Microalbuminuria among patients with type II diabetes mellitus: early screening and intervention required

To the Editor—I am writing with reference to the article by Tam et al[1] in the October 2004 issue of the *Hong Kong Medical Journal*. The authors are to be congratulated for conducting such a comprehensive study on a topic of immense public health and clinical importance that needs prompt attention and intervention. I wish to comment more on the importance of early screening and intervention of microalbuminuria in patients with type II diabetes, which is never a benign condition.

The prevalence of microalbuminuria is as high as 53% among diabetics[2] and is significantly associated with modifiable factors, such as hyperglycaemia and elevated levels of blood pressure.[3] Microalbuminuria is a predictor of advanced nephropathy and a risk indicator for cardiovascular mortality,[3] and is correlated with overall deaths[4] among patients with type II diabetes. Nevertheless, I am concerned about the suboptimal surveillance and screening of microalbuminuria among type II diabetics by care providers in different parts of the world. Khuwaja et al,[5] for example, recently reported that only 38% of patients with type II diabetes were screened for microalbuminuria in a multicentre study in Karachi, Pakistan. Moreover, large number of diabetics in that study had modifiable factors (high systolic blood pressure of 65%, high diastolic blood pressure of 75%, and high glycaemia level of 74%), which were already proven to be strongly associated with microalbuminuria. The literature indicates that intensive diabetes management with modification of risk factors can significantly decrease the burden of this condition.[3]

I highly recommend the early detection of microalbuminuria with aggressive management of modifiable risk factors by means of lifestyle changes and therapeutic measures. Thus, the burden of premature morbidity and mortality associated with this condition can be significantly reduced. In this regard, physicians should be trained about more comprehensive and integrated management protocols for diabetics in general and for diabetics having microalbuminuria in particular.

Ali Khan Khuwaja, MCPS, FCPS
(e-mail: ali.khuwaja@aku.edu)
Department of Family Medicine and Community Health Sciences
Aga Khan University
Karachi, Pakistan

References

1. Tam TK, Cheng LP, Lau DM, et al. The prevalence of microalbuminuria among patients with type II diabetes mellitus in a primary care setting: cross-sectional study. Hong Kong Med J 2004;10:307-11.
2. Sobngwi E, Mbanya JC, Moukouri EN, Ngu KB. Microalbuminuria and retinopathy in a diabetic population of Cameroon. Diabetes Res Clin Pract 1999;44:191-6.
3. American Diabetes Association. Standards of medical care in diabetes. Diabetes Care 2004;27(Suppl 1):15S-35S.
4. Dinneen SF, Gerstein HC. The association of microalbuminuria and mortality in non-insulin-dependent diabetes mellitus. A systematic overview of the literature. Arch Intern Med 1997; 157:1413-8.
5. Khuwaja AK, Rafique G, Azam I, et al. Out-patient care of type 2 diabetes in three settings in Karachi, Pakistan. Proceedings of the 3rd Asia Pacific Conference on Evidence-based Medicine; 2004 Nov 26-28; Hong Kong.

Suicides in general hospitals in Hong Kong

To the Editor—Ho and Tay[1] gave a useful description of the characteristics of suicide patients and their suicidal acts occurring in general hospitals of Hong Kong in the October 2004 issue of the *Hong Kong Medical Journal*. It is a retrospective study and focused on the hospital records of patients who died of suicide or attempted suicide between 2000 and 2002. Results indicated that a total of 166 suicidal acts occurred in general wards, consisting of 34 completed suicides and 132 attempts with a rate of 9.46 on average per 100 000 admissions. Among them, 16.9% (28/166) were admitted to the general ward because of their suicidal act. Certainly, we agree with the authors that there is a particularly high re-attempt risk for these patients, and in the meantime the suicidal risk of other patients should not be neglected. Increased alertness

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-