Serotonin selective reuptake inhibitors are associated with increased risk of suicide in older people

Research question Is there a link between suicide and selective serotonin reuptake inhibitors (SSRIs) in older people?

Answer Yes, but only during the first month of treatment.

Why did the authors do the study? SSRIs have been linked to suicidal thoughts in adolescents. These authors wanted to explore any link in older adults because they are often prescribed antidepressants and may be particularly vulnerable to suicide.

What did they do? The authors did a large case-control study starting with all adults aged at least 66 who had committed suicide in Ontario between 1992 and 2000. They closely matched each of the 1138 cases to four population based controls who had not committed suicide, then looked at the antidepressant drug histories of both groups. They used a technique called propensity scoring to ensure that cases and controls had similar demographic characteristics and illness profiles.

The cases came from records kept by Ontario's chief coroner. Data on antidepressant prescriptions came from the Ontario Drug Benefit Program, which covers all residents over 65. The authors say it is 99% complete. Clinical information and demographic data for the propensity scores came from hospital records, doctors' diagnosis claims, and outpatient prescription claims.

The authors used conditional logistic regression to estimate the odds of suicide associated with starting treatment with any class of antidepressant except monoamine oxidase inhibitors, which are rarely used. Their analysis included the SSRIs fluoxetine, fluvoxamine, paroxetine, sertraline, and citalopram.

What did they find? Starting treatment with any SSRI was associated with a risk of suicide five times higher than the risk associated with any other class of antidepressant (adjusted odds ratio for suicide 4.8, 95% CI 1.9 to 12.2). The increased risk was apparent only during the first month of treatment and was dominated by an increased risk of violent suicide among men.

The absolute risk of suicide in the first month of treatment with any antidepressant was low, however—an estimated 1 in 3353 for SSRIs and 1 in 16 037 for patients taking other antidepressants. 68% of the 1329 suicide cases in this study had received no antidepressants in the six months before death. Venlafaxine was not included in the main analysis.

What does it mean? SSRIs are associated with an increased risk of suicide during the first month of treatment compared with other antidepressants. This could be because doctors prescribe SSRIs to the patients most likely to commit suicide, although the authors think this unlikely given their careful propensity matching. It could also be because SSRIs don't reduce the risk of suicide as much as other antidepressants or because SSRIs increase the risk of suicide in vulnerable people. It's impossible to say from this analysis, but the authors urge doctors not to stop prescribing SSRIs to depressed older people. The risks of undertreatment are likely to be worse than the early risks associated with SSRIs, which are still low. More than two thirds of the cases in this study had no treatment in the 6 months before they committed suicide.

Juurlink DM, et al. The risk of suicide with selective serotonin reuptake inhibitors in the elderly. *Am J Psychiatry* 2006;163:813-21.

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Editor's choice

Not for wimps

What can we expect in old age, assuming we are lucky enough to make it that far? We may hope for physical and mental well being, independence, fun, dignity, and a peaceful death, but what are the prospects?

Based on current trends, it's hard to say. There will be more of us, with proportionately fewer younger people to finance our longer lives. The expansion of private provision in health care (p 1172) raises fears that the old and chronically ill will be increasingly poorly served. And yet recent reports and initiatives suggest that new targets are improving outcomes and changing attitudes.

Jacqueline Morris and colleagues give a cautious welcome to the latest report on the standards of health, treatment, and social care of older people in England (the National Service Framework (NSF)), but they think good care is still too patchy in the NHS (p 1166). Too many elderly people in hospitals suffer routine indignities, such as having to use commodes in mixed sex wards behind wholly inadequate curtains. Too often old people become, in Colin Douglas' words, "souls in cages" (p 1221). "In the rush and glamour of acute care, in the busy system that is designed to cure and doesn't like to lose, there are priorities that may take insufficient account of the worse-than-death outcome that so many of us dread."

And we have clearly lost the plot when elderly people in long term care are asked to order their meals as much as two weeks in advance. Kristel Nijs and colleagues compared these long range forecast meals served on a tray at the bedside with more sociable meals, sitting at a table with a choice of foods and members of staff to talk to and provide help (p 1180). Their randomised trial found significant improvements in quality of life, health, and body weight. Anne Milne and colleagues highlight limitations in the study but confirm the need to tackle social factors such as isolation that can contribute to the "anorexia of ageing" (p 1165).

Both the NSF report and our editorial (p 1166) acknowledge that real transformation won't be achieved by simplistic targets. But targets can bring better priorities. Diana Jelley questions even that (p 1221). By the time her 90 year old patient died her care fell short of many of the Quality and Outcomes Framework (QoF) targets against which GPs are paid. But, says Jelley, other things, such as continuity of care from a practice where everyone knew her, were highly valued but are harder to measure. She says these aspects of care may suffer in the new patient led NHS, where priorities are set by middle aged, middle class people living in middle England.

As someone once told me, old age is not for wimps. We can hope things will be OK when our time comes. Or we can work towards better attitudes, provision, and priorities for elderly people now. Call it enlightened self interest, or just the right values for a civilised society.

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