Dr. D. EVANS (8): I don't think Professor Miller could have made the diagnosis of Klinefelter's syndrome. It could have been suspected by looking at the testis at the same time as eliciting the cremasteric reflexes.

Professor BOOTH: What about the Klinefelter's, Professor Fraser?

Professor T. RUSSELL FRASER (9): This case illustrates very well that the important clinical sign of Klinefelter's syndrome is a small testis, which is the only unequivocal sign always found. Whether this has got anything to do with his liability to all these other disorders I can't say. A lot of neurological and psychological disorders do occur with Klinefelter's syndrome.

Professor BOOTH: Finally, I would very much like to thank Professor Henry Miller for coming and exposing himself to this exercise. It is always a problem—the relation between reading a piece of paper and what you see in a patient, and I think for us the tremendous value is to hear a very distinguished and excellent clinician discussing a problem of this sort. It never matters whether you are right or wrong—what matters is to hear your mind thinking aloud. This has been a tremendous occasion for us, and quite the best Wednesday morning for me for a very long time. We are most grateful to you.

We are grateful to Professor J. P. Shillingford and Dr. E. D. Williams for assistance in preparing this report, and to Mr. W. Brackenbury for the photomicrographs.

The appointments held by the speakers at the time of the conference are listed below.

- (1) Professor of Medicine, Royal Postgraduate Medical School.
- (2) Dean of Medicine, The University of Newcastle upon Tyne.
- (3) Professor of Radiodiagnosis, Royal Postgraduate Medical School.
- (4) Consultant Neurologist, Royal Postgraduate Medical School.
- (5) Professor of Pathology, The University of Nottingham.
- (6) Professor of Virology, Royal Postgraduate Medical School.
- (7) Lecturer, Chemical Pathology, Royal Postgraduate Medical School.
- (8) Lecturer in Morbid Anatomy, Royal Postgraduate Medical School.
- (9) Professor of Clinical Endocrinology, Royal Postgraduate Medical School.

REFERENCES

- ¹ Vanderhaegen, J. J., Périer, O. J., and Bossaert, Y., *Pathologia Europaea*, 1966, **1**, 29.
- ² Howatson, A. F., Nagai, M., and ZuRhein, G. M., *Canadian Medical Association Journal*, 1965, **93**, 379.
- ³ Dayan, A. D., Gostling, J. V. T., Greaves, J. L., Stevens, D. W., and Woodhouse, M. A., *Lancet*, 1967, **1**, 980.
- ⁴ van Bogaert, L., Radermecker, J., and Devos, J., *Revue Neurologique*, 1955, **92**, 329.
- ⁵ Bennett, D. R., ZuRhein, G. M., and Roberts, T. S., *Archives of Neurology*, 1962, **6**, 22.
- ⁶ Miller, J. K., Hesser, F., and Tompkins, V. N., *Annals of Internal Medicine*, 1966, **64**, 92.
- ⁷ Gostling, J. V. T., *Proceedings of the Royal Society of Medicine*, 1967, **60**, 693.
- ⁸ Tokumaru, T., *Journal of Immunology*, 1966, **97**, 248.
- ⁹ Adinolfi, M., Glynn, A. A., Lindsay, M., and Milne, C. M., *Immunology*, 1966, **10**, 517.
- ¹⁰ Szögi, S., and Berge, T., *Acta Pathologica et Microbiologica Scandinavica*, 1966, **66**, 401.

NEW APPLIANCES

Documentation for a Major Incident

MAJOR INCIDENT		NUMBER 507	MEDICAL DETAILS
SURNAME	SEX	BP _____	
FIRST NAME(S)	AGE	PULSE _____	
ADDRESS	RELIGION	RESPIRATION _____	
INITIAL DISPOSAL—	RESUSCITATION WARD PHYSIOTHERAPY MORTUARY	MOUTH _____	
INJURIES _____		CHEST _____	
MANAGEMENT _____		ABDOMEN _____	
		STEROIDS _____	
		OTHER DRUGS _____	
		GENERAL PRACTITIONER _____	
R 3893		continue overleaf	

FIG. 1.—Medical sheet.

Mr. R. A. ELSON, consultant orthopaedic surgeon, and Mr. F. EASTWOOD, group medical records officer, Northern General Hospital, Sheffield, write: One aspect of great importance in a major disaster is the rapid and safe documentation of large numbers of injured people. The plan which has been adopted at the Northern General Hospital in Sheffield includes a system of documentation which it is hoped would be adequate in these respects. The medical records department has available at all times a major incident documentation "box," which contains a set of 500 major incident forms together with supplies of hard-backed writing boards with spring clips, ball-point pens, 2-ft. (60-cm.) lengths of string, felt pen-markers, and message pads. In the event of a major incident being declared, the medical records staff are informed, brought into the hospital, and the major incident "box" is taken to the emergency reception area. Here, teams prepare to record details of each patient on the special major incident forms.

