Suicide among Danes with multiple sclerosis

H Brønnum-Hansen, E Stenager, E Nylev Stenager, N Koch-Henriksen

Objective: To compare the suicide risk among Danish citizens with multiple sclerosis with that of the general population, and to evaluate changes over 45 years.

Methods: The study was based on linkage of the Danish Multiple Sclerosis Registry to the Cause of Death Registry. It comprised all 10,174 persons in whom multiple sclerosis was diagnosed in the period 1953 to 1996. The end of follow up was 1 January 1999. Standardised mortality ratios (SMRs) were calculated for various times after diagnosis and for age and calendar period of diagnosis.

Results: In all, 115 persons (63 men, 52 women) had taken their own lives, whereas the expected number of suicides was 54.2 (29.1 men, 25.1 women). Thus the suicide risk among persons with multiple sclerosis was more than twice that of the general population (SMR = 2.12). The increased risk was particularly high during the first year after diagnosis (SMR = 3.15).

Conclusions: The risk of suicide in multiple sclerosis was almost twice as high as expected more than 20 years after diagnosis. The excess suicide risk has not declined since 1953.

Methods
The Danish Multiple Sclerosis Registry was established as a continuation of a prevalence survey conducted in 1956. The register includes information about persons in Denmark in whom multiple sclerosis was diagnosed after 1921 and who were alive in 1948 or who experienced onset of the disease in the period 1949 to 1996 and were notified before 1997. Virtually all Danish residents in whom multiple sclerosis was diagnosed by a neurologist or in a department of neurology are registered, and the cases are subsequently reviewed and classified, according to the criteria of Alison and Millar for those with onset before 1994 and according to the Poser criteria for those with onset after 1 January 1994. Details of data collection and the validity of the register have been published elsewhere. The persons included in the present study were classified as having clinically definite, probable, or possible multiple sclerosis according to the diagnostic criteria.

Data on emigration and death were obtained by record linkage to the Danish civil registration system established in 1968 and the Cause of Death Registry, which has data on all deaths since 1943. The end of follow up for cause specific mortality was 1 January 1999. Data on deaths and causes of death in the Danish population, distributed by sex, age, and calendar year, were derived from the same official registers. As it was not possible to distinguish between death from suicide and death from accidents in 1951 and 1952 in the Cause of Death Registry records, the observation period for diagnoses of multiple sclerosis was restricted to 1953 to 1996. The expected number of suicides in the general population was estimated for each sex by multiplying the age and time specific population suicide rate. Standardised mortality ratios (SMRs)—that is, the quotient of the observed to the expected numbers of deaths—were estimated and 95% confidence intervals (CI) were established, assuming that the numbers of suicides followed a Poisson distribution.

Results
The study included 10,174 persons (4,061 men and 6,113 women) in whom multiple sclerosis was diagnosed between 1953 and 1996, corresponding by systematic follow up to 160,401 person-years. In all, 115 persons with multiple sclerosis (63 men and 52 women) had committed suicide before 1 January 1999, whereas the expected number of suicides in a matched general population was 54.2 (29.1 men and 25.1 women). Overall, the suicide risk of persons with multiple sclerosis was slightly more than twice that of the general population. Thus the SMR was 2.12 (95% CI, 1.75 to 2.55) for the whole group, 2.16 (1.66 to 2.77) for men, and 2.07 (1.55 to 2.72) for women (table 1). The excess suicide rate during the first 15 years after diagnosis was relatively stable for men (SMR varying between 2.18 and 2.76), but...
that for women it was higher—although not significantly so—in the first year after diagnosis (SMR = 4.03) than in subsequent periods (SMR declining to 1.78). The risk was lowest 15 to 20 years after diagnosis (SMR = 1.33 for men, 0.85 for women) and then tended to rise again to almost twice the risk of the general population (SMR = 1.74 for men, 2.04 for women).

Figure 1 shows estimates of the cumulative suicide hazard rates for men and women with multiple sclerosis (with 95% confidence intervals) and for the matched general male and female population. The figure shows higher suicide rates among men than women with multiple sclerosis, as for Danish men and women in general.

The SMR for suicide among persons aged less than 30 at the time of diagnosis was 2.55 for both sexes; those for persons aged 30 to 39 at diagnosis were 2.82 for men and 2.79 for women. Persons who were 40 or older when multiple sclerosis was diagnosed had a lower excess risk of suicide (SMR = 1.52), which was statistically significantly lower than for persons in whom multiple sclerosis was diagnosed when they were aged 30 to 39.

The excess suicide risk did not change significantly during the observation period, but tended to increase at the end of the period. Thus SMR estimates for persons in whom multiple sclerosis was diagnosed in 1953–1961, 1962–1970, 1971–1979, and 1980–1988 and who were followed up for 10 years were 2.22, 2.32, 1.73, and 2.84, respectively.

The exceptionally long follow up allowed us to evaluate the excess suicide risk among persons with long term disease, including those who were severely affected, with a high degree of disability. The SMR was higher for persons in whom multiple sclerosis had been diagnosed more than 20 years previously than for those who received their diagnosis 15 to 20 years previously, probably because patients typically experience the most serious physical and social consequences of their disease 20 years or more after the diagnosis. The difference was, however, not statistically significant. The overall conclusion from previous studies of suicide risk among persons with multiple sclerosis is that the risk is highest shortly after diagnosis. We found that the risk is still high many years after diagnosis, as was reported in a prospective study.

We were unable to examine the effect of progression of the disease on the suicide risk. Some characteristics of the previously reported suicides were identified. Thus men with multiple sclerosis who were at the highest risk of taking their own lives were characterised by previous mental disorders, previous suicidal behaviour, depression, recent deterioration of health owing to multiple sclerosis, and moderate disability, while the characteristics of women with multiple sclerosis were less clear. An examination of suicidal intent in persons with multiple sclerosis identified social isolation, major depression, and alcohol abuse as predictors. Alteration of the personality leading to suicide may also be a direct result of brain lesions caused by multiple sclerosis. This could theoretically happen even before a diagnosis of multiple sclerosis is made, and then the disease would escape registration. However, in all nine cases of suicide in multiple sclerosis in which a necropsy examination was carried out,
the multiple sclerosis diagnosis was established before the suicide. The time between onset and diagnosis did not differ between persons who committed suicide and those who did not, and the inclusion of the time lag in the analysis did not indicate that disease duration before the diagnosis affected the risk of suicide.

The possibility of depression in persons with multiple sclerosis might be overlooked by primary care physicians, even though depression is extremely common. The results of our study stress the importance of looking for depressive symptoms both immediately after the onset or diagnosis of multiple sclerosis and also in later stages of the disease.

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Authors’ affiliations
H Brønnum-Hansen, National Institute of Public Health, Copenhagen, Denmark
E Stenager, N Koch-Henriksen, The Danish Multiple Sclerosis Registry, Rigshospitalet, Copenhagen
E Nylev Stenager, Institute of Public Health, University of Southern Denmark, Odense, Denmark

Correspondence to: Henrik Brønnum-Hansen, National Institute of Public Health, Øster Farimagsgade 5, DK-1399 Copenhagen K, Denmark; hbh@niph.dk

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