

Conversation with a ...

GP registrar and my iPod

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When I wrote my previous column, I thought that I had settled on the topics that I would be talking about with the group of GP registrars that I had been asked to discuss suicide prevention with.¹ A few weeks before the meeting, I was listening to a podcast, on current health news.² To my surprise there was a brief mention of a very recently published paper that concluded that the risk of suicide was greatest BEFORE starting on antidepressants, not after. This seemed to challenge the recent controversy on this subject, and I did not feel that my talk would be complete without including the paper in the session.

Simon *et al* looked at records of a group health co-operative covering healthcare for half a million people in the US states of Idaho and Washington, between January 1992 and June 2003, they intended to address three questions.³

- 1 What is the risk of death or serious suicide attempt during acute phase antidepressant treatment?
- 2 Is there an increased risk of death by suicide during the month after starting antidepressant treatment?
- 3 Are the drugs included in the FDA warning on 'newer antidepressants' of March 2004 (bupropion, citalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, sertraline, escitalopram and venlafaxine) associated with a higher risk of death by suicide, or serious suicide attempt than are older antidepressants?⁴

The findings initially look non-controversial, and present a good picture of the epidemiology of suicide. Male and female rates of suicide death were broadly similar, and the rate did not vary significantly in the six months after starting treatment.

The authors then looked month by month at the serious suicide attempts, this showed that the risk was highest in the first month of treatment, and dropped month by month. Surprisingly the risk was highest of all in the month before starting medication. Subdivision of the month before and after starting treatment showed that the higher rate of

suicide attempts during the month before starting treatment was primarily attributable to increased risk in the 7 days before the first prescription (65 attempts per 100 000, compared to 10 per 100 000). The graphs in the paper reinforce the fact that the risk is much higher in those aged under 18.

Finally the authors looked at the risk of 'newer' antidepressants, compared to 'older' antidepressants. The risk of suicide death over the first six months of treatment was 34 per 100 000 for the drugs included in the warning, compared to 51 per 100 000 for 'older' drugs. The risk of suicide attempts leading to hospitalisation was 76 per 100 000 for newer drugs and 129 per 100 000 for older drugs.

The authors conclude that, in answer to their questions. First, the rates of serious suicide attempt and suicide death during acute phase antidepressant treatment are approximately 90 per 100 000 and 40 per 100 000. Second, available data do not indicate an increased risk of suicide or serious suicide attempt after starting antidepressant medication. Third, the risk was not higher among those treated with newer antidepressants.

Combining the lessons from this paper, and the two papers that I previously discussed.¹ I told the registrars that they could be confident in reducing suicide, and serious suicide attempt risk by undertaking training to assess suicide risk correctly, then having the courage to act on the results, not ignore them, lastly they should have the confidence to treat depression properly, according to established guidelines, which they should also seek training in.

I have to admit to having got a real buzz at the way that relatively new technologies helped me to teach the group of registrars using the very latest evidence. Hearing about the paper on a podcast, which I listened to while driving into my surgery, then being able to access a copy of a paper published in the USA on the internet, immediately on arriving at work was a real life illustration of technology helping to shrink the world, and markedly shorten the time from publication to achieving influence.

REFERENCES

- 1 Hague J. Conversation with a ... Vocational training scheme organiser. *Primary Care Mental Health* 2005; 3:295.
- 2 Podcaster News network. *Health News Headlines* www.podcasternews.com/details.php?P=12 (accessed 16 February 2006).
- 3 Simon GE, Savarino J, Operskalski B, Wang PS. Suicide risk during antidepressant treatment. *American Journal of Psychiatry* 2006;163(1).
- 4 US Food and Drug Administration, Center for Drug Evaluation and Research. *FDA public health advisory:*

worsening depression and suicidality in patients being treated with antidepressant medications. www.fda.gov/cder/drug/antidepressants/AntidepressantPHA.htm

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