Preventing children drowning

SIR,—Three summers ago our 2 year old son wandered from our garden. He was found in the swimming pool of a neighbouring garden: the pool was unfenced and had a non-weight bearing cover. Resuscitation was not successful. We know of three families within 16 km who have suffered similar tragedies: as Alison Kemp and J R Sibert point out, drowning is a common cause of accidental death in children.[1]

In our society, where there is increased emphasis on out of doors activities, the incidence of drowning in children will surely increase unless effective preventive measures are taken. We have written on this matter to our member of parliament without success. We support Kemp and Sibert's recommendations that domestic pools should have toddler proof fences with self locking doors and covers that can bear the weight of a child. People may argue that this interferes with personal liberty: the same was said about seat belt legislation. The children whose lives are at risk are too young to appreciate such abstract arguments.

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Suicide and vehicle exhaust emissions

SIR,—In his editorial Keith Hawton comments that car exhaust poisoning is the method of suicide most commonly used by young men and suggests that one possible strategy to reduce this would be to alter the design of car exhausts so that it is harder to attach tubing.[1] We suggest that introducing controls on exhaust emissions may also be of benefit.

The introduction of federal standards for car exhaust emissions in the United States in 1968 led to a reduction in deaths from exhaust poisonings that was not seen in the United Kingdom, where no similar controls were imposed.[2] Controls on the levels of various pollutants, including carbon monoxide, in exhaust fumes, have been included in the MOT test since 1 January this year. This is in accordance with a European Community directive on standards for emissions, which will come into force on 31 December this year. The exact standard required depends on the age of the car.[3] Levels of pollutants can be reduced by manufacturers in various ways, including by fitting a catalytic converter, which reduces pollutants such as carbon monoxide by 80-90%.[4]

A 43 year old man was admitted to hospital after a serious suicide attempt: he had connected a hosepipe to the exhaust of his car and led it into the car through a small opening in one of the windows. The engine of the car (a Saab fitted with a catalytic converter) had been running for about five hours when he was discovered by police; he was semiconscious.

On arrival at hospital he was found to have a carboxyhaemoglobin concentration of 21%. He made a good recovery, with no evidence of cognitive impairment, and was later transferred to the local psychiatric unit for further assessment.

Our patient suffered relatively mild carbon monoxide poisoning despite spending five hours inhaling exhaust fumes. Previous reports indicate that when people use ordinary vehicles and a similar method to that reported here death may be expected within 20-30 minutes of them starting to inhale fumes.[5] At that stage carboxyhaemoglobin concentrations would be above 50-60%. We speculate that this suicide failed because the car was fitted with a catalytic converter. To our knowledge, this is the first such report in the United Kingdom.

Introducing controls on exhaust emissions may have a beneficial effect on suicide rates.

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Suicides in prison

SIR,—Keith Hawton did not mention the relevance of suicide in prison in his editorial on suicide among men.[1] The rate of suicide in prison far outstripped the rate in the rest of the population during the 1980s[2]; therefore it is fair to surmise that suicides in prison have contributed considerably to the national statistics. Suicide in prison is a well established problem, and even in 1913 the suicide rate of prisoners was three times that of the general population.[3] Although car exhaust poisoning is the method of suicide used most commonly by men aged 15-44,[1] hanging seems to be the commonest method in prison.

Preventing suicide in prisons or in the community is not primarily a medical matter; nevertheless, different methods of screening all new prisoners—for example, initially by trained psychiatric nurses—and, as recommended,[4] contracting in specialist mental health care services may considerably reduce the rate of unnatural deaths in prison.

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New study of suicides needed

SIR,—Keith Hawton's proposal for a fresh inquiry into the clinical and social features of suicide based on the "psychological necropsy" approach deserves serious consideration.[1]

According to the citation index, studies that describe clinical aspects of a consecutive series of suicides are often referred to, indicating a continuing need for facts on the symptoms and signs of mental disorder in suicide. But the three studies most often referred to are over 25 years old,[2-6] and there are grounds for believing that different findings might emerge today. These grounds include a changed composition of the population, increased suicide rates among the young, improvements in the treatment of mental disorder, changes in coroners' practice, improved methods of classifying mental illness, and a greater tolerance of suicide.

Changes in ethical standards intended to protect supposed vulnerable relatives being interviewed might, however, prevent a complete consecutive series being collected.

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Treating elderly patients with breast cancer

SIR,—Although elderly patients with cancer have special needs, it does not follow that optimal treatment should necessarily be withheld. Indeed, whom do we define as elderly? J Michael Dixon cites the age of 70 as the arbitrary cut off point.[1] In our opinion, specific age is not the main issue. More important criteria are how active the patient is, concomitant medical conditions, and the patient's choice of treatment. Patients' preferences may include perceptions of the relative value of quantity versus quality of life.

Treatment options should be explicitly formulated for individual patients. Some patients may prefer a modified radical mastectomy without the need for postoperative radiotherapy in most cases, whereas others may wish to be managed with a local excision followed by adjuvant radiotherapy. Axillary dissection could be optional, but it is crucial to explain that this would determine whether long term tamoxifen should be given. If axillary dissection is declined, however, it is reasonable to offer irradiation of the axilla to potentiate local control.

In our experience, radiotherapy is well tolerated by elderly patients. As long term cosmesis is unlikely to be of overwhelming importance