in both early-onset and late-onset cases. Also, like Dr Burvill *et al* I found an excess of physical health problems, notably chronic, active disease, among the late-onset group, but similarly these differences were not statistically significant. Using a simple health rating (Baldwin & Jolley, 1986) the late-onset group scored a mean of 2.25 compared with 2.00 for the early-onset group (NS).

This data supports the findings of Dr Burvill *et al*. Their paper and that of Dr Musetti *et al* suggest that perhaps the adage "depression is depression at any age" is largely true. Although the findings of a positive family history of depression were in the expected direction, surprisingly high rates were found for the late onset groups – two-fifths in the study of Dr Burvill *et al* – thus challenging another conventional myth that a positive family history of depression is rare in depression arising in later life.

Does this mean that the search for specific aetiological factors in late-life depression is fruitless? I think not. The limited evidence we have suggests that aetiological differences between late- and early-onset depressions are subtle – see for example the pioneering work of Jacoby *et al* (1981) concerning biological factors. Unravelling aspects of biological, genetic, and life event factors in the genesis of depression in old age, not to mention the tantalising but neglected area of personality and temperament touched on by both sets of authors, will necessarily require studies involving much larger numbers of elderly patients than those to date – surely a strong argument in favour of collaborative research.

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Who benefits from lithium?

SIR: Markar & Mander (*Journal*, October 1989, **155**, 496–500) report the outcomes of a selected group of bipolar patients on lithium as only marginally superior to those of a group not taking lithium, but as the subjects were not randomised the validity of the outcome comparison is dubious. The efficacy of lithium prophylaxis is well established, but clearly not all patients benefit from lithium (Priern *et al*, 1984) and certain characteristics are associated with a better response (Abou-Saleh & Coppen, 1986; Bouman *et al*, 1986). Until predictors of treatment response are more refined and reliable, practice should remain initially to treat all bipolar patients. The crucial question for the clinician is whether the course of an individual's illness is beneficially affected by the introduction of lithium, and this cannot be answered without detailed data collected longitudinally. Studying the outcome of a cohort of patients that will include good and poor responders will minimise a lithium effect and fail to address the problem facing the clinician, where the 'before and after' design has more relevance to the ordinary clinical situation.

A recent prescribing survey of lithium clinic attenders (Anderson, 1989) included 61 bipolar patients whose past records were available for study. Patients had a mean duration of illness of 21 years (13.5 years pre-lithium) requiring a mean of 7.6 admissions (5 pre-lithium) with a range of illness duration of up to 47 years, the maximum number of admissions being 33 over 28 years. When the whole group ($n=61$) was considered regarding relapse rate (relapses per unit time) there was no significant difference between the periods before and after the start of lithium treatment. However, this concealed a sub-group ($n=27$) who had no admissions following lithium prophylaxis yet were statistically indistinguishable from lithium relapsers in terms of duration of illness before lithium, relapse rate before lithium, and time on lithium (mean 7.1 years). This study design also tends to bias against a lithium effect (Hullin *et al*, 1972).

The problem facing the clinician is that of not having easy access to this sort of data that will allow the identification of poor responders who are not benefiting from long-term prophylaxis but whose psychiatric histories are buried in the depths of multiple case notes.

Lithium clinics and registers should create continuity of care, allow collation of the data necessary for informed clinical judgements about continued treatment, and provide valuable populations for research. Case notes and clinical memory cannot handle and organise the amount of longitudinal data needed to objectively evaluate treatment response in the normal clinical setting, and computerisation is essential to store, organise, and retrieve information used to chart progress and assist the clinician, researcher and auditor.

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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.

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