of trypsin[2] cannot be substantiated. This study further supports the conclusion that serum trypsin measurements are of no value in quantifying the degree of exocrine pancreatic deficiency.

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[1] Frier BM, Adrian TE, Saunders JHB, Bloom SR. *Clin Chim Acta* 1980;**105**:297-300.
[2] Dandona P, Elias E, Beckett AG. *Br Med J* 1978; **2**:1125.
[3] Adrian TE, Barnes AJ, Bloom SR. *Clin Chim Acta* 1979;**97**:213-6.
[4] Frier BM, Saunders JHB, Wormsley KG, Bouchier IAD. *Gut* 1976;**17**:685-91.

**We sent these letters to the authors, who reply below.—ED, *BMJ*.

SIR,—We thank Dr Frier for his comments on our paper. Glucose tolerance was not formally assessed in this study and we are not in a position to provide a detailed analysis of its relationship with serum trypsin concentration. However, of the seven patients with chronic pancreatitis and low trypsin concentration, only two were known diabetics, one of whom required insulin, and a further three gave normal results in oral glucose tolerance tests. An additional two patients with chronic pancreatitis and normal trypsin concentrations were diabetic, one of whom required insulin. We have no information on glucose tolerance in the remaining six controls and non-pancreatic patients with low trypsin concentrations, but none were overtly diabetic.

The comments of Mr Keynes do not appear relevant to our study, which did not include patients with acute pancreatitis. We do not, of course, have any information on the relevant contributions to serum trypsin levels of trypsinogen and activated trypsin. There is no reason to suspect that other than random trypsin measurements (for example, post-prandial) would be more helpful in diagnosis.

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SIR,—Your correspondent Alan Ferris (28 November, p 1471) found the use of nouns as verbs widespread in Massachusetts General Hospital, and he has given some examples of the practice, which he describes as "horrors." This highly infectious disease has, alas, already reached the *Journal* (28 November, p 1443), where Professor Sam Shuster offers advice to anyone wanting to "author" a conference book. I wonder if he is a carrier. Can you do anything to check the spread of the infection in your columns?

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**Yes—and we do.—ED, *BMJ*.

The loneliness of the long distance reviewer

SIR,—Professor Sam Shuster's comments (28 November, p 1443) on the quality of new medical books is both timely and apt. I feel, however, that his knowledge of publishers is somewhat rudimentary. For instance, where did he get the idea that publishers carefully read the proofs of the books that they publish? I doubt if publishers will ever be able to "withdraw their encouragement of the indifferent writing that characterises much of their lists."

I have always found publishers rather simple chaps who tend to seek out impressive-looking authors (in terms of the curriculum vitae). This procedure eventually produces a list about as full of Professor Shuster's "humour and bounce" as the average edition of the London telephone directory. Sometimes publishers ask me for advice with reference to the commissioning of a book. I always tend to suggest that they choose the younger rather than the older author, steer well clear of authors who have received high honours, and—with a few noteworthy exceptions—eschew the professorial chair. Understandably perhaps, few publishers seem to take my advice.

ERIC TRIMMER

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"New chronic" patients

SIR,—Dr Thomas H Bewley and his colleagues (31 October, p 1161) provide further evidence of the need for continued residential care for patients with chronic psychiatric illness. At present this level of care is only available in a psychiatric hospital. I am concerned that they may in fact be underestimating this need by limiting their "new chronics" to below the age of 65. It is my impression that a significant proportion of older patients, in good physical health and with no evidence of dementia, develop severe psychoses which respond poorly to treatment and add to the load of "new chronics." Have Dr Bewley and his colleagues any information on these older patients at Tooting Bec?

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**We sent this letter to the authors, who reply below.—ED, *BMJ*.

SIR,—Dr J L T Birley has inquired whether we have further information about "new chronic" patients aged 65 or over. Although we did not review this group in the published study (31 October, p 1161), we have the information from another survey. In a similar five-year period 20 "new chronic" patients aged 65 or over were admitted to Tooting Bec Hospital, of whom only one was likely to be discharged (though nine might possibly be). Their diagnoses were: affective illnesses—12; schizophrenia/paraphrenia—4; other diagnoses—4. These patients represent a considerable long-term commitment, since our approximate life-table projections suggest that 12 will still be inpatients in five years' time and four will remain as inpatients after 10 years. There were 136 admissions of patients aged 65 or over with a diagnosis of organic dementia in this period, five of whom might possibly be discharged.

The accompanying table shows the likelihood of discharge of all "new chronic" patients aged 65 and over. It also gives the ages of the "old chronic" patients in this age group. The number of patients in the hospital at the time of this census was 820. There had been 1010 admissions during the previous 12 months, 321 being patients aged 65 and over (118 males and 203 females). The final column of the table shows the numbers remaining at the end of that year. We agree with Dr Birley that there are a number of old patients, in good physical health, with no evidence of dementia who have severe psychoses which respond poorly to treatment and add to the load of "new chronics."

Dr Oscar Hill, whom we would like to thank for his careful perusal of our paper, has drawn attention to an error (which is formally corrected on page 182). At the end of the results section (p 1163) the final sentence should be corrected to read: "The follow-up of the original cohort would suggest that 27 of the new group might be discharged, and that 54 might remain as inpatients indefinitely"; and in the abstract (p 1161) the penultimate sentence should read: "Many new chronic patients were old chronics with intervals of community care, and two-thirds of them were likely to require permanent care."

The points in this letter add further weight to our original contention that there will be a continuing need for appropriate residential care for patients with chronic psychiatric illness, and that the DHSS must reconsider their present inadequate plans to provide treatment and care for this group.

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MARTIN BLAND

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No evidence of transfer of fluoride from plasma to breast milk

SIR,—J Ekstrand and colleagues (19 September, p 761) have concluded that there is no evidence of transfer of fluoride from maternal plasma to breast milk. The results of this study are supported by those of another,[1] which suggested that the increase in fluoride concentration in cows' milk was very slight (from 0·1 ppm to 0·4 ppm) when the fluoride concentration in the feed was markedly raised (from 3-5 ppm to 50 ppm).

"New chronic" patients at Tooting Bec Hospital: likelihood of discharge

	"New chronic" patients aged 65 and over						
	Organic dementia		Other diagnoses			No of patients aged 65 and over and inpatient for more than 5 years	Remaining population after one year from admission in preceding 12 months of patients aged 65 and over
	Discharge		Discharge				
Age	Possible	Unlikely	Likely	Possible	Unlikely		
65-69	1	10	1	2	3	30	14
70-74	1	24		5	4	44	31
75-79		30		2	2	40	24
80-84		34		0	1	54	27
85-89	2	22				35	18
90-94	1	8				14	8
95 and over		3				5	
Total	5	131	1	9	10	222	122