



Brief report

Family history of suicide: A clinical marker for major depression in primary care practice?

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ABSTRACT

Background: The aim of this study was to investigate the family history of suicide among primary care patients with or without current major depressive episode (MDE).

Methods: This study was performed in 2 GP practices in Budapest on 255 consecutively investigated primary care attendees. The diagnosis of current MDE (symptomatic MDE or MDE in partial remission) was made by the Hungarian version of the Primary Care Evaluation of Mental Disorders (PRIME-MD). Family history of suicide was rated as positive where the patients reported at least one first or second degree relative with completed suicide.

Results: Out of the 255 consecutively investigated patients 45 (17.6%) have had current MDE and 24 (9.4%) have had positive family history of suicide. The family history of suicide was significantly more common among patients with current MDE than among those without it (26.6% vs 5.7%, $p = 0.0001$). Fifty percent of patients with, and 14.3% of patients without family history of suicide have had current MDE ($p = 0.0001$).

Limitation: Small sample size, and lacking data on fully remitted major depressives as well as on comorbid psychiatric and medical disorders.

Conclusion: History of completed suicide among first or second degree relatives could be a good and simple clinical marker for current and lifetime MDE in primary care patients.

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1. Introduction

Studies from different parts of the world consistently have shown that the current prevalence of major depression in the primary care practice is around 8–10% (range 4–18%) (Al-Windi, 2005; Anseau et al., 2004; Christensen et al., 2001; Lecrubier, 2001; Spitzer et al., 1994; Szadoczky et al., 1997, 2004; Voros et al., 2006). However, despite the increasing awareness of depression recently, GPs still have some difficulties recognizing

depression (Berardi et al., 2005; Lecrubier, 2001; Szadoczky et al., 2004). In order to improve detection of depression in primary care practice without use of prolonged structured interviews simple tools like the Primary Care Evaluation of Mental Disorders (PRIME-MD) (Spitzer et al., 1994) have been developed.

As depression and suicidal behaviour are strongly related (Angst et al., 1999; Renaud et al., 2008; Rihmer, 2007; Sokero et al., 2005) and both of them aggregate within families (Kim et al., 2005; Mann et al., 2005; Melhem et al., 2007; Roy et al., 1999) a simple indicator, like past suicide attempt of the patient or completed suicide among blood-relatives would also serve as a simple tool for screening depression in primary care practice, where the main reasons of medical contact are

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Table 1
Clinical characteristics and family history of suicide of the 255 patients.

	N	%
All patients (mean age: 49.5 ± 19.7 years, range 18–86 years)	225	100
Females	145	58.8
Patients with current MDE	45	17.6
Symptomatic MDE	21	8.2
MDE in partial remission	24	9.4
Patients with FH-S *	24	9.4
Patients with FH-S among those with MDE **	12	26.6
Patients with FH-S among those without MDE **	12	5.7
MDE among those with FH-S	12	50.0
MDE among those without FH-S	33	14.3

MDE = major depressive episode.

FH-S = family history of suicide among first or second degree relatives.

*16 patients have had FH of suicide among the first degree relatives and 8 among the second degree relatives. Because of the small numbers, these data were not analyzed separately.

**Symptomatic MDE and MDE in partial remission combined.

Chi-square = 19.08, df = 1, $p = 0.0001$.

somatic disorders or somatic symptoms and the busy GPs are under permanent pressure not to miss life-threatening organic disorders.

Using the Hungarian version of the PRIME-MD (Voros et al., 2006), a useful rapid procedure for diagnosing mental disorders by primary care doctors (Spitzer et al., 1994) we recently surveyed the current prevalence of PRIME-MD defined DSM-IV major depressive disorders among 984 consecutively screened primary care patients in 6 GPs' offices in Hungary (4 practices in Budapest and 2 in Pest county). We have found that the current prevalence rate of PRIME-MD defined current symptomatic major depressive episode (MDE) was 7.3% (females: 8.5%, males: 5.7%) and the same rate for MDE in partial remission was 2.3% (females: 2.1%, males: 2.7%) (Torzsa et al., 2008). In a subsample of this study ($n = 255$) we also have data on family history of completed suicide among the first- and second degree relatives, and in the present paper we analyze the relationship between family history of suicide and the PRIME-MD defined current MDE in this subset of our primary care patients.

