applied in the way recommended by its author.

Because of the problems in its application, adjustments have been made for Wales (taking into account standardized mortality ratios and council housing) and for Scotland (using enumeration districts and the Jarman UPA(8) scores excluding the unskilled factor). It is clear that for England similar adjustments are indicated. Indeed, a simpler method of assessing deprivation at enumeration district level or practice level is needed for the whole of the United Kingdom. The excellent paper from Hopton and colleagues (June *Journal*, p.236) attempted this and suggested in particular, assessment of housing tenure at practice level. Balarajan and colleagues[7] have also suggested a different deprivation index, their main indicators being council housing tenure, access to a car, socioeconomic group and country of birth.

We work on a large post-war peripheral council housing estate in south Bristol and have thought for some time that housing tenure was linked to deprivation. The most disadvantaged (those on low income, unemployed people, young families and single parent families) are housed in the least desirable and least appropriate dwellings, namely the high rise blocks and three storey flats with no lift. Thus the powerless and voiceless are marginalized.

The new data from the 1991 census will soon be available and will necessitate some adjustments to the Jarman index. It is important that at the same time other alterations are made to ensure a more sensitive allocation of resources for deprivation, so they reach those who are disadvantaged.[8] The alternative is to use a simpler practice-based method of deprivation assessment as indicated above.

It is important that this issue is tackled now because many practice populations similar to our own in 'forgotten areas of deprivation'[9,10] are being stripped of resources, and the opportunities for disadvantaged people having 'an average chance of health'[10,11] are diminishing.

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