

Patients at increased suicide risk following cancer diagnosis

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CANCER PATIENTS ARE AT INCREASED RISK OF SUICIDE, PARTICULARLY IN THE FIRST SIX MONTHS after diagnosis, a national population-based study in England has found.¹

Data were obtained from Public Health England's national cancer registration database and the Office for National Statistics' cause of death records. In accordance with standard research practice, death from injury or poisoning with undetermined intent was classified as suicide.

The study cohort comprised patients, aged 18-99 years, diagnosed with cancer during the period January 1995 to December 2015 inclusive. Those with nonmelanoma skin cancer were excluded. Patients were followed up from the date of diagnosis until death, loss to follow-up or 31 August 2017.

A total of 4,722,099 individuals received a diagnosis of cancer, just over half were men. During follow-up, 2,491 patients were recorded as having died by suicide; more than twice as many men as women (1,719 vs 772). Compared with the general population, cancer patients had a 20% increased risk of suicide; standardised mortality rate (SMR) 1.20 (95% CI: 1.16-1.25). However, suicide accounted for only 0.08% of all deaths and the absolute excess risk was only 0.19 per 10,000 person-years (95% CI: 0.15-0.23).

Cancer-specific analyses showed that patients with mesothelioma had the highest suicide risk (SMR 4.51), followed by those with pancreatic (SMR 3.89), oesophageal (SMR 2.65), lung (SMR 2.57) and stomach (SMR 2.20) cancer. The risk of suicide was highest during the first six months after diagnosis, SMR 2.74 (95% CI: 2.52-2.98), but remained raised for three years.

A study of verdicts given in 12 English coroner districts in 2005 classified 593 deaths as suicide. Of these, 388 (65.4%) received a suicide verdict, 126 (21.2%) an open verdict, 54 (9.1%) an accident/misadventure verdict and 25 (4.2%) a narrative verdict.² Thus, 13% of suicides would not have been identified by the present study. Moreover, the use of narrative verdicts has increased since 2005 and the authors acknowledge that they may have underestimated the risk of suicide.

The variation in risk between different cancer types is likely to reflect differences in prognosis, pain levels and body image disruption, and specific tumour and

treatment-related neuropsychiatric side effects.³

It is reassuring that the absolute risk is very low. Nevertheless, completed suicide is only the tip of the iceberg. Approximately 10% of cancer patients have anxiety and 15% have major depression.³ A recent study from Scottish cancer clinics found that 73% of those with major depression were not receiving any potentially effective treatment.⁴

A Swedish study found that the first week after cancer diagnosis was the critical period of increased suicide risk.⁵ This is comparable with the aftermath of bereavement where the greatest risk of survivor suicide also occurs during the first week.⁶

Suicide is often impulsive and hard to predict. Nevertheless, I would agree with the authors' conclusion that: 'all patients, and particularly those with the cancer types at highest risk, require improved psychological

support and screening for suicidality in the immediate aftermath of cancer diagnosis.'

I recommend that GPs should review patients as soon as possible and certainly within one week of receiving notification of a cancer diagnosis. For those with a high-risk cancer or history of mental health problems this should be a face-to-face review. GPs should:

- Enquire about psychological symptoms and provide ongoing psychological support
- Identify risk factors for suicide and ask about suicidal ideation
- Provide effective treatment for those who develop a mental disorder, ideally incorporating some form of collaborative care.

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