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LEADING ARTICLES

Antipsychiatrists and ECT.....	1	Fractures of the shaft of tibia.....	4
Confirming the diagnosis of coeliac disease....	2	In the public interest.....	4
Artificial insemination (donor).....	2	Materia Non Medica.....	5
VIP and watery diarrhoea.....	3	Instructions to authors.....	6

PAPERS AND ORIGINALS

Survey of dietary policy and management in British diabetic clinics A S TRUSWELL, BRIONY J THOMAS, ANN M BROWN.....	7
Survival of infants with unoperated myeloceles M F ROBARDS, G G THOMAS, L ROSENBLOOM.....	12
Transport of newborn infants for intensive care A M BLAKE, N MCINTOSH, E O R REYNOLDS, D ST ANDREW.....	13
Aminocaproic acid and menstrual loss in women using intrauterine devices J M KASONDE, J BONNAR.....	17
Vitamin E deficiency and platelet functional defect in a jaundiced infant M KHURSHID, T J LEE, I R PEAKE, A L BLOOM.....	19
Effect of ethamsylate and aminocaproic acid on menstrual blood loss in women using intrauterine devices J M KASONDE, JOHN BONNAR.....	21
A chromosome study of patients with uveitis treated with chlorambucil B R REEVES, VIVIANNE L PICKUP, SYLVIA D LAWLER, W J DINNING, E S PERKINS.....	22
Clonidine overdose S N HUNYOR, K BRADSTOCK, P J SOMERVILLE, N LUCAS.....	23
Bacillus cereus intoxication followed by periorbital oedema B J GUTKIN.....	24
Circulatory collapse after oral oxprenolol NICHOLAS H BROOKS.....	24

RECEIVED

MEDICAL PRACTICE

OCT 17 1975

De motu urbanorum R E WILLIAMS.....	25	PROCUREMENT SECTION.....	25
Should undergraduate medical training in a developing country be different? BRIAN SENEWIRATNE, V A BENJAMIN, D A GUNAWARDENA, M KANAGARAJAH.....	27	CURRENT SERIAL RECORDS.....	27
The Nottingham medical school J S P JONES.....	29		
Management of backache in general practice A E DOSSETOR.....	32		
Diseases of the central nervous system: Pharmacological basis of treatment JOHN C GILBERT.....	33		
Letter from Chicago: Drug censorship GEORGE DUNEA.....	35		
Any Questions?.....	31, 36		
Materia Non Medica—Contributions from LORD PLATT, KEITH NORCROSS, STEPHEN LOCK.....	37		
Personal View JOHN LAUNER.....	38		

CORRESPONDENCE—List of Contents..... 39

OBITUARY NOTICES 47

BOOK REVIEWS..... 48

NEWS AND NOTES

Epidemiology—Salmonella contamination of therapeutic
pancreatic preparation B ROWE, M L M HALL..... 51

Medical News—Breast cancer screening..... 51

SUPPLEMENT

The Week..... 53

Private practice and the NHS..... 54

Covering letter to the Secretary of State, 24 September 55

GPs support their consultant colleagues..... 58

The attack on inflation..... 62

Politics of incomes R E KLEIN..... 63

Association Notices..... 64

CORRESPONDENCE

"Sectorisation" in psychiatric hospitals D A Spencer, MRC PSYCH.....	39	Diarrhoea and colitis associated with antibiotic therapy R L Parsons, MRCP, and others.....	42	Injectable quinine for falciparum malaria H A Reid, FRCP ED.....	44
Brain abscess H R Ingham, MRC PATH and others.....	39	Use of bacteriological investigations by general practitioners D J Rodgers, MRCP.....	42	Junior hospital staff contract J A Ford, MB.....	44
Delayed fibrinous peritonitis after practolol treatment D Allan, FRCS, and D Cade, FRCS.....	40	Plasma CEA concentrations in pancreatic disease G Lindstedt, MD, and others.....	43	Salary cut for young consultants J F Davidson, FRCP ED, and others.....	45
Haematemesis from metastatic carcinoma B A Scobie, FRCP.....	40	Respiratory function in rheumatoid arthritis G Schernthaner, MD, and others.....	43	Private practice in the NHS P M Morris, MB.....	45
Colour disturbance as a symptom M J Pleydell, MD.....	40	Disaster wound treatment Col A G D Whyte, FRCS.....	43	NHS superannuation and war service R V Goodliffe, MRCS.....	45
Early thymectomy for myasthenia gravis C Grimshaw, FRCS.....	40	Misleading job advertisements T J Cantor, MB.....	44	NHS family planning services A A Templeton, MRCOG, and others; D Hooker, MRCGP.....	46
Sexual aspects of medicine Gwen M Prentice, SRN.....	41	Diazepam withdrawal fits Indirad Vyas, MB, and M W P Carney, FRC PSYCH.....	44	Warning from British Columbia D L Sweeney, FRCS.....	46
Adverse reactions to prazosin J R T Gabriel, MRCP, and others.....	41	SI units G T Watts, FRCS.....	44	Points from letters Heparin preparations (C H Smith); Antibiotic cover for dental extractions (D A McGowan); Itching in pregnancy (T H Gillison); Hearing aids for the elderly (M Anwar); Rheumatic heart disease in South Africa (J G K Dean); Early detection of bronchial carcinoma (J C Roberts); GPs' workload (C Lipp).....	46
Behavioural medicine I G Tait, MB.....	41	Miliary tuberculosis presenting with polymyalgia rheumatica C R McGavin, MRCP.....	44		
Genetics of duodenal ulcer J H Baron, FRCP; M J Goodman, MRCP.....	41				
Prison control units Sarah Trevelyan and M J D Hobbs, MB.....	42				

