Goodmayes we did not find a single example of the progressively deteriorating course which is the traditional stereotype of chronic schizophrenia. All the patients had either been maximally disabled at the time of first admission to hospital, or their deterioration had ceased to progress at least ten years previously; the end-state described by Bleuler (1972) in *Die schizophrenen Geistesstorungen im Lichte langjahriger Kranken- und Familiegeschichte*.

This evidence that chronic schizophrenia tends to stabilize is supported by a number of long-term studies, including Bleuler's own personal follow-up of over 200 patients and Daum, Brooke and Albee's 20 year follow-up of 253 patients, and accords well with clinical experience.

This is not, of course, to suggest there will be no chronic schizophrenics in the community, but taken in conjunction with evidence that the most severe and crippling forms of the illness are less common than in the past (Hogarty, 1977, *Schizophrenia Bulletin*, **3**, 587–99) it predicts a more hopeful future than the tenacious myth of inevitable, progressive deterioration.

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DAUM, C. M., BROOKS, G. W. & ALBEE, G. W. (1977) Twenty year follow-up of 253 schizophrenic patients originally selected for chronic disability. *The Psychiatric Journal of the University of Ottawa*, **2**, 129–32.

NO LUNG CANCER IN SCHIZOPHRENICS?

DEAR SIR,

I was prompted by the letter from Dr D. Rice (*Journal*, January 1979, **134**, 128) and by the recent death of one of my chronic schizophrenic patients to look at post-mortem records at Rainhill Hospital—made available to me by Dr A. S. Woodcock, F.R.C.Path. In the past five years post-mortem examination has confirmed the presence of lung cancer in eight patients. Three with no previous psychiatric history had an acute psychotic episode of the type familiar in this condition; two had long-standing recurrent depressive illnesses; three were typical chronic schizophrenic patients of at least twenty years duration before the terminal illness. Two of them had been continuously in hospital (since 1953 in one case and 1956 in the other), while the third had been maintained at home, thanks partly to a supportive family. Histologically the tumours were: oat cell, poorly differentiated squamous, and a well differentiated papillary adenocarcinoma.

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BRITISH POLICY ON OPIOID MISUSE

DEAR SIR,

Professor G. Edwards (January, 1979, **134**, 1–13) refers to a paper of mine (1) by the wrong title, date and page, and misquotes some figures from it. He has made the mistake of combining results from my study with those of a previous one by Bewley *et al* (2), though he lacks the necessary data. The passage in his article should have read: 'of 112 opioid users whose deaths were reported in the United Kingdom, 24 were not known to the Home Office before they died'. These deaths deserve more attention than Edwards has given them because they represent some of the price paid for the present British policy.

The prescribing of NHS heroin or methadone—whether this is done by general practitioners or by specially licensed doctors—does not protect against the high morbidity, mortality and infectious nature of opioid misuse (1, 4). There is, therefore, an alternative option to the ones Edwards has proposed. This is to stop the prescribing of opioids for self-administration altogether, and for medical personnel to administer them to patients considered suitable for maintenance treatment. The advantages of this approach are that it would diminish the above risks, officially acknowledge that the medical risks are too great to justify using medical means (prescribing opioids) for social ends ('keeping the Mafia out') and enable different maintenance schedules to be tested. Certain problems would remain such as when to start maintenance treatment (5) for a 'new case' or for one who has relapsed, and when to stop because, say, a patient is misusing illicit drugs. The disadvantages would include the logistics of implementing this scheme and the possibility of stimulating a criminally organised black market.

Although it may have been justifiable in 1967 to be so fearful of what might happen, Edwards shows that there is less cause for alarm today and that the present policy should be reviewed.

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