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## LEADING ARTICLES



## PAPERS AND ORIGINALS





## MEDICAL PRACTICE




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# CORRESPONDENCE



*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 recommendation 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 a 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