The Editor

Sir,

The number of suicides in Japan has increased from about 22,000 per year between 1988 to 1997 to over 30,000 per year since then. Mie Prefecture, in central Japan, has also seen an increase in suicide. We believe suicide victims express suicidal signs before they act. According to a report by Yoshioka for the Ministry of Education, Culture, Sports, Science and Technology of Japan, which presented a statistical analysis of suicides in Mie Prefecture between 1989 to 1995, the prefecture showed intermediate levels of suicide and patterns of suicide similar to those of Japan as a whole (1). Therefore, the Mie Prefecture suicide data were analyzed as a reflection of the national problem. In the present report, the authors investigated the incidence and the circumstances surrounding all suicide cases from 1996 to 2002 in cooperation with the first department of criminal investigation of the Mie Prefectura police headquarters. Pre-suicide signs were also examined in detail. All data in the records were completely anonymous after encoding.

Pre-suicide signs were determined by psychiatric specialists and divided into four stages: direct linguistic signs, indirect linguistic signs, direct action signs and indirect action signs. Direct linguistic signs are direct expressions of suicidal thoughts, such as “I want to die”. Indirect linguistic signs are indirect expressions, such as “I want to disappear”. Direct action signs are actions that directly indicate a preparation for suicide such as the purchase of knife or drugs. Indirect action signs are actions that indirectly indicate preparation for suicide such as a person who settles all his/her personal affairs (2, 3).

During the test period, there were 2948 suicides (1979 males and 969 females). Pre-suicide signs were noted in 40.4% of the cases. Among them, direct linguistic signs, indirect linguistic signs, direct action signs and indirect action signs accounted for 32.5%, 27.8%, 6.5% and 33.2% of cases respectively.

The rate of pre-suicide signs is quite high. Since they are expressions and actions leading to suicide attempts, they must be given due attention. To prevent suicide, all these pre-suicide signs must be reported in due time for early intervention (4).

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Chest Wall Abscess due to Aspiration of Grass Inflorescence

The Editor

Sir,

Foreign body aspirations (FBAs) in childhood is frequent. Grass inflorescence aspiration is rare and may cause some serious complications (1–3). We present a case of grass inflorescence aspiration which caused a chest wall abscess (CWA) by migration into the chest wall.
A six-year-old boy was referred with complaints of right chest wall mass and chest pain. Twenty days previously, he had been hospitalized due to complaints of fever, cough, chest pain and dyspnoea. Ten days later he developed swelling on the lateral chest wall (Fig. 1). Chest X-ray showed a bulging in the soft tissue on the right upper lateral chest wall and a foreign body. Chest ultrasonography confirmed a subcutaneous abscess without pleural effusion. Chest computed tomography demonstrated a chest wall abscess but no sign of foreign body. A thick, yellowish fluid was retrieved by puncture of the abscess (Fig. 2). The gram and Ziehl-Nielson stainings and cultures of the fluid were all negative. On the third day of hospitalization, the abscess fistulized spontaneously through the skin and the tip of a foreign body appeared in the opening of the fistula. The tip was withdrawn with a forceps and it was a grass inflorescence (Fig. 3). He was discharged the day after on oral antibiotic therapy. At the six-month follow-up, he was quite well.

Grass inflorescence is an uncommon aspirated material. Because of its morphological and botanical characteristic features, an aspirated grass inflorescence moves unidirectional. It is almost impossible to expel once aspirated. Aspirated grass inflorescence either may remain local by penetrating into the airway, and then cause obstruction and pneumonia, or migrate to the periphery of the lung, and cause pneumonia, lung abscess, haemoptysis, bronchiectasis or empyema (1–3). Diagnosis of grass inflorescence aspiration in children is quite difficult (1). It is not detectable radiologically and has the tendency of migration. Meticulous anamnesis is crucial for diagnosis. Bronchoscopic evaluation is mandatory in suspected patients. In asymptomatic patients, diagnosis may be delayed and this can increase morbidity and mortality (1).

Chest wall abscess may occur anywhere on the chest wall and present as primary infections or may be due to secondary causes such as trauma or surgery (4). Foreign body aspiration as a cause of chest wall abscess is quite rare. Migration of grass inflorescence into the chest wall may present as a chest wall mass and/or abscess which may be confused with empyema necessitatis, Tietze’s syndrome, costochondritis, osteomyelitis and benign or malignant chest wall tumours (4).

Therefore, even if it is extremely rare, aspiration of grass inflorescence may cause chest wall abscess and physicians should be aware of this uncommon complication.

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Escherichia coli and Amoxicillin/clavulanate Resistance at the University Hospital of the West Indies 1994 versus 2003

The Editor

Sir,

Amoxicillin/clavulanate is widely used for the treatment of *Escherichia coli* infection. However, resistance has emerged in the Caribbean (1–3).

The laboratory methodology in 1994 (disc diffusion with measured zones of inhibition) and in 2003, for selected isolates (Vitek GNS 118 and GNS 204 cards), allowed categorization of the susceptibility of strains of *E. coli* into susceptible, intermediate and resistant. We compared the distribution of results for the two years. The study was designed to detect a shift towards increased resistance.

Several major assumptions had to be made: first that the spectrum of patients seen at the University Hospital of the West Indies had not changed over the nine years; secondly, that the sampling of specimens was representative of the patients seen in 1994 and 2003; thirdly, that the selection of isolates for Vitek testing in 2003 did not introduce a selection bias; fourthly, that the use of the GNS 118 card for non-urinary isolates, which contained ampicillin/subactam, did not influence the results.

In 1994 susceptibility testing was by the disc-diffusion method with amoxicillin/clavulanate. In 2003 susceptibility testing, the GNS 204 card containing amoxicillin/clavulanate was used for urinary isolates, whilst the GNS 118 card containing ampicillin/subactam was used for isolates from other sites. *E. coli* ATCC 25922 was the control strain.

Statistical analysis was by chi-squared with two degrees of freedom, *p* > 0.05 was considered significant.

The 1994 survey included 520 isolates and the 2003 sample 165 isolates. In 1994, isolates susceptible to amoxicillin/clavulanate numbered 314 (60.4%), intermediate susceptibility, 138 (26.5%) and resistant 68, (13.1%). In 2003, isolates susceptible to amoxicillin/clavulanate or ampicillin/subactam numbered 108 (65.5%), intermediate susceptibility 36 (21.8%) and resistant 21 (12.7%). Chi-square was 1.55 with two degrees of freedom, *p* > 0.3, considered not significant.

Only a limited analysis can be made of the 1994 versus 2003 findings. This is because of the major assumptions made. The rates of resistance of *E. coli* to amoxicillin/clavulanate are similar to previous studies from Jamaica and Trinidad and Tobago (1–3).

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