

Correspondence

A further note on filicide with suicide in Turkey

To the Editor

I read with great interest the recent paper appearing in the journal on filicide in the city of Hong Kong by Kam Lun Hon.^[1] As there are very few reports on this tragic crime of one's own child, I wanted to add five attempts with different reasons from Turkey.

I have been collecting data on suicidal attempts of mothers from the archives of newspapers since 2008. Incidents were included if at least two of the newspaper had the news. Of these, five of them were included as filicide (Table).

It is interesting that two of them had immigration history as the underlying condition and of the three couples they either divorced or husband left home. One of them was saved by chance as the neighbors felt the smell of gas, finally saved by the police and the other was persuaded by a phyciatrist.

One of the mothers was immigrant to Germany from Turkey. The data on this case are missing as the German police did not give any information about the incident. This may be correct ethical way of attitude.

Nationwide collection of data on filicide with suicide may bring new insights to the problem.

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Author reply

It is good that filicide is also reported from Turkey to further enhance the pediatric literature. The author is right to comment that there are very few reports on this tragic crime of killing one's own child. Nevertheless, filicide is probably not rare. Indeed, it is the third leading cause of death amongst American children 5 to 14 years old; and parents were responsible for 61% of children murders under the age of 5.^[1]

Filicides have long been reported in history, religion, myth, folklore, fiction and culture (<http://en.wikipedia.org/wiki/Filicide>). In the Hebrew Bible, Genesis 22:1-24 tells Abraham's faith is tested by God by ordering him to sacrifice his son, Isaac, on Mount Moriah. Both Abraham and Isaac survive!

Underlying psychosocial issues are noted in some of the five incidents reported by the author. Interestingly, all perpetrators were mothers. It is a little unclear as to whether some of the mothers died in the incidents. Unlike the Hong Kong series, the mode of filicide appears to be varied.^[2] I concur with the author that nationwide systematic collection of data on filicide with suicide may bring new insights to the problem.

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Table. Filicide-suicide cases from Turkey

Perpetrator	Sex	Age	Incident	Outcome
45 y mother (Divorced but mother had violence from the father, Escaping from Germany)	Male	6 y	Burned charcoal	All died
40 y mother (Mother had brain tumor, Child was mentally retarded)	Female	8 y		
	Male	15 y	Suicide attempt with home gas	Saved by the police
34 y mother (Depression, Husband left home)	Female	14 y	First given a drug (?) then shot by the gun	All died
	Female	2 y	Died with the drug (?)	
19 y mother (Depression, Husband left home)	Male	9 mon	Suicide attempt from third floor	Saved by the psychiatrist
23 y mother (Immigrant to Germany)	?	18 mon	Data not given by the police	Not available

Laparoscopic cholecystostomy and bile duct lavage for treatment of inspissated bile syndrome: a single-center experience

To the Editor

We enjoyed reading the article "Laparoscopic cholecystostomy and bile duct lavage for treatment of inspissated bile syndrome: a single-center experience" by Gao et al, which appeared in *World J Pediatr* 2011;7:269-271.^[1] It is an interesting and excellent paper regarding the treatment of inspissated bile syndrome. However, we would like to question about the diagnosis of inspissated bile syndrome. There are many causes of neonatal jaundice. The most important and frequently encountered differential diagnosis is neonatal hepatitis. Tang et al^[2] noted that 8 out of 38 patients who underwent laparoscopic cholangiography had hepatitis. Senyüz et al^[3] also noted 10 of 24 cases proved to have neonatal hepatitis. Inspissated bile syndrome is rare and represents only a small fraction of the patients.

