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NEWS AND NOTES

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Who cares?

SIR,—Dr Keith Andrews mentions that many severely dependent elderly people are maintained in the community only by the constant attention provided by their immediate family (6 April, p 1023). Just how true that is is shown by the following saga.

A demented elderly woman was refusing to leave the bedside of her husband, who had been admitted to an orthopaedic ward for surgery to his fractured femur. The nursing officer had decreed that the woman must leave because of her disrupting influence on the ward. The ward sister had tried all the usual avenues without success and as a last resort contacted the couple's general practitioner, who happened to be me.

After the customary attempts to avoid involvement, I agreed to visit, and as it was such an emotionally charged situation I took the precaution of contacting the hospital administrator, who in turn took the precaution of monitoring the 20 or so phone calls I made in an attempt for action. It will surprise nobody that I drew a total blank in finding a psychiatric or psychogeriatric bed in the same hospital, as indeed I did in even contacting a psychiatrist or psychogeriatrician. However, I was lucky, because out of the goodness of her heart a psychiatric registrar from a psychiatric hospital agreed to visit and try to sort out the problem. Three hours after my arrival at the hospital the situation was eased temporarily when promazine suspension was poured down the woman's throat and she was frogmarched to her son in law's car. The originally hoped for action—admission to a psychogeriatric bed—happened on the evening of the second day, after a domiciliary visit by the psychogeriatrician to the daughter's house. By this time the daughter was in a parlous state, having been buffeted by her mother all day long. The mother's dementia was such that she did not recognise her only daughter.

What conclusions can be drawn from all this? Paramount is professional ineffectiveness. I am unable to comment on the lack of action from the ward itself but gather that the houseman had tried. The consultant psychiatrist's reason for non-intervention was easy to understand: he did not appreciate the interruption to his free time. In fairness the social worker promised to come in the likely event of a psychiatrist not arriving on the scene. The psychiatric registrar came, probably entirely out of kindness, but maybe also because I know her parents. Lest I give the impression of being "holier than thou" I am aligning myself with the professionals. The person for whom I have the greatest respect and admiration is the husband, who over the years has had his demented wife constantly at his side, 24 hours a day, with not infrequent bouts of aggression and without recourse to any help from the state. He has taken his marriage vows seriously and without complaint. With such a man as this, one is privileged to play a small part to ease the burden of his anxiety about what would happen to his wife in this impossible situation.

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Chronic bronchial sepsis

SIR,—I read with interest Dr G M Cochrane's leading article on chronic bronchial sepsis (6 April, p 1026) and feel that further studies in this condition should be encouraged. I would like to emphasise that although most patients with chronic bronchial sepsis have bronchiectasis, most patients with bronchiectasis lead relatively normal active lives. Our studies have been aimed at determining whether a subgroup of patients with bronchiectasis, who do show progression and ill health, can be identified. In this respect the permanent production of purulent sputum may be important, as outlined by Dr Cochrane.

Complicated measures of lung biochemistry may not be a necessary part of future studies. Our elastase measurements[1] were initially undertaken since elastase from the neutrophil has been the most extensively studied proteinase so far and has been shown in vitro to produce many of the changes seen pathologically in bronchiectasis. The role of this enzyme remains uncertain, and indeed measurements of another proteolytic enzyme (cathepsin B like activity) in these secretions parallel the elastase results.[2] Thus elastase may merely be a marker of excessive proteolytic activity in secretions. Although measurement of proteolytic activity will be required for some future studies in these patients, the fact that such activity is an almost constant feature of frank purulence ($\approx 89\%$) means that purulence alone could be used as a marker. Indeed, we have shown that lung function was more impaired both in patients with persistently purulent secretions and those who were only elastase positive.[1]

Longitudinal studies are going to be needed and I would hope that simple lung function data may be useful in identifying patients with progressive disease. However, although patients with bronchiectasis do have airflow obstruction it should be remembered that many also have acute reversibility with bronchodilator. A 10-15% improvement in peak expiratory flow rate can occur even with antibiotic treatment alone (unpublished observation). Thus further studies will be necessary to determine the usefulness of such a test.

However, I am confident that alternatives to measuring sputum to serum albumin ratios as a marker of lung inflammation will emerge. Certainly serum acute phase proteins have potential use in these ways (even the erythrocyte sedimentation rate). We have so far measured the serum concentrations of α_1-antichymotrypsin (a rapid acute phase reactant) and shown that it falls when sputum purulence is cleared with antibiotic therapy (figure).

Conclusive data supporting an aggressive antibiotic policy in patients with chronic bronchial sepsis have not been obtained so far.