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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.

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'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.

It is necessary to identify the 'new chronic inpatients' if we are to attend to their needs.

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Is schizophrenia a G-I disease?

SIR: I read with interest the paper by Lambert *et al* (*Journal*, November 1989, **155**, 619–622) and would like to offer a rather different interpretation of their findings.

It may be perhaps that the controls in this study were particularly healthy, in that every one appeared to have a similarly low urinary excretion of ^{51}Cr EDTA. The 24 schizophrenic patients, apart from the two with somewhat raised values, were within the same range and were in fact as normal as the controls. I do not find this result surprising, as all but one were medicated. The exception had previously been tested when taking neuroleptics. We are not told how long this patient had been off drugs. They could perhaps still have been exerting their effects.

Neuroleptic drugs are known to stabilise membranes, including the gut membrane. P. S. Guth (pers. comm.) wrote that when he and his colleagues were first studying chlorpromazine it was thought to be inhibiting its own absorption. This drug is presently being used as an anti-secretory agent in the treatment of cholera and other diarrhoeral conditions. It seems very possible that the neuroleptics taken by the patients in this study could have been the reason for their apparently normal gut permeability.

The Schizophrenia Association of Great Britain (SAGB) had previously considered supporting a study similar to this using ^{51}Cr EDTA, but I was worried about the effects of medication on the validity of the results of such an experiment. The experiment was dropped largely as a result of these doubts.

The SAGB has initiated, and is funding, a programme of research in the Department of Biochemistry in the University of Wales, Bangor, under the supervision of Professor J. W. Payne and Dr J. I. Davies. A gut permeability study is underway with schizophrenic patients, their near relatives, and controls. We have also asked the researchers to investigate the effect of neuroleptics on gut permeability.

It would seem important to investigate gut permeability in never-medicated patients before dismissing too readily the idea that schizophrenia may, for at least a sub-group of patients, be related to coeliac disease. Anecdotally, it has seemed to me that there is a reduction in digestive troubles in well-medicated schizophrenic patients. In the absence of non-medicated schizophrenics, further permeability studies on their near relatives might throw light on the genetic lesion in schizophrenia.

There is a high incidence of coeliac disease among the families of SAGB members in which there is also a patient with schizophrenia. Out of 239 returned questionnaires sent to members, there were 10 cases of coeliac disease, three of which were in the patient and seven in a near relative. The incidence of the disease in the general population is said to be between 1/500 and 1/2000. Were permeability studies to be done in families in which there is both schizophrenia and coeliac disease, it might be possible to identify a sub-group of schizophrenia related in its pathology to coeliac disease. Such patients might respond to a dietary treatment. Certainly I knew one schizophrenic, whose first cousin was a coeliac, who improved greatly on a gluten-free diet. I know also of two families in whom of two siblings, one was schizophrenic and the other coeliac. Unhappily, one of each pair (one coeliac and one schizophrenic) committed suicide.

There is much evidence that members of the SAGB suffered a high incidence of digestive problems before the onset of their schizophrenia. It would seem extremely premature to dismiss lightly the long-held view that schizophrenia is primarily a disease of the digestive system in which the brain is only secondarily affected by the disease process. This view was held at the beginning of the 19th century. It is essential in all gut studies investigating this possibility to beware of the direct effect of neuroleptics in stabilising membranes. The gut may be their chief site of therapeutic action. Who knows?

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More on multiple personality disorder

SIR: Simpson (*Journal*, October 1989, **155**, 565) hypothesised that multiple personality disorder (MPD) is an "iatrogenic, largely culture-bound dis-