mortality within the heterosexual population, but there is a serious danger in interpreting every morbid phenomenon in our lives today in the context of HIV. That we have reached the stage where it is fashionable to blame most deaths in the population on HIV or AIDS may distort the perception of what the real problem is.

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EDITOR,—John Aldous and colleagues report the mortality in men with HIV infection in Riverside Health Authority; eight of the 213 men who died committed suicide.¹ Suicidal behaviour in people with HIV infection has been the subject of considerable interest, and Marzuk *et al* argued that suicide is considerably increased in this group,² although there are complex methodological problems in establishing its prevalence accurately.³

We have identified six completed suicides in people with HIV infection over two years in Riverside Health Authority. Four of the patients had a history of psychiatric illness: in two this preceded the diagnosis of HIV infection and included a history of deliberate self harm. The two patients without a history of psychiatric illness were in an advanced stage of disease, and one had planned his death for over a year. The mode of suicide was predominantly by jumping—usually a rare form of suicide—but suicides by overdose may be underreported in patients with AIDS. We also looked at deliberate self harm and found 23 cases in people positive for HIV over two years; HIV infection played a part in most cases.⁴

In recent years a significant increase in suicides in young men has been noted, and HIV infection may well be a contributing factor.⁵ Staff who care for patients with HIV infection should be aware of the risk of suicidal behaviour and should refer to psychiatric services patients with suicidal ideas, particularly those with a history of psychiatric illness or deliberate self harm, especially as the disease becomes more advanced.

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Treatment of natal cleft sinus

EDITOR,—Patients who have had recurrent treatment for persistent pilonidal sinus^{1,2} are sometimes referred, in the last resort, to plastic surgeons. This is done in the hope that the plastic surgeon can either create skin flaps to obliterate the natal cleft

or perform expert skin grafting which will remove the hair follicles in and around the natal cleft.

In a few patients who have tightly opposed, muscular buttocks friction between the buttocks may play an important part in the persistence of pilonidal disease. I carried out a combination of liposuction and limited skin grafting in such a patient. Liposuction of the medial aspect of the buttocks reduced the sharp angle of the cleft and eliminated the tendency of one buttock to rub against the other. Excision of the scarred area in the base of the cleft and use of a quilted meshed skin graft completed the procedure. This was followed by primary healing, and the patient has been free of any pilonidal problems for the past six months. He had suffered recurrent disease every month or so for the previous four years despite innumerable operations.

I hesitate to make any claims for this procedure based merely on one case, but I thought it worth reporting because other surgeons might be interested in trying it. I am unlikely to be able to build up a series because these difficult recurrent cases are relatively rare.

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Over the counter treatment for candidiasis

EDITOR,—Susan Mitchell and Caroline Bradbeer provide an interesting interpretation of the presentation patterns for vaginal candidiasis that may follow the change in legal status for intravaginal imidazoles.¹ The recommendation of the Committee on Safety of Medicines to exempt such antifungals from prescription only control recognises the efficacy of the products and the role of community pharmacy in primary health care and resolves the distinction between infection in men for whom over the counter preparations have been available for some time, and that in women.

Because of the complexity of the differential diagnosis in women presenting with "thrush," over the counter imidazoles are available only to clients experiencing a suspected recurrence of candidiasis. The pharmaceutical press has made strenuous efforts to ensure that pharmacists are aware of the circumstances for medical referral, describing 11 scenarios in which over the counter treatment would be inappropriate.² Accurate diagnosis of vaginal candidiasis will therefore necessitate assimilation of potentially embarrassing information from a client who may expect to receive her over the counter preparation automatically on request. This requires a private area for counselling and competency in communication skills on the part of the pharmacist. The importance of communication skills forms an integral part of undergraduate education for pharmacists.³

The most problematic issue, however, is obtaining a history of sexually transmitted disease or exposure to a partner with sexually transmitted disease. A client may presume that she has a recurrence of candidiasis when the aetiological agent is in fact a sexually transmitted pathogen, such as herpes simplex virus or *Trichomonas vaginalis*. The danger is that a woman may not disclose, or even be aware of, exposure to a sexually transmitted disease.

Exempting vaginal imidazoles from prescription only control may be of considerable benefit to women who can recognise their recurrent symptoms and can afford to pay for their treatment over the counter. The caveat is clearly that wider

availability may lead to more cases of treatment failure and undiagnosed sexually transmitted diseases. Ultimately, medical practitioners will detect whether a change in the pattern of presentation of vaginal candidiasis has indeed occurred.

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Screening for depression in elderly patients

EDITOR,—In describing use of a new screening instrument for depression in elderly patients¹ Fiona Adshead and colleagues address a problem with self rating scales²: many elderly patients are unable to use them and require help. This difficulty is illustrated by the use of a mixed mode of presentation of the geriatric depression scale in the study (self administered or staff assisted). This is clinically relevant as a staff assisted scale is associated with a lower score than the self administered form.²

Two points are worthy of comment. The brief assessment schedule depression cards (BASDEC) are printed in a large typeface. If all patients could read the BASDEC but some could not read the geriatric depression scale this suggests that the typefaces were of different sizes: could this partly explain the patients' modest preference for the BASDEC? Although the BASDEC took less time to administer in Adshead and colleagues' study, a shortened form of the geriatric depression scale is under evaluation⁴ and may reduce the difference in time required to perform the measures.

The geriatric depression scale has an advantage over the BASDEC in that it has been shown to be useful in people with mild to moderate cognitive impairment.⁵ If the BASDEC can be shown to share this quality its utility to clinicians will be further enhanced.

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Human milk banks

EDITOR,—In an editorial on human milk banks D P Davies states, "At 9 months the mean developmental quotient was shown to be significantly lower in infants fed donor breast milk than in those fed a preterm formula,"¹ citing the work of Lucas *et al*.² Although this is widely believed, it is a view not entirely borne out by the data.

According to Lucas *et al*'s paper, at 9 months of age the mean (SD) developmental quotient of the babies fed banked human milk was 97.2 (8.5) and that of the babies fed preterm formula 98.2 (11.0).² Thus the difference between the groups was not