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

"Sectorisation" in psychiatric hospitals

SIR,—Paragraph 267 of Command Paper 4683 (1971), "Better Services for the Mentally Handicapped," refers to the possibility of "sectorisation" of larger hospitals. In essence this implies the designation of particular wards or other units in the hospital for patients from one sector of the hospital's total catchment area, each with its own team of staff. On paper to the armchair theorist it looks logical, efficient, and convenient. Unfortunately patients and their relatives are human beings who tend not always to feel and think in accordance with administrative tidiness or planners' ideals. The subject of "sectorisation" has recently come to a community health council in this area and its implementation has not found much favour, especially from relatives of patients.

In filling a new hospital or a reopened hospital ward the principle of "sectorisation" can be followed, but a problem arises in the older large hospitals if patients are to be moved not on strictly clinical grounds but purely to achieve "sectorisation." In these hospitals many patients have been in the same wards for years. They have friends among other patients and in some instances they have been nursed by the same staff for a long time. Staff and patients in this position may be criticised as "in a rut" or "institutionalised," but in practice there are many advantages in psychiatric nurses knowing their patients over many years and in leaving well alone.

During the lifetime of patients in hospital nurses and doctors may change many times, but the patients have the security of familiar

surroundings and their families are frequently happy to have patients left where they are. The strict implementation of "sectorisation" would border on the absurd if, for example, because parents moved from one sector of the catchment area to another the patient had to change ward and consultant accordingly.

It is claimed that "sectorisation" is helpful to the discharge of patients, but most long-stay patients in hospitals for mental handicap today are not likely to be discharged. The hospital wards are their home and they pursue a daily round of occupational and recreational activities irrespective of their consultant.

Another minor objection to "sectorisation" is that it tends to curtail the freedom of patients, parents, and family doctors to choose a particular consultant or hospital. More sinister is that the recommendation smacks of administrators and managers telling doctors how to organise their clinical work. It gives the impression that patients are to be regarded as commodities to be processed through a particular system rather than people with a right to respect and individual consideration.

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Brain abscess

SIR,—Your leading article on "Brain abscess" (30 August, p 504) indicated that the mortality in this condition has not fallen for a considerable time, and one recom-

mendation stressed the need for anaerobic culture and the choice of appropriate antibiotics. In the latter respect we would like to report briefly our recent encouraging experience with metronidazole in the treatment of otogenic brain abscesses.

The first patient, a 30-year-old woman, was admitted in a stuporose condition with bilateral papilloedema, marked dysphasia, and a right hemiparesis. A left temporal lobe abscess was aspirated and on the following day radical mastoidectomy was performed. Immediate chemotherapy consisted of chloramphenicol 0.5 g 6-hourly intramuscularly, metronidazole 0.6 g 8-hourly intravenously, and penicillin 0.6 g 6-hourly intramuscularly. Culture of the abscess yielded *Proteus* spp., *Bacteroides fragilis* resistant to clindamycin (minimum inhibitory concentration 5 mg/l), *B. melaninogenicus*, and an anaerobic streptococcus. Chloramphenicol was withdrawn after two doses and gentamicin 80 mg 8-hourly intravenously substituted. After two days there was a marked clinical improvement and a further aspirate of the abscess yielded only a scanty growth of *Proteus* spp. Treatment with metronidazole was continued by mouth for a further 25 days, by which time the patient had completely recovered.

The second patient, a woman aged 25 years, had undergone a left radical mastoidectomy two months previously. On admission she had bilateral papilloedema and a right upper quadrant hemianopia. Pus aspirated from a left temporal lobe abscess yielded the same bacterial species encountered in the first case. Initial chemotherapy was with chloramphenicol 0.5 g 6-hourly and penicillin 0.3 g 6-hourly intramuscularly; this was changed after 12 hours to gentamicin 80 mg 8-hourly intramuscularly and metronidazole 0.6 g 6-hourly by mouth. There was a rapid clinical and bacteriological response and the patient was discharged three weeks after admission on metronidazole 0.6 g 6-hourly and amoxycillin 0.5 g 8-hourly. Three weeks later she experienced painful paraesthesiae in the hands and feet but did not report this until seen as an outpatient two weeks later, when peripheral sensory neuropathy was diagnosed and all chemotherapy stopped. After four weeks' observation only minimal paraesthesiae remain.

A further case of otogenic cerebellar abscess due