These forms have been adapted for our special requirements, but the

principles governing their design could be modified to suit any hospital. It is intended that at the hospital patients should be screened by an experienced surgeon and classified into: urgent cases requiring resuscitation in the specially prepared resuscitation area; major cases requiring operation or hospitalization or both, and who are sent to specially cleared wards; minor cases requiring outpatient treatment and subsequently to be sent home; and the dead,

who are sent directly to the mortuary.

The problems of documentation in an emergency are: speed; the avoidance of confusion between the patient (who may be alone and unable to speak) and his documents; safety, especially in such measures as blood transfusion and drug administration; and maintenance of a list of patients arriving at the hospital for police, next of kin, and news reporters. The patient may be known by a number only, if unconscious, in

which case it is vital that there should be no possibility of error. The set of forms printed for use at this hospital is numbered consecutively from 1 to 500, and on arrival each patient receives a Major Incident Number. The latter appears on all his documents and on a label tied round the patient's neck, wrist, or ankle; the number is written with a purple marker on his face or chest as an added safeguard.

The Major Incident Form is a three-part form, the sheets being easily separable into:

MAJOR INCIDENT		NUMBER 507	
SURNAME	SEX	MAJOR INCIDENT	NUMBER 507
FIRST (NAME(S))	AGE		
ADDRESS	RELIGION		
REQUEST FOR BLOOD		BLOOD GROUP	SEX
NUMBER of bottles required			
URGENCY—IMMEDIATE (A. B. Grouped)			
QUICK CROSSMATCH (20 minutes)			
FULL CROSSMATCH (2 hours)			
PAST TRANSFUSIONS	REACTIONS		
PREGNANCIES			
GROUP IF KNOWN			
WHERE		AGE	SEX
R 3893			

FIG. 2.—Blood transfusion form.

MAJOR INCIDENT		NUMBER 507	
SURNAME	SEX	MAJOR INCIDENT	NUMBER 507
FIRST NAME(S)	AGE		
ADDRESS	RELIGION		
INITIAL DISPOSAL		NUMERICAL LIST	PATIENT'S LABEL
tear (perforated)			
SURNAME	SEX	ALPHABETICAL LIST	tear (perforated)
FIRST NAME(S)	AGE		
INITIAL DISPOSAL—	RESUSCITATION WARD PHYSIOTHERAPY MORTUARY		
MAJOR INCIDENT		NUMBER 507	
R 3893			

FIG. 3.—Medical records form.

(1) A Medical Sheet on which the medical records staff write such details as are available, on the shaded panel. This is a patch carbon area, and transfers these details to the blood transfusion form and the medical records form. The Major Incident Number is preprinted on all parts of the form. Subsequently (after removal of the records sheet described below) the medical sheet is used by the screening surgeon, who places a tick against the initial destination of the injured patient: resuscitation (urgent cases), ward (major cases), physiotherapy (where minor cases would be treated), or mortuary. The remainder of the medical sheet is for the use of the medical staff, and can be written upon overleaf and stapled to follow-up sheets as necessary. Certain basic reminders are included, such as previous drug therapy and whether or not the patient is on steroids should such information be available.

(2) Blood Transfusion Sheet. In the event of blood transfusion being indicated, the relevant details are written on this form. Provision is made for the degree of urgency, history of past transfusions (including recent plasma or plasma expander solutions), and where the blood is to be sent. The perforated strip (again bearing the Major Incident Number) is for the use of the laboratory technician for labelling the cross-match.

(3) Records Sheet. Unlike the medical and blood transfusion sheets, which are printed on ordinary paper, this sheet is a card and can be torn along the perforations into three parts. The small section on the right, which has a hole at one end, is tied round the neck, wrist, or ankle of the patient (it bears the Major Incident Number). The remaining two portions are passed to the medical records officer, who thereafter keeps an alphabetic list of cards and a numerical list. By this means the patient can be named and located because the initial disposal is recorded.

As patients are discharged home, the medical cards are returned to the medical records officer, who amends his alphabetic and numerical lists of patients accordingly. Once the forms and the major incident records box have been prepared, it is only necessary to keep staff informed of its use and location. Every three months the forms are checked to ensure that the patch carbon is still functioning adequately; when changes of staff occur new personnel are instructed in the major incident procedure and their important role therein.