and siblings had committed suicide together as a way of holding on to what little autonomy they had left in that ghastly totalitarian society.

Suicide is an ethical issue, not a medical issue. In his review of Szasz' book, *Fatal Freedom: the Ethics and Politics of Suicide*, Paul Links confuses the two.[1] This reaction is not new. Institutional psychiatry has felt threatened by Szasz' ideas since he wrote *The Myth of Mental Illness* 40 years ago. Szasz' writings undermine psychiatric totalitarianism and are the tolling bell of the therapeutic state.

Institutional psychiatry may not go gentle into that good night. Nevertheless, into that good night it will eventually go.

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[The author responds:]

I welcome the opportunity to respond to the letters from Mark Latowsky and Jeffrey Schaler concerning my book review.[1] The debate about suicide and the role of psychiatry needs to be encouraged, and both subjects need to be better understood.

Suicide is a multidetermined act; it is not solely an ethical or medical issue. Although "a person who commits suicide might be sane," as Latowsky argues, let us not lose sight of the fact that 9 out of 10 suicide victims have a diagnosable psychiatric illness. Psychiatry is equally misperceived. With major thrusts into community care, psychiatry has evolved far beyond its institutional beginnings. However, psychiatric practices have created the perception of "totalitarianism." In a 1999 report, the US Surgeon General suggested that improving the effectiveness of treatment strategies and accessibility to care could significantly reduce the coercion of psychiatric practices.[2] Rather than retreating to the dark of night, let's push forward to the light of better understanding.

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Inoculation blastomycosis

Robert Lester and colleagues have reported 2 cases of infection with *Blastomyces dermatitidis* acquired in Toronto.[1] They conclude that the infections were due to inoculation blastomycosis. This seems unlikely, especially in the first case.

The first patient developed a skin lesion that was not precipitated by any significant trauma, followed by multiple, multifocal skin lesions at a distant site. The rarity of inoculation blastomycosis, coupled with the clinical presentation, suggests that this woman suffered from an infection that disseminated from a primary pulmonary portal of entry. This may occur in the absence of active pulmonary disease. In addition, skin disease is a marker for multiorgan infection.[2] In this patient, it is interesting to note that no bone scans or radiographs were taken to look for musculoskeletal involvement. The authors suggest that these tests were unwarranted and would have been arduous. After the skin, bone is the second most common focus of extrapulmonary infection and the patient may be asymptomatic. Recent guidelines for the management of patients with blastomycosis recommend that patients with mild to moderate disseminated disease be treated with itraconazole for at least 6 months.[3] The higher response rate in bone infection mandates treatment with itraconazole for at least 1 year.[3] We suggest that this patient was underinvestigated and potentially undertreated because she received itraconazole for only 4 months.

The second patient was scratched by a cat 2 months before the onset of her skin lesion. Although blastomycosis is known to occur in cats, it is much rarer than in dogs. Furthermore, all reported dog-associated cases of inoculation blastomycosis have been due to the bite of a dog that was ill with advanced pul-