fortiori a paragraph, to open with functional or attention-catching words.

The principle I am defending is the same that applies in choosing the titles of articles. All authorities agree that functional words should occupy the initial or strong position. Thus "Retinoblastoma: a study of the natural history and prognosis in 268 cases" is a better title than "A study of the natural history and prognosis in 268 cases of retinoblastoma"; "Acute myeloid leukaemia treated according to the Hammersmith protocol: a preliminary report" is preferable to "A preliminary report of treatment of acute myeloid leukaemia according to the Hammersmith protocol".

Similarly, "The possible role of nitrosamines in the genesis of oesophageal carcinoma has been suggested by Magee and Barnes and McGlashan *et al*" (12 July, p 61) is a more enticing beginning for a paragraph than "Magee and Barnes and McGlashan *et al* have suggested a possible role of nitrosamines in the genesis of oesophageal carcinoma" would have been. On the other hand, instead of "A recent North American survey has re-examined the problem of chest pain in smokers" (15 November, p 368) I should have preferred "The problem of chest pain in smokers has been re-examined in a recent North American survey". This example also shows one of the pitfalls to which too strict avoidance of the passive can lead. A problem can be examined in a survey, but could a survey, even a computerised one, examine a problem? Examination calls for conscious intellectual effort.

My second point is to recall Sir George Wilson's warning[1] against the misuse of "develop," as in "the patient developed pancreatitis." The patient did not develop pancreatitis; pancreatitis developed in the patient. One develops photographs. An investigator develops disease in experimental animals. But one does not develop disease in oneself—unless one is a self-experimenter, a psychopath, or a cigarette smoker. I expect it was with this third exception in mind that you (13 December, p 607) wrote of smokers "who have already developed chronic bronchitis or coronary artery disease."

Finally, it is disquietening to note in how many otherwise respectable American journals the word "data" is treated as a singular noun. It is true that neuter plural nouns took singular verbs in classical Greek, but I doubt if the perpetrator of "This data was carefully analyzed" was under the influence of deep reading in Plato and Thucydides. He would not have spelled "analysed" with a z.

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1 Wilson, G, *Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service*, 1965, **24**, 280.

Long-stay mental hospital population

SIR,—The terrible chronicity rate, causing so much suffering to the patients and relatives concerned, reported by Dr Thomas Bewley and Dr Eamonn Fottrell and others (p 675) at Tooting Bec Mental Hospital needs an explanation.

Can a lot of it be due to lack of intensive treatments when the patients were admitted there or elsewhere earlier in their illness? Will these authors also tell us how many now "chronic" schizophrenics and affective states had insulin, electric conversion therapy, the phenothiazines, and finally a modified lower medial leucotomy before being condemned to a lifetime of suffering in the chronic wards of Tooting Bec?

When Tooth and Brooke[1] and also Baker[2] made their calculations on the emptying of mental hospitals, so criticised by Dr Bewley and his colleagues, they had already found, for instance, that over 40% of 10 000 supposedly chronic patients had been able to leave mental hospitals following mostly modified lower medial leucotomies.[3] Baker had worked with me, and learnt also at Banstead, what can now be achieved by the use of intensive physical treatments and not "giving up" before *all* such treatments had been used.

Unless we know about the treatment of all these supposedly chronic patients this paper loses most of its value as a guide to whether or not we shall be able to close our mental hospitals and use general hospital units instead.

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1 Tooth, G C, and Brooke, E M, *Lancet*, 1961, **1**, 710.
2 Baker, A A, *Lancet*, 1969, **1**, 1090.
3 Tooth, G C, and Newton, M P, *Leucotomy in England and Wales* 1942-1954. London, HMSO, 1961.

The third man

SIR,—In his interesting letter about the Everest expedition (10 January, p 92), Dr C R A Clarke mentions the curious sensation of two climbers that their snow-hole bivouac had been shared by a third. Some claim that this is a well-recognised phenomenon in near-exhausted travellers, and it inspired T S Eliot to write in "The Waste Land":

Who is the third who walks always beside you?
When I count, there are only you and I together
But when I look ahead up the white road
There is always another one walking beside you.

In his own notes on the poem Eliot says, "The lines were stimulated by the account of one of the Antarctic expeditions (I forget which, but I think one of Shackleton's): it was related that the party of explorers, at the extremity of their strength, had the constant delusion that there was *one more member* than could actually be counted."

I cannot recall having seen this mentioned in medical literature before. Has it ever been noted and investigated by any psychiatric authority?

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Commercial and NHS factor VIII concentrates

SIR,—One of the inevitable dangers of a journalistic approach to medical problems is that limitations in time (radio or television) or space (newspapers or periodicals) may give rise to a selection of comments made by experts which, when taken out of context and put together for a programme or article, are misleading. This probably arose during the ITN television series "World in action" in which two consecutive programmes attempted to deal with the availability of factor VIII concentrates for haemophilia patients in the United Kingdom.

There is no doubt that the import into the United Kingdom of factor VIII concentrates derived from external sources, however well screened for hepatitis viruses, represents an unequivocal pathway by which the level of a potentially lethal virus into the *whole* community is being deliberately increased. Although the absolute magnitude of this problem was exaggerated and overdramatised by the television programmes, nobody with direct or indirect responsibilities for this phenomenon would wish to belittle the serious nature of the moral and practical dilemmas which face us all.

Perhaps the most important misleading feature of the second television programme was the impression given that the recent and specific injection of £500 000 by the DHSS into the blood transfusion services will have worked its way through by mid-1977, and by that time the necessity to purchase further supplies of factor VIII concentrates will be eliminated. Our own experience indicates that this will not occur, not least because the present NHS production target for factor VIII concentrates is too low. What seems more certain, however, is that by mid-1977 we shall begin to understand that the problems are multifactorial, a good deal more complex than hitherto appreciated, and only partly related to the haemophiliac. In the meantime we would be well advised not to raise the expectations of the patients, their relatives, and the staff of the regional haemophilia centres beyond the certainty that things will improve very slowly, and at the same time look at the problem once again.

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Sodium valproate and platelet function

SIR,—Dr A Richens and Dr S Ahmed (1 November, p 255) and Jeavons and Clark[1] have shown that sodium valproate reduces the frequencies of seizures in epilepsy. The drug is likely to be widely used and, while reported side effects have so far been minor, there has been one report[2] of a prolonged bleeding time in four out of five patients who also showed coagulation abnormalities. The prolonged bleeding time was attributed to defective platelet function, but one patient was thrombocytopenic. We have therefore studied the effects of sodium valproate on platelet function and coagulation to determine the clinical significance of these findings.

Sodium valproate was added to citrated plasma from six healthy adults to give final concentrations of 0·2, 1·0, and 5·0 g/l corresponding to one, five, and 25 times the therapeutic level. Platelet adhesiveness to glass beads, platelet factor 3 release, and ristocetin- and collagen-induced aggregation were normal. Inhibition of the secondary phase of platelet aggregation following normal primary aggregation with adenosine diphosphate ($2\text{-}4\times10^{-6}$ mol/l), adrenaline, and thrombin was demonstrated in all six plasmas at 25 times the therapeutic level and, with thrombin, in three plasmas at the therapeutic level. Standard tests of coagulation (prothrombin, partial thromboplastin, thrombin, Reptilase, and Stypven times) were normal at all three concentrations.

Platelet function tests were also performed on 23 patients (aged 4-22 years) taking sodium valproate. Inhibition of the secondary phase of aggregation following primary aggregation with adenosine diphosphate, adrenaline, or thrombin was demonstrated in six patients, five of whom were taking sodium valproate as the sole anticonvulsant.

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