to the possibility of depression and suicidal risk among general ward patients is required. General practitioners and nurses should improve their care and awareness to patients who have not previously attempted suicide but who have suicidal risk in general wards during their normal daily practice.

However, we would like to add some observations on the re-attempt suicidal risk of in-patients in local hospital setting. The suicide rate for the general population and the attempt rate were 16.4 and 37.3 per 100 000, respectively, in 2002.[2] The suicide and attempt rates in hospital wards were actually lower than that of the general population. Also, based on the Hospital Authority's data warehouse system, there was a record of 4289 cases of in-patients with suicidal attempts who were admitted via Accident and Emergency Department during the captioned period (1 April 2000 to 31 March 2002). The rate of re-attempt of these suicidal patients in general ward was about 652.8 per 100 000 admissions (28/4289). The odds ratio (OR) of these two groups, ie (i) patients admitted to general wards primarily due to their suicidal acts and (ii) general ward patients as a whole, was estimated to be about 69 (OR= [28/166]/[4289/1 754 500]) with a 95% confidence interval (46-103), which shows that those admitted to general wards because of attempted suicides are exposed to a significantly higher risk of attempt than that of other patients. Those who are admitted to general ward due to suicidal attempt have the highest risk of re-attempt and they should be monitored closely. Many long-term follow-up studies on deliberate self-harm patients have already concluded that an unexpectedly high risk of re-attempt is present within the first-year follow-up and its impact lasts several years afterwards.[3-5] Also, focusing on suicidal attempts has been identified as one of the core interventions in suicide prevention programmes in a number of national programmes, for example, in the United States, United Kingdom, and Australia. In view of this, our Centre is currently collaborating with two local hospitals to study suicidal attempts and how to improve on the existing service (including the follow-up) for suicide attempters.

Given the importance of Accident and Emergency Department as the first point of contact for a major proportion of people who attempt suicide, a systematic surveillance and monitoring of deliberate self-harm patients presented to this department is essential for any suicide prevention programme.

PSF Yip, PhD
(e-mail: sfpyip@hku.hk)
KCT Yang, MPhil
FYW Law, MSW
The Hong Kong Jockey Club Centre for Suicide Research and Prevention, University of Hong Kong, Pokfulam, Hong Kong

References

1. Ho TP, Tay MS. Suicides in general hospitals in Hong Kong: retrospective study. Hong Kong Med J 2004;10:319-24.
2. The Hong Kong Jockey Club for Suicide Research and Prevention website: http://csrp1.hku.hk. Accessed 1 Nov 2004.
3. Hawton K, Zahl D, Weatherall R. Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. Br J Psychiatry 2003;182:537-42.
4. Hawton K, Fagg J, Simkin S. Deliberate self-poisoning and self-injury in children and adolescents under 16 years of age in Oxford, 1976-1993. Br J Psychiatry 1996;169:202-8.
5. Yim PH, Yip PS, Li RH, Dunn EL, Yeung WS, Miao YK. Suicide after discharge from psychiatric inpatient care: a case-control study in Hong Kong. Aust NZJ Psychiatry 2004;38:65-72.

Halitosis and the nose

To the Editor—We read with interest the article 'The aetiology and treatment of oral halitosis: an update' by Lee et al.[1] The authors rightly pointed out mouth breathing as a cause of halitosis but they failed to discuss the important issue of causes of mouth breathing. Only by tackling the aetiologies of mouth breathing can we treat halitosis effectively. Nasal breathing is usually the preferred route of breathing at rest, and mouth breathing occurs when there is nasal obstruction. The most common cause of persistent nasal obstruction in Hong Kong would be allergic rhinitis which has been reported to affect 52% of 13- to 14-year-olds[2] and 37% of 6- to 7-year-olds.[3] Hence, prescription of topical nasal corticosteroid and avoidance of allergens would be important in halitosis due to mouth breathing secondary to allergic rhinitis.

Another important cause of halitosis is subacute rhinosinusitis. We found halitosis in 29 of 41 children with subacute rhinosinusitis.[4] Hence, appropriate an-

tibiotics and treatment of co-morbid allergic rhinitis would be important in halitosis secondary to rhinosinusitis.

In conclusion, we would urge readers to consider the nasal source if there is no oral source in approaching a person with halitosis.

DKK Ng, MMedSc, FRCP
(e-mail: dkkng@ha.org.hk)
PY Chow, MRCP, FHKAM (Paediatrics)
KL Kwok, MRCP, FHKAM (Paediatrics)
Department of Paediatrics
Kwong Wah Hospital
25 Waterloo Road, Kowloon, Hong Kong

References

1. Lee PP, Mak WY, Newsome P. The aetiology and treatment of oral halitosis: an update. Hong Kong Med J 2004;10:414-8.
2. Leung R, Wong G, Lau J, et al. Prevalence of asthma and allergy in Hong Kong schoolchildren: an ISAAC study. Eur Respir J 1997;10:354-60.
3. Lee SL, Wong W, Lau YL. Increasing prevalence of allergic rhinitis but not asthma among children in Hong Kong from 1995 to 2001 (Phase 3 International Study of Asthma and Allergies in Childhood). Pediatr Allergy Immunol 2004;15:72-8.
4. Ng DK, Chow PY, Leung L, Chau KW, Chan E, Ho JC. A randomized controlled trial of azithromycin and amoxicillin/clavulanate in the management of subacute childhood rhinosinusitis. J Paediatr Child Health 2000;36:378-81.

Answers to CME Programme
Hong Kong Medical Journal
December 2004 issue

Hong Kong Med J 2004;10:373-7

I. Stapled haemorrhoidectomy in Chinese patients: a prospective randomised control study

A	1. False	2. True	3. False	4. True	5. False
B	1. False	2. False	3. True	4. False	5. True

Hong Kong Med J 2004;10:406-13

II. Childhood obstructive sleep apnoea: an update

A	1. True	2. False	3. True	4. True	5. False
B	1. False	2. False	3. False	4. False	5. False
C	1. True	2. False	3. True	4. False	5. False
D	1. False	2. True	3. True	4. False	5. True