ANTIDEPRESSANTS AND SUICIDALITY IN THE GENERAL HOSPITALIZED PATIENT

To the Editor:

We congratulate *Hospital Physician* on the publication of the practical and timely review article "Suicidality in the General Hospitalized Patient" by Dr. Wint and Dr. Akil.[1] However, the review omitted mention of antidepressant-induced suicidal thoughts and behavior. Our concern is that such an omission might imply that this risk is not significant.

The risk of antidepressants producing suicidality has emerged recently as a public health concern. The US Food and Drug Administration (FDA) concluded after reanalysis of existing research data that antidepressants increased the risk of suicidal behavior and ideation in children and adolescents between 2% and 3% over placebo.[2] The highest risk of suicidality is in the initial 10 days after starting antidepressants, with a significant risk remaining during the first month. Depression, a common cause of suicidality, may require the initiation of medication while the patient is in the hospital.

The FDA has directed manufacturers to add a "black box" warning to labeling instructing physicians to closely monitor pediatric patients taking any of 34 antidepressants for symptoms of suicidality.[3] The FDA Medication Guide for using antidepressants in children and adolescents[4] says to watch for the appearance or worsening of thoughts of suicide, depression, anxiety, agitation, difficulty sleeping, irritability, aggressive acts, anger, hyperactivity, hypomania, mania, or other unusual changes in behavior. As Drs. Wint and Akil point out,[1] prompt consultation with a psychiatrist is essential to ensure the patient's safety. The Guide[4] also states that after starting an antidepressant, patients should see their doctor once a week for 4 weeks; every 2 weeks for the next month; at the end of their 12th week taking the drug; and more often if problems arise.

Understanding the risk of these medications to cause potentially dangerous behaviors is important. Reanalysis of available data regarding antidepressant use in adults for evidence of suicidality is underway.[5] Inpatients who are started on antidepressants should be closely monitored during initial therapy, dose changes, and the transition to outpatient status. We recommend that physicians prescribing antidepressants to inpatients follow the FDA labeling changes and the Guide pertaining to suicidality. Such caution is in the best interest of patients.

Jonathan E. Fuller
Florida State University, Tallahassee, FL
A. Kenneth Fuller, MD
Southwestern State Hospital, Thomasville, GA

References

1. Wint DP, Akil M. Suicidality in the general hospitalized patient. Hosp Physician 2006;42:13–8.
2. US Food and Drug Administration. FDA Public Health Advisory: suicidality in children and adolescents being treated with antidepressant medications, October 15, 2004. DHHS, Center for Drug Evaluation and Research. Available at www.fda.gov/cder/drug/antidepressants/SSRIPHA200410.htm. Accessed 30 Mar 2006.
3. US Food and Drug Administration. Labeling change request letter for antidepressant medications. DHHS, Public Health Service, Center for Drug Evaluation and Research. Available at www.fda.gov/cder/drug/antidepressants/SSRIlabelChange.htm. Accessed 30 Mar 2006.
4. US Food and Drug Administration. FDA Proposed Medication Guide: about using antidepressants in children or teenagers. DHHS, Center for Drug Evaluation and Research. Available at www.fda.gov/cder/drug/antidepressants/SSRIMedicationGuide.htm. Accessed 30 Mar 2006.
5. US Food and Drug Administration. FDA Talk Paper: FDA reviews data for antidepressant use in adults. U.S. DHHS. Available at www.fda.gov/bbs/topics/ANSWERS/2005/ANS01362.html. Accessed 30 Mar 2006.

(continued on page 7)

(from page 4)

In response:

We thank Mr. Fuller and Dr. Fuller for their interest in our review on suicidality in hospitalized patients. Our review was intended to help hospital physicians identify suicidality and promptly initiate appropriate measures to ensure the patient's safety and was not intended to tackle specific treatments. Although the issue of antidepressant-associated suicidality is critical to the treatment of depression, it is beyond the limited scope of our paper.

Nevertheless, we are grateful for the reminder that antidepressant treatment does not preclude suicidality. The same guidelines we recommended for the untreated suicidal patient, namely psychiatric consultation, careful observation before and during treatment, and timely psychiatric and medical follow-up, should be applied in the patient already on antidepressant medication. In fact, some side effects of antidepressant treatment, such as akathisia, reduction in psychomotor retardation before depressed mood is lifted, and hypomania, have been implicated in suicidal behavior.[1]

Mr. Fuller and Dr. Fuller's careful review of scientific findings in children and adolescents documents the increased interest in antidepressant-associated suicidality. The specific association between selective serotonin reuptake inhibitors and suicidality remains controversial, however. Understanding the relationship between antidepressants and suicidality is a top priority of the National Institute of Mental Health (NIMH), and the Institute is funding large-scale studies investigating adverse effects of antidepressants. More information about NIMH findings and initiatives in this area can be found at www.nimh.nih.gov/HealthInformation/antidepressant_child.cfm and www.nimh.nih.gov/scientificmeetings/ssrisummary.cfm.

From our perspective, because no direct causative relationship between antidepressant use and suicidality has been found, suicidality should not lead to discontinuation of an antidepressant medication in a hospitalized patient without psychiatric consultation.

Dylan P. Wint, MD
Mayada Akil, MD
National Institute of Mental Health, Bethesda, MD

Reference

1. Schweizer E, Dever A, Clary C. Suicide upon recovery from depression. A clinical note. J Nervous Ment Dis 1988;176:633–6.