



Suicide Attempt in a Terminally Ill Patient
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Case: A 75-year old Caucasian man was admitted to the trauma service after stabbing himself in the neck, abdomen and wrist with a 10-inch kitchen knife while his family was out. His wounds required surgical repair, but were non-lethal.

His family reported that macular degeneration had resulted in his failing vision. Chronic obstructive lung disease required him to use home oxygen therapy. Four months prior, he had been diagnosed with lung cancer, and had declined therapy. His previously written advance directive specified no CPR, no intubation.

The patient had neither longstanding depression nor previous suicide attempts, but had depressive symptoms beginning after his cancer diagnosis, and was taking an antidepressant. He was a retired engineer, and lived with his wife. His children remembered his having helped them work on their houses. His family worried he would be transferred to a psychiatric hospital. Recently they had been considering home hospice, but hadn't decided.

When seen by palliative care, the patient was awake, had a flat affect and monotone speech, without delirium. His family sat at some distance. He described worsening vision (still occasionally winning at cards), increasing dyspnea, poor appetite, weight loss, and insomnia. He said he wanted to die, and would again try suicide if he went home. During the interview, he developed respiratory distress secondary to pneumonia, and worsened despite aggressive therapy and BiPAP. Two days later, after discussions with the patient and family, he was made CMO, and died comfortably in the hospital.

Discussion: Although a small percentage (2-3%) of terminally ill patients commits suicide, the prevalence of depression in terminally ill patients is significant (10-25%). Most suicides are depressed (93%).

When serious illness occurs, rates of depression rise. Although many diseases have no associated suicide risk, some illnesses (HIV/AIDS; brain, nervous system, and head and neck cancers; multiple sclerosis) are reported to carry an increased suicide risk. More recent studies demonstrate an increased suicide risk for patients with other kinds of cancer, including cervical, breast, prostate, lung, and in adult survivors of childhood cancer.

Both men and women with cancer are at an increased risk of suicide (relative risk 2.3 times the general population for men and 1.9 times for women). Cancer patients older than sixty may be particularly vulnerable. Terminally ill patients share suicide risk factors with the general population: depression, history or family

history of psychiatric illness, substance abuse, certain personality traits or disorders, male gender, Caucasian race, and advanced age. However, terminally ill patients (irrespective of the cause) may have additional suicide risk factors: untreated pain and symptoms, fatigue, exhaustion, hopelessness, delirium, decreasing autonomy, increasing dependency and functional decline, concern about caregiver burden, isolation, and an inability to escape what they consider an intolerable situation.

The DSM-IV criteria for diagnosing major depression are considered by some experts as inadequate for terminally ill patients because the diagnosis depends heavily on somatic symptoms that the examiner may incorrectly attribute to terminal illness, not depression. Alternative criteria for seriously ill patients have been proposed, and include social withdrawal, fearfulness, persistent negativism, no "connection with caregivers," and poor pain and symptom control.

Screening and monitoring terminally ill patients for depression is important, as is exploration of expressions of a desire to die. Such thoughts may be transient, a method of coping or discussing existential concerns, or they may be associated with depression and suicidal intent. Patients benefit from treatment of depression, pain and other symptoms; cognitive therapy, and social support services. Antidepressant therapy cannot always forestall suicidal intent. For the suicidal terminally ill patient, avoiding hospitalization in a psychiatric hospital can be considered, employing alternatives such as a no-suicide contract (its efficacy has not been demonstrated) or by safe-proofing the home—if the patient wants to go home—or changing a patient's living environment.

The 75-year old Caucasian man presented here had been a highly functional engineer, now terminally ill with lung cancer and severe, debilitating co-morbidities including failing vision, COPD, and more recently, depression. After stabbing himself, he was hospitalized, and died of respiratory complications not directly related to his suicide attempt.

For further information please contact the Palliative Care Program at PUH/MUH, 647-7243, beeper 8511., Shadyside Dept. of Medical Ethics and Palliative Care, 623-3008, beeper 263-9041, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644 – 1724, Interventional Pain 784-4000, Magee Women's Hospital, 641-2108, beeper 917-9276, VA Palliative Care Program, 688-6178, beeper 296. For ethics consultations at UPMC Presbyterian-Montefiore, and Children's call 647-5700 or pager 958-3844. With comments about "Case of the Month" call David Barnard at 647-5701.

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Had there been opportunity, determining and ameliorating factors that had made this patient's life intolerable would have included separate interviews with him and his family, optimizing antidepressant therapy, treating distressing physical symptoms, and offering an alternative living environment. A system of palliative/hospice care and social support for him and his family may have reduced his anguish and improved quality of life.

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