Pediatric Dosage Handbook published by the American Pharmaceutical Association to be far superior to *Master Index of Medical Specialties* (MIMS). In a review of management of upper respiratory tract infection,[3] we found that codeine was not recommended in those younger than 2 years. Up till now, there is still no evidence that codeine is more effective in reducing cough than a placebo in children.[3]

From the authors' personal observation, it is common for infants to be prescribed codeine and not uncommon for young infants less than 3 months old to be given codeine. The cough for infant could only be one of two things: mild or not mild. If it is mild, it should not be treated with codeine—this is not recommended and dangerous as illustrated. If it is not mild, for example, pertussis, gastroesophageal reflux or bronchiolitis, codeine would only delay proper treatment and potentially aggravate the situation as in codeine and bronchiolitis. In the lay press coverage of Lee et al's report,[4] a medical practitioner was quoted as saying that codeine is acceptable for those under 1 year old. This suggestion is rather unfortunate in view of the fact that among the five case reports of six young infants, defined as 3 months old or younger, who suffered adverse effects associated with codeine used as a treatment of cough retrieved from our search in Medline (Ovid) from 1970 to 2004 using the following key words: codeine, child, and newborn infant, two were reported from Hong Kong.[1,2] This disproportionate over-representation (33%) of Hong Kong in the published evidence of the adverse effect of codeine is in line with our observation that the practice of codeine prescription is common in Hong Kong. It is often argued that experienced medical practitioners observe no problems in infants who are given codeine. However, this statement must be viewed with extreme caution because those with problems might not inform the prescribing doctors, as in our case. In conclusion, we would urge all medical practitioners not to prescribe codeine-containing medications to infants as the benefit, if any, is not worth the risk and better alternatives are available[3] unless and until we have solid evidence that Chinese young infants tolerate codeine well and all the previous cases are unrepresentative.

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Suicides in general hospitals

To the Editor—The article by Ho and Tay[1] draws our attention to a very important problem in hospital practice. A number of important factors relevant to suicide have been pointed out and discussed. To this list I would like to add two points in patient management which might induce suicidal tendency.

The first is drug-induced suicidal tendency. Theoretically all drugs causing depression can cause it, eg *Harrison's Principles of Internal Medicine* has listed beta blockers, reserpine, methyldopa, clonidine, glucocorticoids, levodopa, and even amphetamine (withdrawal) to this effect.[2] Many years ago, as a junior trainee, I had the unpleasant task to certify the suicidal death of seven patients within 3 months in a chest unit. The alarm was raised and the culprit was traced to cycloserine which was being tried on tuberculous patients resistant to standard treatment. Stopping cycloserine put an end to the suicide epidemic.

The second is the attitude of the health-care personnel. At the same unit mentioned, we had a patient with chronic empyema who broke hospital discipline on some trivial matter. He was summoned to the astute nursing officer in charge of the floor, and given a no-nonsense reprimand. In the end he turned around, rushed to the window and climbed out. I had to use all my strength to pull him back (not the safest procedure for both doctor and patient)! Later we transferred him to another hospital and operated on his empyema successfully.

Happily, I am sure that both drug safety and the attitude of hospital staff are vastly improved nowadays.

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