We were puzzled by their rationale for routine serum investigations, in particular the annual measurement of folate levels, thyroid function, serum calcium, alkaline phosphatase and full blood counts in all patients irrespective of the anticonvulsant medication prescribed. We would suggest that serological monitoring is tailored for the drugs prescribed. Serum folate levels, for example, only need measuring if prescribing phenytoin and should be done six monthly as advised by the data sheet. Thyroid function and serum calcium are not recommended investigations for any anticonvulsant as far as we are aware. Only carbamazepine frequently induces hyponatraemia and justifies electrolytes being measured on a six monthly basis.

In our audit we found significant clinical and biochemical side-effects from anticonvulsant medication which affected drug therapy. Twenty-eight patients on carbamazepine had an identifiable abnormality; 8% with low sodium, 1% with high sodium, 3% with low potassium, 4% with other electrolyte abnormalities and 2% with abnormal full blood counts. In addition 11% had a raised alkaline phosphatase and 11% had high drug levels. Although neither of these latter states in themselves required intervention, it was felt to be useful for the clinician to be aware of this. We also identified 13 abnormal results in patients on sodium valproate which included five (14%) patients with high alkaline phosphatase, one (3%) with an abnormal full blood count, four (11%) with other electrolyte abnormalities and five (14%) with low sodium (three of these patients were also on carbamazepine). Several of these results triggered clinical review of therapy.

We suggest that the tailored monitoring of haematological, biochemical indices and some anticonvulsant levels is an important part of day to day monitoring of the effects of epilepsy and that failure to do so may cause patients to suffer and leave little justification in the court room especially given the data sheet recommendations.

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Clozapine prescribing

Sir: We read with interest the survey on clozapine prescribing undertaken by Seabourne & Thomas (*Psychiatric Bulletin*, 1994, **18**, 618–619).

A similar audit was recently completed by ourselves. Comparable findings included age, diagnosis and chronicity of illness. Doses of clozapine were similar (mean=385mg/day) as were reasons for discontinuing treatment; although in our sample 16/19 (63%) have received clozapine without interruption for at least 18 months, while only three deregistered permanently (all within five months of starting the drug).

Most patients had positive symptoms of schizophrenia (85%). In addition, a relatively high proportion exhibited secondary mood (40%), or behavioural disturbance (50%). Definite improvement, in at least some aspects of mental state, was recorded in 11/16 (68%), with, in particular, an improvement in positive symtomatology (delusions and hallucinations). As perhaps expected, clozapine was less beneficial for those patients with mood impairment, or aggressive or overactive behaviour. In two patients, no change was recorded.

In common with Seabourne & Thomas, we found that accurate documentation of mental state and recording of change over time, was lacking. The response to clozapine of six patients (27%) could not be ascertained by inspection of the case-notes. Similarly, dates of commencement on clozapine, current dose and reasons for starting (or discontinuing) the drug, were not always clear, or easy to find.

Measures to improve and objectify recording of patients' response to treatment would benefit patient care, help justify the use of more costly drugs and facilitate future audit. We suggest a 'clozapine front sheet', to be inserted in the notes, giving easy access to basic information such as start date, dose changes, and progressive and objective ratings of mental state. This could also include an indication that the patient fulfils locally agreed prescribing criteria. Confirmation that full information had been given to the patient would help to signify their commitment to the blood testing regime and ensure that risks of blood dyscrasia etc had been discussed.

Regular reviews in a dedicated 'clozapine clinic' rather than in general psychiatry out-patient clinics could ensure that this information is collected in a systematic and comprehensive manner.

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