2. Patients and methods

The details of the study population, the screening and diagnostic procedure as well as the main findings were published previously (Torzsa et al., 2008). In a subsample of that study, collected in 2 GP offices in Budapest, 255 patients (145 females and 110 males) also were systematically asked about completed suicide among family members. Family history of completed suicide was rated as positive where patients reported at least one first or second degree relative with definitely completed suicide. The study was approved by the local ethics committee of the Semmelweis University, Faculty of Medicine, Budapest, Hungary. For data analysis descriptive statistics and chi-square test has been used.

3. Results

Demographic, clinical and familial data are presented in Table 1. Fifty-nine percent were females and 45 patients (18%) have had PRIME-MD/DSM-IV current major depressive

episode (symptomatic and in partial remission combined) and 24 (9.4%) have had family history of suicide among first or second degree relatives. The family history of completed suicide in first or second degree relatives was significantly more frequent among those with current MDE than among those without current MDE (26.6% vs 5.7%, $p = 0.0001$). On the other hand, 50% of patients with, and only 14.3% of those without family history of suicide have had current MDE ($p = 0.0001$).

4. Discussion

The current prevalence rate of MDE (symptomatic and in partial remission combined) among our primary care patients (17.6%) is in the same range (18.0–19.9%) as reported from the United States (Spitzer et al., 1994) and from Belgium (Anseau et al., 2004). The 7.3% prevalence of current symptomatic MDE is also in good agreement with previous Hungarian studies showing that 5–11.5% of consecutively investigated primary care patients have had current major depressive episode (Szadoczky et al., 1997; Szadoczky et al., 2004; Voros et al., 2006). The 9.4% rate of family history of completed suicide among first or second degree relatives in our primary care attendees is compatible with the 4.2–4.8% rates in first degree relatives of psychiatric patients reported from the United States (Roy et al., 1999) particularly if we consider the fact that the national suicide rate of Hungary is more than 2.5-times higher than that the national suicide rate of the United States (Rihmer and Akiskal, 2006). We found that the family history of suicide in first or second degree relatives was significantly more frequent among those with current MDE as compared to patients without current MDE (26.6% vs 5.7%). This is also in good agreement with the well documented familial aggregation of depression and suicidal behaviour (Kim et al., 2005; Mann et al., 2005; Melhem et al., 2007; Roy et al., 1999). As first degree relatives of major depressives with major depressive disorder had more than fourfold higher rate of suicidal behaviour, compared to relatives of depressed patients with no depressive disorder (31% vs 7%) (Mann et al., 2005), indicating that suicidal behaviour in first degree relatives of patients with depressive disorders is clearly linked to depressive disorders in relatives, it is very likely that the majority of the suicide victims of family members of our patients also have had depressive disorder. The new finding of our present study is that 50% of patients with, and only 14.3% of those without family history of suicide have had current MDE (symptomatic and in partial remission, combined). In other words, every second primary care patient with, but only every seventh patient without family history of completed suicide have had current MDE, suggesting that history of completed suicide among first or second degree relatives could be a good and simple clinical marker for current MDE in primary care patients. While the lifetime prevalence rate of MDE is about 4–5 times higher than its current prevalence rate both in the general population (Rihmer and Angst, 2005) and in primary care practice (Rihmer and Angst, 2005; Szadoczky et al., 1997, 2004), also showing that depression is commonly episodic, it is very likely that the majority of our primary care patients with family history of suicide but without current MDE have had MDE in the past or will have it in the future. Therefore our findings suggest that positive

family history of suicide in first or second degree relatives could identify the vast majority of major depressives in primary care practice who are at lifetime risk of MDE. The relative few patients with family history of suicide represent a high-risk group for depression and suicide, therefore they should regularly checked for depression in primary care practice. This is particularly important since better recognition of depression in primary care practice can decrease suicide mortality in this population (Rutz et al., 1999; Szanto et al., 2007).

However, the small sample size and the lack of data on fully remitted major depressives and on comorbid psychiatric and medical disorders in our patients limit the generalizability of our present study that needs a replication on larger sample of primary care attendees.

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Conflict of interest

None of the authors have any conflicts of interests to declare. Pfizer Hungaria Kft. provided technical support (provided the PRIME-MD questionnaires).

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