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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Violence and mental illness

SIR,—Dr Malcolm Weller (7 July, p 2) is right to condemn neglect of mental illness by successive governments. In the now to be expected criticism of community care, however, he misses two important points. Firstly, the change of policy being argued is not one of hospital care versus community care but of the relative merits of distant large mental hospitals and smaller local units with adequate community support. Goldberg's studies in south Manchester have shown that local services are more effective in treatment and are preferred by both patients and their families to distant mental hospitals.[1 2]

The second point is a practical one. Most cases of "community neglect" originate with patients being discharged from large mental illness hospitals into inadequate community provision without the responsible hospital consultant paying any adequate attention to the nature of the care to which his patient is returning. I am sure that Dr Weller will agree that a consultant's responsibility does not stop at the gates of a mental hospital.

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[1] Glass N, Goldberg OP. Cost benefit analysis and the evaluation of psychiatric services. *Psychol Med* 1977; **7**:701-7.
[2] Jones R, Goldberg OP, Hughes B. A comparison of two different services treating schizophrenia: a cost-benefit approach. *Psychol Med* 1980;**10**:493-505.

SIR,—I found the two articles by Dr Pamela J Taylor and Professor John Gunn on violence and psychosis (30 June, p 1945 and 7 July, p 9) revealing and disturbing. Working as a police surgeon, I have been told by police officers (and this has sometimes been confirmed by personal observation) that at times it has proved impossible for them to secure admission into a mental hospital of a prisoner brought into a police station who was considered to be emotionally disturbed. Quite often the only way that the police felt that they could deal with the problem was to charge such a prisoner and get him before a magistrate, who could then remand him for the usual psychiatric reports.

The finding of such emotionally disturbed prisoners on remand in prison is then due not so much to the "tendency on the part of the police to view mentally ill men as more dangerous than their more psychiatrically normal peers," but to the admission policies of a particular psychiatric team or mental hospital.

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Treatment of oesophageal cancer

SIR,—The audit by Mr Richard Earlam of regional practice in the management of oesophageal carcinoma (23 June, p 1892) comes at a time when important advances are occurring in the palliation of this difficult problem. These have included accurate staging for operability,[1] pertubation,[2] and radiotherapy.[3] We would like to contrast the experience in north east Thames region with ours in a specialist unit in a medium sized district.

Over three and a half years 66 patients were recruited from an estimated catchment population of 232 000. This was achieved by a combination of orthodox outpatient referrals and a GP open access endoscopy service. These patients were all admitted to hospital for management of nutritional problems or staging by fibreoptic endoscopy, isotope liver scan, and laparoscopy. One quarter (27%) were referred subsequently for surgery, which in 60% was radical. Palliation was achieved in the remainder by endoscopic pertubation (27/66; 41%) or radiotherapy, chemotherapy, or both (32%). There were no early deaths after surgery. Good or excellent swallowing was achieved by one or other method in 80% of patients. One year survival rates in patients treated with surgery were 60%, in patients treated with pertubation 25%, and patients treated with radiotherapy 10%.

These results compare well with those of Mr Earlam's survey. They show, we believe, the virtues of the specialist approach to diagnosis and nutritional management, combined with accurate staging and appropriate referral to experienced surgeons. The treatment of oesophageal carcinoma in our area has also been facilitated by trained endoscopy nurses