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. 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. 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.

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**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. 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 and 37% of 6- to 7-year-olds. 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. Hence, appropriate an-
Antibiotics 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.

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