Suicide attempts in patients with systemic lupus erythematosus

F B Karassa, M Magliano, D A Isenberg

Background: Suicide and suicide attempts, although well recognised in patients with systemic lupus erythematosus (SLE), have been commented on relatively little.

Objective: To obtain a better understanding of the reasons for suicidal behaviour in patients with SLE.

Methods: The records of 300 patients with SLE were reviewed to identify completed or attempted suicides.

Results: Five patients made seven attempts at suicide over a 20 year follow up period; one of them was fatal. All of those attempting suicide had a history of neuropsychiatric SLE (NPSLE) presenting with depression and they made the attempts soon after the onset of NPSLE (median time 12.5 months). Two patients had appreciable disease activity at the time of the suicide attempt. Lymphopenia was present in five suicide attempts. Anti-SSA/Ro antibodies were detected in three patients, none of whom had anti-SSB/La. All patients apart from one responded to treatment for depression; the remaining female patient made two subsequent suicide attempts, with a fatal outcome despite intensive treatment.

Conclusion: Greater awareness of the risk of suicide in patients with psychiatric manifestations of SLE may help to reduce the incidence of this potentially fatal phenomenon.

RESULTS

A suicide attempt is an act of self inflicted harm accompanied by explicit or implicit intent to cause death. Although only one in eight to 10 people attempting suicide succeed, suicide remains a major cause of death. More than 90% of suicide victims are psychiatrically ill and 45–77% of them have a mood disorder at the time of death.1 Chronic physical illness is an important risk factor for suicide. Systemic lupus erythematosus is one with a risk quoted to be fivefold higher than expected.2 Many factors may contribute to this occurrence: pathophysiological changes in the brain resulting from the underlying disease (NPSLE), depression related to the variable course and the unpredictable nature of the disease, and corticosteroids may rarely induce mental disturbance.

METHODS

We reviewed the medical records of the first 300 patients with SLE attending our lupus clinic over a 20 year period to identify attempted and completed suicides. Our aim was to identify any potential risk factors for the suicide in these patients related to their underlying condition.

All patients fulfilled the American College of Rheumatology (ACR) 1982 revised criteria for the classification of SLE.3 Demographic, clinical, and laboratory data as well as current and previous treatments were recorded from patients’ charts. Disease activity was evaluated using the British Isles Lupus Assessment Group (BILAG) index (version 3).4 Neuropsychiatric lupus (NPSLE) was defined according to the ACR definitions.5 Table 1 lists the details.

Abbreviations: ACR, American College of Rheumatology; BILAG, British Isles Lupus Assessment Group; CNS, central nervous system; NPSLE, neuropsychiatric systemic lupus erythematosus; SLE, systemic lupus erythematosus

REFERENCES


Table 1 lists the details.
Suicide attempts in patients with systemic lupus erythematosus

Table 1 BILAG index (version 3) for each organ system on suicidal attempts

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Date of suicide</th>
<th>CVS/respiratory</th>
<th>Renal</th>
<th>CNS</th>
<th>Musculoskeletal</th>
<th>Vasculitis</th>
<th>General</th>
<th>Lymphocytes (10^3/μl)</th>
<th>Total Haemorrhological score</th>
<th>DNA‡</th>
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The BILAG index is scored as follows: A, disease of sufficient activity to warrant disease modifying treatment with high dose steroids or immunosupression; B, disease of less activity than in A, requiring only symptomatic treatment, antimalarial drugs, or low dose steroids; C, stable mild disease; D, system was previously affected but currently inactive; E, system was never involved.

†no data available on patient 1 at the time of the last suicide attempt.
‡DNA: normal range <50 units/ml.
§C3: normal values 0.75–1.75 mg/ml.

DISCUSSION

Patients with SLE are at almost five times greater risk for suicide than expected.1 In our cohort of patients 2% had a documented history of attempted suicide. Could we have missed more suicide attempts? We cannot completely exclude this possibility but consider it unlikely as the BILAG form that we complete at every patient assessment specifically records depression and any worsening of this feature would have led to further enquiries about suicide attempts. As a control we reviewed the notes of 140 patients with primary Sjogren’s syndrome followed up by us from 1988 to 2001. To date none have attempted suicide.

All our patients who made attempts at suicide had been diagnosed with depression at some time before the attempt. Psychiatric dysfunction represents a common NPSLE manifestation and may range from mild affective disorders to severe psychosis.1,7 Our patients with NPSLE made suicide attempts within two years of the onset of involvement of the CNS; all but one had favourable outcomes with more intense treatment. Similarly, five out of seven previously reported suicidal patients with SLE presented either with depression or schizophrenia; all three survivors had a favourable response to increased dose of steroids or immunosuppressant drugs.7 To our knowledge none of our 300 patients have attempted suicide after treatment with large amounts of corticosteroids. Insomnia was a feature in all patients before the suicide attempts, and the presence of hypocomplementaemia and reducing dose of steroids possibly resulting in suboptimal control of the disease activity were implied as important suicidal risk factors.7,9 Futrell et al described six suicide attempts in 31 patients with NPSLE with major behavioural changes.7 Suicidal patients with SLE coupled with depression and aggressive behaviour have also been reported.11

Although a link between lupus psychosis and antiribosomal P antibodies has been claimed,12 assays to detect these antibodies are not readily available for identifying patients at risk in routine clinical practice. Interestingly anti-SSA/Ro was detected in three of our patients; this is twice the 30% prevalence of these antibodies in our patients with SLE overall (relative risk = 3.66; D A Isenberg, unpublished observations). None of them had concomitant anti-SSB/La antibodies. The relevance of this finding is unknown.

Patients with SLE are at greater risk of suicide, and vigilance to identify and treat symptoms and signs of depression is crucial. Although involvement of the CNS creates an additional risk we should not underestimate the importance of the psychosocial factors that coping with life threatening and unpredictable illness creates.

 AUTHORS’ AFFILIATIONS

F B Karassa, M Magliano, D A Isenberg, Centre for Rheumatology, The Middlesex Hospital, University College London, UK

Correspondence to: Professor D A Isenberg, The Middlesex Hospital University College, London, Arthur Stanley House, 40–50 Tottenham Street, London W1T 4NJ, UK; d.isenberg@ucl.ac.uk

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