our series, as in his, water immersion fatalities were limited to the bathtub. In each of our fatal cases the patient had bathed alone in a tub that was almost filled with water. We therefore advise that older epileptics bathe alone only in tubs containing generally no more than 5-7·5 cm of water. Young children, whether epileptic or not, should not be permitted to bathe alone in a bathtub. An alternative method of cleansing consists of showering while seated on the floor of the bathtub, with the drain open so that the water flows out constantly. We prefer that the patient use a hand-held showering instrument in the bathtub rather than the overhead, wall-implanted type because the former immediately ceases operation on release of finger pressure.

Contrary to Dr Pearn's recommendation, however, we do not advise that epileptics be allowed to shower alone, at least not in a standing position and especially not in glass or plastic enclosed stalls. Several of our patients who experienced a convulsion while showering fell through glass enclosures and severely injured themselves. In addition, two of our patients who had seizures in a shower stall fell against the tap that regulates the hot water flow and suffered extensive burns. Finally, some of our patients sustained serious bruises and lacerations in association with seizures occurring while showering in the upright position. In environments that include only a wall shower and in cases where the individual insists on bathing in a shower stall we recommend that the patient be seated on an appropriate type of chair or bench during the entire shower.

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A case of intrinsic asthma

SIR,—I find it a little difficult to understand why this simple and straightforward case report (23 July, p 250) should have been published under the inappropriate and grandiose title of "Community Clinics in Clinical Pharmacology," but I hope you will permit a practising clinician to voice his disquiet over some of the views expressed in the article.

In the case history reference is made to treatment with "intravenous aminophylline and hydrocortisone," which suggests that this was the only treatment the patient received for his episodes of acute status asthmaticus. I think it should have been made clear in the Advice section that if an attack of asthma is ever sufficiently severe to warrant these forms of intravenous therapy it should always be followed up by a course of oral corticosteroids.

It is stated that the patient's symptoms were due to "intrinsic asthma," but this diagnosis cannot be made without skin sensitivity tests, of which there is no mention in the report.

Since the patient had a peak expiratory flow of only 80 l/min his asthma must have been quite severe and he therefore ought to have been given an initial course of treatment with an oral corticosteroid preparation to bring his symptoms under control before beginning maintenance treatment with a corticosteroid aerosol. As all respiratory physicians know, severe asthma cannot be controlled by a corticosteroid aerosol and it is vital in these circumstances to prescribe an oral corticosteroid, such as prednisolone, for the first few days.

Although it is true that sodium cromoglycate is seldom effective in elderly asthmatics, it is not correct to say that this drug is of *no* value in intrinsic asthma, since this is a controversial issue which has not yet been resolved.

I would strongly dispute the final conclusion that the most important point is "to educate the patients in the dangers of overdosing themselves with any inhaled β-agonist." It is equally important, if not more so, to warn patients that if they fail to obtain the usual degree of relief from the use of a bronchodilator aerosol they are in a potentially dangerous situation and should seek medical help immediately.

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SIR,—In the article by Dr G M Bell and Professor M D Rawlins on "A case of intrinsic asthma" (23 July, p 250) Professor Rawlins makes the mistake of dismissing sodium cromoglycate (SCG) as being "of no value for intrinsic asthma." This is at variance with the findings of the MRC collaborative trials reported from London in 1972[1] and jointly from London and Edinburgh in 1976.[2] Using the FEV_1 as an index of improvement the latter paper showed that those patients receiving SCG derived very similar benefit whether their asthma was of extrinsic or intrinsic type. Indeed, none of the patients with intrinsic asthma on placebo continued successfully for the first 52 weeks of the trial, whereas 60% of those with the same type of asthma on SCG (with or without isoprenaline) were still on this treatment after 52 weeks with an improved FEV_1. In view of the benign nature of SCG in terms of side effects (no adrenal suppression or oropharyngeal candidiasis), it is a pity to dismiss its use for intrinsic asthma in the presence of good evidence of the converse.

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[1] Brompton Hospital MRC Collaborative Trial, *British Medical Journal*, 1972, **4**, 383.
[2] Northern General Hospital/Brompton Hospital/MRC Collaborative Trial, *British Medical Journal*, 1976, **1**, 361.

Accident or suicide?

SIR,—I was very interested to read your leading article on this subject (23 July, p 212) but feel that certain fundamental considerations, if not ignored, have at least been left unmentioned.

In the first place a coroner's verdict is based upon legal rather than medical reasoning and to that extent official suicide rates so far as England and Wales are concerned are quite useless for the purpose of medical statistics.

One can approach the facts in any given case along one or two legal paths. In the first one adopts a presumption against suicide (analogous to the presumption of innocence in a criminal trial—the law never having fully accepted that suicide is not a crime) and, in the absence of any express or implied intention to end life by the deceased, one must conclude that the death was accidental. The second approach does not make any presumption but asks whether (*a*) in ending his or her own life the deceased must have intended to do so, or (*b*) whether he or she may have had an expectation of merely inflicting serious damage or illness while accepting the possibility of death (especially in self-poisoning) or (*c*) whether he or she could have suffered the damage entirely inadvertently. In the first case the verdict must be suicide, but in the second and third the evidence of intention falls short of suicide and results in open verdicts. In this approach the verdict of accidental death is reserved for those cases in which there is overwhelming evidence of inadvertence.

A history of mental illness or previous attempts to end life are of minor importance legally in reaching a verdict; indeed, one could argue that it is improper even to consider them since they are analogous to previous convictions in a criminal trial and the verdict in any death must be reached only on the basis of the pathological and circumstantial evidence immediately surrounding the death. Those who are mentally disturbed usually have problems of concentration and it could be argued that they are more accident-prone than those not so disturbed and that the mental condition would therefore equally favour an accidental death in some circumstances. Furthermore, by the rules of chance alone a proportion of depressed persons, alcoholics, drug-dependents, and schizophrenics must be involved in accidents to which they have made only an inadvertent contribution.

Within the near future coroners hope to be freed from some of the rules which at present govern their inquiries. At present when death is unnatural they are bound to hold an inquest, but it is to be hoped that in the future the distinction between the non-inquest and the inquest case may depend on whether or not a second party is directly involved in causing the death. This would be a more useful distinction and it could even be accompanied by a reclassification of deaths in which all self-induced deaths were put into a single category. The present classification of unnatural deaths has to some extent outlived its usefulness from a legal point of view. The responsibility of deciding what is suicide would then fall on the Office of Population Censuses and Surveys, if they still wished to draw a distinction, and their findings would no doubt be more acceptable to the psychiatrists who are interested in this problem.

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Induction of labour and perinatal mortality

SIR,—We would like to continue the discussion started by the paper of Dr Margaret B McNay and others (5 February, p 347), which essentially advocates routine induction of labour as a means of avoiding deaths of "unknown aetiology" among mature babies—that is, 38 weeks (266 days) or more. Our concern is that the benefits of such a practice in terms of perinatal salvage may be outweighed by the recognised morbidity that accompanies routine induction due to failed induction, an increase in neonatal jaundice,[1-5] and hypoxia from excessive oxytocin infusion.[6 7] Unquestionably the occurrence of mature unknown (MU) stillbirths and neonatal deaths represents obstetric failure; but we suggest that techniques other than induction are now available for dealing with this problem.

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