In this paper, 58 patients underwent laparoscopic exploration. Among them, 42 patients had biliary atresia and the rest 16 patients had inspissated bile syndrome. My question is: why is there no neonatal hepatitis among any of them? In our experience, while performing bile duct lavage for inspissated bile syndrome, there is an initial complete obstruction sensation followed by sudden release of the obstruction when the impacted thick bile or sludge is washed away. The visualized expansion of the common bile duct may be caused by sudden increased pressure generated by lavage itself, not necessarily indicating distal obstruction. We postulate that, perhaps some of the patients actually had neonatal hepatitis, not all had inspissated bile syndrome. It would be ideal that liver biopsy is included as a routine procedure during the operation and complement with the final diagnosis.^[4,5]

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Author reply

We thank Dr. Yeh and Chang for their valuable comments on our paper. We agree with their view points, which are complementary to our study. In our practice, cholangiography was a little bit difficult to perform with soft pressure while injecting 38% meglumine diatrizoate into to the bile duct. If more pressure was given, it disappeared suddenly as described in our paper. Thus the patients were diagnosed with inspissated bile syndrome. In our series, persistent conjugated jaundice was the indication for surgery. Since neonatal hepatitis may also be seen as conjugated jaundice, we might have taken a few cases of neonatal hepatitis as inspissated bile syndrome. Certainly if routine liver biopsy is possible, the diagnosis can be more accurate. In infants with conjugated jaundice, characterized by increased bilirubin level and cholestasis syndrome, laparoscopic gallbladder cholangiography and biliary duct lavage are better than conservative treatment.

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Drug treatment of acute severe asthma in children

To the Editor

I read with great interest the article by Wang and Hong.^[1] The authors have discussed nicely the management of severe asthma exacerbation in children. However, the following points on drug treatment need some comment.

The authors described that, a systematic review failed to identify any significant differences in lung function or hospital admission rates between continuous and intermittent strategy in adults with acute asthma. But in a Cochrane review including 8 trials (461 patients),^[2] continuous beta-agonists (CBAs) were found to be superior to intermittent beta-agonists. CBAs reduced hospital admission (relative risk: 0.68; 95% CI: 0.5 to 0.9) and significantly improved pulmonary function [% predicted forced expiratory volume in one second (weighted mean difference: 0.3; 95% CI: 0.03 to 0.5) and peak expiratory flow rate (weighted mean difference: 0.33; 95% CI: 0.1 to 0.5)]. Patients with severe airway obstruction could be treated effectively with this intervention (relative risk: 0.64; 95% CI: 0.5 to 0.9). Current evidence has supported the use of CBA in patients with severe acute asthma.

Regarding corticosteroid therapy, the authors have neither described oral prednisolone nor the duration of its use. Prednisolone has its place in acute exacerbation, provided the child is able to take it orally, and the dose is usually as follows: 10 mg for <2 years, 20 mg for 2 to 5 years, and 30-40 mg for >5 years.^[3] The patients who have already received maintenance steroid should be given prednisolone at a dose of 2 mg/kg (maximum = 60 mg). Once the exacerbation is controlled, the duration of treatment with oral prednisolone is 5-10 days.^[4] In a recent trial, 3-day treatment was as effective as 5-day treatment in children aged 2-15 years.^[5] The 3-day treatment can also be used in children aged below 2 years.^[3] Weaning is unnecessary unless the duration exceeds 14 days. But as the authors have described, the length of treatment should be tailored to the number of days necessary to bring about recovery from acute episode.

Surprisingly, terbutaline is also not mentioned although many trials have found it to be useful in the treatment of severe asthma.^[6-8] Intravenous terbutaline is a useful adjunct in patients who failed to respond to standard initial therapy, with a safe dose ranging from 1 to 5 µg/kg per minute.

Lastly, regarding the bronchodilator action of epinephrine, it is used in patients with asthma because of its beta effects (β₂-receptor) on the bronchi. Action on α-receptors is not required for beneficial effect in asthma.

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Author reply

We thank Dr. Rashmi Ranjan Das for raising some issues for discussion regarding the management of severe asthma exacerbation in children. For acute severe asthma, repetitive or continuous administration of short acting β₂-adrenergic bronchodilators (SABAs) is the cornerstone of therapy. In our article, we mentioned continuous or intermittent administration of SABAs. But a study of intermittent versus continuous nebulized SABAs in severe asthmatic exacerbations provided conflicting results.^[1] In clinical practice, intermittent use of SABAs may be more acceptable in most pediatric patients. It provides time for clinical observation and comforting the patients. The current guidelines for management of severe asthmatic exacerbation in children recommend regular inhalation of SABAs. The recommended regimen is 3 doses for every 20 minutes and then every 1-4 hours.^[2-4] The systematic use of corticosteroids is recommended for children with severe asthmatic exacerbation. We do agree that oral administration should be considered as a first line treatment just as Dr. Das pointed out. For severe cases, the symptoms such as dyspnea and vomiting may prevent the patients from taking any oral medication.

