References

ABOU-SALEH, M. T. & COPPEN, A. (1986) Who responds to prophylactic lithium? *Journal of Affective Disorders*, **10**, 115–125.

ANDERSON, D. N. (1989) A comparison of in-patient and out-patient prescribing. *British Journal of Psychiatry*, **154**, 644–649.

BOUMAN, T. K., NIEMANTSVERDRIET-VAN KAMPAN, J. G., ORMEL, J. *et al* (1986) The effectiveness of lithium prophylaxis in bipolar and unipolar depressions and schizoaffective disorders. *Journal of Affective Disorders*, **11**, 275–280.

HULLIN, R. P., MCDONALD, R. & ALLSOPP, M. N. E. (1972) Prophylactic lithium in recurrent disorders. *Lancet*, **i**, 1044–1046.

PRIERN, R. F., KUPFER, D. J., MANSKY, P. A. *et al.* (1984) Drug therapy and the prevention of recurrences in unipolar and bipolar disorders. *Archives of General Psychiatry*, **41**, 1096–1104.

The new genetics

SIR: I would like to broaden the debate on the implications of the new genetics and psychiatry started by Pelosi (*Journal*, October 1988, **153**, 570), David (*Journal*, January 1989, **154**, 119), and Bristow (*Journal*, June 1989, **154**, 882). Granted, psychiatric genetics is always going to be controversial and has potential for abuse by governments for ideological or economic reasons. Genotyping, when it becomes available, could also lead to discrimination against individuals by employers and insurance and mortgage companies. This has considerable social and economic implications, and there must therefore be safeguards to ensure strict confidentiality to protect people's human rights. A strong case can be made for setting up a body to consider these issues. Perhaps the lessons learned from the AIDS epidemic and HIV testing will be useful in developing genetic testing services.

As our knowledge of psychiatric genetics increases, the demand for genetic counselling and abortion is likely to increase. This is another emotive and under-researched area, but would increase the options available for prospective parents. Some relatives of schizophrenics will welcome the chance to choose to abort a genetically vulnerable foetus. Other relatives who have deliberately refrained from having children may be reassured by marker studies that they are at low risk of transmitting the disease and thus decide to start a family. Some families will choose to avoid the choice.

A major role of the genetic counsellor should be to furnish families with information upon which they can make their own decisions. Unfortunately, the estimate of risk is always likely to be vague as the penetrance of schizophrenia is incomplete and variable. In the families studied by Sherrington *et al* (1988) the penetrance was 71% for schizophrenia. This is an unusually high figure. We know that there are high density families with severe disease, and in these families the decisions regarding abortion facing prospective parents may well be easier than for other families with lower penetrance and illness density.

It is possible that the penetrance will fall over the next generation. Research is likely to focus on how to minimise morbidity in the genetically vulnerable and this may involve psychological, social, or physical intervention or other such measures such as fastidious obstetric care. However, children growing up with a known schizophrenia genotype will face special, potentially stigmatising problems of their own and this, together with the emotional reactions arising in schizophrenic families as a result of genotyping, could pose a new set of challenges for psychiatrists.

TIM READ

Wolfson Building
Middlesex Hospital
Riding House Street
London W1N 8AA

Reference

SHERRINGTON, R., BRYNJOLFSSON, J., PETURRSSON, H., *et al* (1988) The localisation of a susceptibility locus for schizophrenia on chromosome 5. *Nature*, **336**, 164–167.

'New chronics'

SIR: We were most interested to read the paper by McCreadie & McCannell (*Journal*, September 1989, **155**, 348–351). There are a small number of studies following up patients from individual hospitals. We would like to report the findings of one such study. We conducted a follow-up study of all the patients (147) admitted to the Psychiatry Department of Hospital de Sant Pau in Barcelona, during 1981. We identified 18 (12%) 'new chronic in-patients' (patients admitted and not discharged) at the end of the period. Elderly patients, without family, suffering from schizophrenia or organic disorders were more prone to remain hospitalised (Ruiz-Ripoll *et al*, 1986, 1987).

We followed these 18 'new chronic in-patients' for five years more: seven remained in-patients, seven had died (two suicides), and four were discharged (three living in group homes with community psychiatric nurse supervision). So, out of the initial cohort, seven patients remained in hospital seven years later.

As Drs McCreadie & McCannell demonstrated, there are new chronic patients who become old chronic patients, and a minority of the new chronic in-patients could be discharged if alternative accommodation were available.

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