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Newer antidepressants not necessarily safest for older people

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New generation antidepressants, known as selective serotonin reuptake inhibitors (SSRIs) are associated with an increased risk of several severe adverse outcomes in older people compared with older tricyclic antidepressants (TCAs), finds a study published on bmj.com today.

The authors say the risks and benefits of different antidepressants should be carefully evaluated when prescribing these drugs to older people.

Depression is a common condition in older people, and antidepressants - particularly SSRIs - are widely used. Yet very little is known about the safety of these drugs in older people.

So a team of researchers at the Universities of Nottingham and East Anglia set out to investigate the association between antidepressant treatment and the risk of a number of potentially life threatening outcomes in older people.

They identified 60,746 UK patients aged 65 and over with a newly diagnosed episode of depression between 1996 and 2007. Many patients had other conditions, such as heart disease and diabetes, and were taking several medications.

Patients were tracked until the end of 2008. During this time, 54,038 (89%) received at least one prescription for an antidepressant: 55% of prescriptions were for SSRIs, 32% for TCAs, 0.2% for monoamine oxidase inhibitors (MAOIs), and 13.5% for other antidepressants.

Antidepressant use was then analysed against several adverse outcomes including all-cause mortality, attempted suicide or self harm, heart attack , stroke, falls, fractures, epilepsy or seizures, and hyponatraemia (high salt levels in the blood).

After adjusting for factors which could affect the results, including age, sex, severity of depression, other illnesses and use of other medications, the team found that SSRIs and drugs in the group of other antidepressants were associated with an increased risk of several adverse outcomes compared with TCAs.

SSRIs were associated with an increased risk of all-cause mortality, stroke, falls, fracture, epilepsy or seizures, and hyponatraemia compared with TCAs. The group of other antidepressants were associated with an increased risk of all-cause mortality, attempted suicide or self harm, stroke, fracture, and epilepsy or seizures.

Depressed patients who were not taking antidepressants at all had a 7% risk of dying (absolute risk of all-cause mortality) some time in the next year, while the comparable risks were 8.1% for those taking TCAs, 10.6% for SSRIs, and 11.4 % for the group of other antidepressants. For stroke, one-year risks were 2.3%, 2.6% and 3.0% (compared to 2.2% for those not on antidepressants) and for fracture they were 2.2%, 2.7% and 2.8% compared to 1.8%.

Among individual drugs, trazodone, mirtazapine and venlafaxine were associated with the highest risks for several outcomes.

Rates of most outcomes were highest in the first 28 days after starting an antidepressant, and also in the first 28 days after stopping.

The authors point out that TCAs were prescribed at lower doses than SSRIs and other antidepressant drugs, which they say "could in part

explain our findings." They also warn that differences between patients prescribed different antidepressant drugs may account for some of the associations seen in the study and suggest that further research is needed to confirm these findings.

However, they conclude that the risks and benefits of different antidepressants should be carefully evaluated when prescribing these drugs to older people.

In an accompanying editorial, Professor Ian Hickie from the University of Sydney says that, despite some limitations, "the study has clear implications for more informed prescribing and enhanced clinical monitoring."

He adds: "Given the potential harms, the decision to prescribe for an older person with depression should not be taken lightly."

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