of the anergic schizophrenic. Further subjects are at present being added to this trial.

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Reference

CHIEN, C. P., JUNG, K. & ROSS-TOWNSEND, A. (1978) Efficacies of agents related to GABA, dopamine and acetylcholine in the treatment of tardive dyskinesia. *Psychopharmacology Bulletin, 14*, 20.

UP TO DATE RECORDS OF LONG-STAY PATIENTS

DEAR SIR,

Dr Henryk-Gutt (*Journal*, February 1980, **136**, 203–4) describes the difficulty of quarrying the gems of information that are contained in the petrified pages of a thick file of old case notes. The problem concerns every patient under long-term care and not only those who are long-stay in-patients. A remedy similar to the one she suggests has been in use in this hospital since 1961 and it works quite well. Dealing as we do entirely with chronically ill patients who have on average upwards of ten years illness (and notes) behind them and who stay here on average for some 3–4 years, our need to make and keep key information accessible is important to us.

There are two parts to the method we use. Part one is a summary of the patient's history up to the time when he comes under care here. His old notes come with him when he is transferred from his previous hospital. They are then sent to the Night Superintendent. He and one particular Night Charge Nurse have shared the task of summarizing the notes of about 1,500 patients to date. Delivery of the typed summary is within three or four days and the service provided is well done and extremely valuable. A sample is appended which describes a real case disguised by a fictitious name. The headings have suited our needs. If the space allocated to any one of them is too small, the narrative continues on the back of the page.

Part two is the handwritten record of the patient's Case Conferences, compiled by the chairman of the Review team. Another sample is appended. The rating scores, abbreviations etc. are understood by the people using them so there is no point in explaining them here. The problem is to reach a compromise between being too brief and too wordy which must depend on individual taste. This sheet contains as you see a mixture of relatively permanent items (e.g. IQ, bereavements) together with very potted progress notes. Again the narrative can continue on the back of the page. It can readily be found at a set place in the file, separate from the routine continuation notes and other records which are kept and filed in the conventional way.

It feels logical in practice to keep the up-dated record in these two parts. The division between the two is the point in time when some new initiative in the management of patient care begins. Whether this involves (as in our case) an inter-hospital transfer or as is more usual a move to the hospital's own rehabilitation unit is as you might say neither here nor there. There may well be a need for a further summary say ten years later when a further stack of notes has accumulated, but I will leave it to somebody else to write to you about that in 1990.

ROGER MORGAN

St Wulstan's Hospital,
Malvern, Worcs

Summary of Previous Casepapers

Name: A. Patient. *Ref. No.:* 1257. *Date:* October 1978.

Previous admissions	*Hospital*	*Admitted*	*Discharged*
1.	St Elsewhere's	10. 5.54	2.10.54
2.	,,	8. 1.55	15. 6.55
3.	,,	30. 6.77	2.10.78
4.	St Wulstan's	2.10.78	
5.			

History before first admission

Born 18.1.23 in Birmingham. C of E. Single Storekeeper.

Only child. Normal childhood, school etc. Machine hand, National Service in Far East, then returned to engineering. Quiet, no friends, no hobbies. Liked football, cricket, cinema. No interest in opposite sex. Heavy smoker, seldom drank.

Onset 18 months before first admission. Took time off work and given the sack. Thought people were after him. Stayed at home wandering about at night and sitting about all day silently staring into the fire. (Father's maternal uncle was at one time inpatient in mental hospital).

History since first admission

(In 1954 aged 31). Quiet detached apathetic strange. Believed some influence had prevented him getting jobs. Believed he had VD following a rash on his thighs. ECT × 6, brighter but solitary manneristic and fatuous. Given Deep Insulin (32 comas) with no change. Gave notice and left. Second admission, dull childish mute no acute symptoms. ECT × 17, no improvement. Had weekend leave and from one of these refused to return. Discharged not improved. Then 22 years at home alone with father (mother was dead). At first helped but later expected everything done for him. No treatment, hearing voices, sometimes aggressive, never violent. Father finally

felt he couldn't cope any longer. Third admission c/o voices like a Hoover all the time. Retarded, thought-disordered. Treated Largactil then Modecate and Stelazine, spoke more, lost voices, started work in hospital but remained dull and apathetic and needed prompting to do everything.

Physical data

1954. Dermatitis both legs. WR & Kahn negative.
1955. Teeth need attention.
1977. NAD Thin BP 140/80
Chest X-ray NAD.
Blood WR & VDRL negative.

Miscellaneous

Next of kin: Father
Mr W. Standard
28 Taunton Road
Selly Oak, Birmingham.

GP Dr MacTavish
480 Cardiff Road
Selly Oak.

Summary of treatments:
ECT × 6+17
Deep Insulin × 32 comas

Largactil	100 mg tds
Stelazine	5 mg tds
Modecate	25 mg 3-weekly
Redeptin	6 mg weekly
Integrin	80 mg qds
Mogadon	1 tab nocte
Artane	5 mg bd

Last worked in about 1952 for P. J. Evans Stores, motor spares.

Case Conferences

Name:	*A. Patient*
Age:	*55*
In hospital:	*1954–5 → 23 years at home → 16/12 at St Elsewheres*
Wing group:	*/c*
Diagnosis:	*Chronic schizophrenia*
Previous drugs:	*Largactil, Stelazine, Redeptin, Integrin, Modecate*
Physical state:	*NAD except blocked nose*
Relatives:	*Father, 83, Selly Oak. Distant elderly aunts not interested*
Money:	*Savings £926* *Benefit £3.50/week*
Psychologist:	*IQ (WAIS) V61* *P75* *F65 (? underestimate)*
Previous occupations:	*Storekeeper* *Machine hand* *No job since 1952*
Behaviour report:	*3+0* *Solitary, suspicious, no initiative. Self care, adequate with prompting, not without. Not been out of hospital.*
Other:	*Impossible to complete social assessment*
Treatment:	
Drugs	*Stop Redeptin continue Oxypertine 80 mg qid*
Classes	*Not known yet*
Clothing	*Complete*
Work	*Workshop*
Leave	*Unrestricted*
Other	*Dentures loose, need replacing* *Review in 6/12 for ENT appointment* *Interesting case—long ill* *—short in hospital*

22.3.79 (one month early). Father died on 1.12.78. Behaviour 6+0. Withdrawn, no motivation. Won't wear new teeth. Old loose ones + blocked nose impair speech. No leisure interests or activities. Not been out of hospital except to fathers' funeral. Work 25. Slow steady worker with faultless attendance and timekeeping.

Savings—£74 in hospital account
—£867 in Post Office

Clopixol 1 ml fortnightly—first dose disastrous → severe akathisia. Change to Thioridazine. Still awaiting ENT appt.

6/12 R.M.

27.9.79. Aunt from Kent has written. Affairs need referral to C of P. Behaviour 3+0. Recently recovered from prolonged akathisia. Mentally no better. Work 20. Simple jobs without supervision. Works all day. Average pay £5.63.

Savings— £178 in hospital
—£1080 in Post Office
— £867 in bank

Orap 4 mg o.m. On waiting list for SMR or similar. Not been out, not fit to go out till lately. To go on trips etc.

6/12 R.M.

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