The intravenous use of β_2 -adrenergic bronchodilators including terbutaline may be used in certain cases. But questions have been raised about the safety of intravenous administration of β_2 -adrenergic bronchodilators. According to a systematic review, there is no evidence to support the use of intravenous β_2 -adrenergic bronchodilators, even in life-threatening asthma.^[5] Its use should be given to the patients who are unable to use or who are unresponsive to the inhaled route. Such patients may require intubation and assisted ventilation. Regarding the use of epinephrine, its mechanisms of action are mainly related to its beta receptor effects on the bronchi. But as a catecholamine, epinephrine has both alpha and beta effects. It has been postulated that its potent vasoconstrictive effect as well as reduced microvascular leakage may contribute to relieving the symptoms by decreasing airway edema. And epinephrine also decreases parasympathetic tone, leading to further bronchodilation.^[6]

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Risky driving behaviors should be screened to prevent motor vehicle crashes related spinal cord injury

To the editor

The recent report by Rasouli et al^[1] addressed an important issue of motor vehicle crashes (MVCs) related spinal cord injury (SCI) in children. They suggested that making behavior, roads and vehicles safer can significantly reduce MVC-related SCI in children. This review^[1] focuses on the risk factors of MVC-related SCI, but misses the risky driving behaviors, which is of great relevance to MVCs in the children's safety. We will share our concerns with respect to this topic.

There is a body of literature^[2-4] on the population with high risk of traffic accidents, which shows that human factors, in addition to vehicular and environmental factors, are the main contributors to MVCs. Empirical studies indicate that the risky driving behaviors play a crucial role in MVCs involvement. The most common risky driving behaviors^[3] include high-level speeding and speeding for the thrill of it, using cellular phones while driving (including text messaging), following too closely to the vehicle ahead, driving during night time hours, drinking and driving, violating traffic rules, and so on. It is reported that there is a higher incidence of persistent risky driving behaviors in young adult males than in young adult females.^[4] Those drivers aged 18-24 years have highest risk of MVCs in New Zealand, and the similar tendency is found in the USA and Europe. The possible cause is demonstrated by some studies that as adolescents "come of age" for learning to drive, they have risky attitudes towards dangerous driving practices, which contribute to all types of risky driving behaviors.^[5] The risky attitudes may result from the general overconfidence that young people have with regard to their driving ability.^[4]

However, not all young people engage in risky driving behaviors. Therefore, it will be effective to develop tools to screen the risky driving attitudes and prevent young people from developing risky driving behaviors. In addition, it will be of great benefit to develop the interventions targeting the high-risk group to reduce the MVCs. Considering the role of risky driving behaviors in MVCs, it is not enough only to make the vehicle safer to lower the incidence of SCI in children. Therefore, we suggest that risky driving behaviors in drivers should be screened, which is important to prevent MVCs related SCI in children.

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Author reply

We would like to thank the authors for their comments on our article^[1] in which they highlighted the role of risky driving in the development of spinal cord injury (SCI). We acknowledge that "risky driving" increases the risk of motor vehicle crashes (MVC) and may result in subsequent SCI; however, we would like to point out that this topic was addressed in our review. In the last paragraph of page 313 and first of paragraph of page 314 we reviewed the role of so-called "risky driving" behaviors. Almost all activities characterized in the letter to the editor as risky behaviors with the exception of night driving and using a cell phone during driving have already been covered. It should be noted that in this article, we reviewed risk factors for SCI, not risk factors for MVC. Although it has been shown that risky driving increases the risk of MVC, no study has been performed to show an association between these

"risky driving" behaviors and SCI. Additionally, all types of MVCs do not significantly increase the risk of developing SCI. The probability of SCI increases considerably in specific types of MVCs and/or situations such as ejection from the vehicle,^[2] vehicle rollover^[3] and head-on collision.^[4]

Finally, it should be noted that this review article addresses SCI in children and adolescents. It is more likely that these cases are injured as either pedestrians or passengers rather than as drivers.

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