

duration) has been under-reported due to the lack of EEG monitoring of seizures (Weiner *et al*, 1980). Nevertheless, the occurrence of either a prolonged seizure or spontaneously occurring seizures should be treated expeditiously, perhaps with anti-convulsant medication and immediate consultation with a neurologist. (c.f., Strain & Bidder, 1971; Weiner *et al*, 1980; Weiner, 1981).

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SUICIDE IN HOSPITAL

DEAR SIR,

I read with great interest your recent Symposium on Suicide in Hospital (*Journal*, November 1984, **145**, 459–476). I recently carried out a small retrospective survey on all known in-patient suicides at Fulbourn Hospital over the five year period 1979–84. There were fourteen such suicides in a 455 bed mental hospital serving a catchment area of 570,000, giving a rate of 0.49 per 100,000 per year of the general population which seems similar to that found by Langley and Bayatti (*Journal*, November 1984, **145**, 463–467).

I would like to raise two points from the study. Firstly, I found that ten out of the fourteen had

made previous attempts and that in seven cases this involved the use of a violent method. In seven cases (six using a violent method) the attempt was just prior to or during admission. This suggests that attempted suicide by a violent method is an important risk factor in the assessment of in-patient suicides where death by overdosage is more difficult to accomplish. Secondly, I found that in twelve of the fourteen cases the medical notes contained as their last entry little more than a note of the patient's death or of details of attempted resuscitation (the nursing notes were far more complete). This may have resulted from a wish to deny the patient's death or perhaps more simply because the doctor becomes too busy at the time, forgets or thinks it of no value.

Regular audit would improve this practice which, if it is widespread, would make retrospective surveys more difficult.

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DIAGNOSTIC ISSUES IN THE HYPERVENTILATION SYNDROME

DEAR SIR,

We would like to take issue with the methods used by Kraft and Hoogduin (*Journal*, **145**, 538–542) to establish the diagnosis of hyperventilation syndrome (HVS). They remark that a patient had to be suffering from "at least 18 out of 45 complaints commonly associated with the hyperventilation syndrome" to qualify for inclusion in their study. The symptoms in their checklist are so non-specific that conclusions based on patient groups satisfying these criteria are bound to be tentative. Grossman and de Swart (1984) have already demonstrated that reported complaints are an unreliable guide to the diagnosis of HVS.

No clinician would diagnose diabetes without measurement of blood sugar: similar objective measures should be used to establish a diagnosis of HVS. Hyperventilation implies arterial hypocapnia. In patients with normal lung function it has long been accepted that end-tidal (equivalent to alveolar) pCO₂ (or PACO₂) is very close to arterial pCO₂ (PaCO₂) (Bannister *et al*, 1954). We believe that objective measurement of PACO₂ is essential before establishing a diagnosis of hyperventilation.

Diagnostic issues are important for two reasons. Firstly, the array of symptoms in HVS and panic disorder is similar (Bass & Gardner, 1983). Diagnostic criteria for panic disorder have been established (American Psychiatric Association,