

SUICIDE RISK AND CHOICE OF ANTIDEPRESSANT

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SUMMARY

Introduction: There is presently concern that patients treated for depression with venlafaxine have a higher suicide rate than those treated with other antidepressants, based on results from observational studies. The aim of this study was to determine whether higher suicide risk, defined as previous suicide attempt or suicidal ideation, influenced the choice of antidepressant prescribed in an outpatient mental health unit, the Bedford East Community Mental Health Team.

Subjects and Method: A database held by the Community Mental Health Team was used to identify patients with Depression who have been treated with Venlafaxine, Citalopram, and patients diagnosed with bipolar II affective disorder. The data was analysed in terms of presence of suicide risk, gender, and whether bipolar II patients on venlafaxine were treated with mood stabilisers.

Results: The results showed that a risk of suicide did not prevent the prescription of venlafaxine, that less venlafaxine was prescribed to male patients than females, and that bipolar II patients were indeed treated with mood stabilisers.

Discussion: It appears that in this Community Mental Health Team, the possibility of suicide risk with venlafaxine therapy is considered and appropriately managed.

Conclusion: Early diagnosis and appropriate treatment of bipolar disorder is likely to be the most effective step that we can take to reduce the risk of suicide in patients with bipolar disorder. Appropriate care regarding the judicious use of Venlafaxine as a first line treatment in Unipolar Depression is secondary to this.

Key words: bipolar affective disorder – depression – venlafaxine - suicide rate

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INTRODUCTION

There is presently concern that patients treated for depression with venlafaxine have a higher suicide rate than those treated with other antidepressants, based on results from observational studies (Cheeta et al. 2004). Most of this risk is attributable to the prescription of venlafaxine to patients with more severe depression (Mines et al. 2005). The prescription of venlafaxine to patients with bipolar II disorder, misclassified as having depression, may account for the remaining excess risk, by causing a mixed affective state which is associated with an increased risk of suicide (Akiskal et al. 2005).

The aim of this study was to determine whether higher suicide risk, defined as previous suicide attempt or suicidal ideation, influenced the choice of antidepressant prescribed in an outpatient mental health unit, the Bedford East Community Mental Health Team.

SUBJECT AND METHODS

A population of two consultants' current outpatients, recorded on a database, was filtered using Microsoft[®] Excel[®] to give a sample of patients with an ICD-10 diagnosis of either acute depressive episode (F32) or recurrent depressive disorder (F33) who were currently prescribed either venlafaxine or control monotherapy (citalopram) (n=50). The database was anonymised before use.

Individual patient records were then reviewed and assessed to determine suicide risk. We classified patients into three groups:

Patients who have experienced a previous suicide attempt, Patients who experienced - Suicidal ideation, and patients who have not experienced either suicidal ideation or a suicide attempt.

Additionally, a second sample (n=94) was taken from the same population and defined as any patient on antidepressant monotherapy in order to assess venlafaxine prescription by gender.

A final sample (n=10) was defined by having a diagnosis of bipolar II disorder (F31.8) and a prescription of venlafaxine to determine if they were also being prescribed mood stabilisers, as suggested by the NICE Guidelines on Bipolar Disorder (NICE 2006).

RESULTS

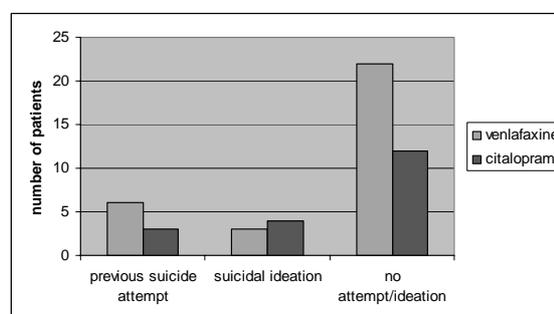


Figure 1. Choice of antidepressant, according to suicide risk

In the first sample, venlafaxine was prescribed more often than citalopram (n=31 vs n=19). Of those patients prescribed venlafaxine, 9 had a higher risk of suicide

(defined as previous attempt (n=6) or ideation (n=3), compared to 7 patients prescribed citalopram (previous attempt (n=3); ideation (n=4)).

Therefore, in this sample, a risk of suicide did not prevent the prescription of venlafaxine.

Table 1. Choice of antidepressant according to gender

| Gender | Patients on monotherapy for depression | Number of patients on venlafaxine | % on venlafaxine |
|--------|--|-----------------------------------|------------------|
| Male | 48 | 6 | 12.5 |
| Female | 46 | 19 | 41.3 |

In the second sample, 6 males were prescribed venlafaxine, compared to 19 females. Men are three times more likely to commit suicide than women.

Correspondingly, in this sample less venlafaxine was prescribed to male patients than females.

Regarding prescription of mood stabilisers to patients with bipolar II disorder, in the third sample, the whole sample (n=10) were also prescribed a mood stabiliser, either lithium or valproate.

DISCUSSION

Few studies of antidepressant prescribing have been carried out at the level of individual Community Mental Health Teams. We found that venlafaxine is prescribed to more patients than citalopram, reflecting the secondary care setting of this study: many GPs might trial citalopram before referring a patient to psychiatry.

Suicide risk did not prevent clinicians prescribing venlafaxine. This is in line with a recent study which found that most of the excess suicide risk associated with venlafaxine is due to confounding factors (Rubino et al. 2007).

We note an interesting disparity between the proportion of women who were prescribed venlafaxine and the proportion of men. Although male gender is a risk factor for suicide, the first part of our study showed that suicide risk did not deter clinicians from prescribing venlafaxine, so this is unlikely to account for the difference. Further research into this area is desirable.

The patients with bipolar II disorder were all prescribed a mood stabiliser with venlafaxine. This is good practice as it reduces the risk of a mixed affective state.

CONCLUSION

A policy of early diagnosis and appropriate treatment of bipolar disorder is likely to be the most

effective step that we can take to reduce the risk of suicide in patients with bipolar disorder (Hall et al. 2006, Rihmer et al. 2006a, Rihmer et al. 2006b).

Appropriate care regarding the judicious use of Venlafaxine as a first line treatment in Unipolar Depression must be seen as secondary to this (Cipriani et al. 2007, Agius et al. 2007).

We recommend that such a policy of early diagnosis of bipolar disorder be instituted within CMHTs, and that yearly audits of the parameters we have studied be carried out in order to ensure good practice in choice of anti-depressants and in treatment of bipolar II disorder.

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