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2173-5050/

Usefulness of the Short Personality and Life Event Scale (S-PLE) for detection of suicide attempters☆

A propósito de la utilidad de la Escala Abreviada de Personalidad y Acontecimientos Vitales (S-PLE) en la detección de las tentativas de suicidio

Dear Editor,

Suicide is a worldwide public health problem, and it is the primary cause of non-natural death in our country.[1] The genesis of suicidal behaviour is influenced by multiple biological and social factors that often, as is the case with the economic recession, may have effects which are hard to determine.[2] To date previous attempted suicide (AS) has been considered to be the best predictor of the risk of suicide.[3] We therefore consider that all efforts to predict and prevent AS to be an indirect way of contributing to a reduction of suicides.

One of the most interesting efforts aimed at identifying individuals at risk of suicidal behaviour was undertaken by Blasco-Fontecilla et al.[4] They developed the Personality and Life Event scale (PLE) which includes 27 of the most discriminatory items from a series of questionnaires that are commonly used to evaluate suicidal behaviour (personality disorders scale, impulsiveness, aggressiveness, stressful life events and sociodemographic data) with excellent results in terms of sensitivity (80.8%) and specificity (89.6%). The authors developed this further with the brief version of the said scale (S-PLE),[5] which with only 6 items makes it possible to indirectly and non-intrusively evaluate the risk of suicidal behaviour in situations where time is lacking.

The authors themselves propose the following cut-off points to maximise the precision of the classification: (i) healthy individuals, scores lower than 1.70; (ii) individuals with a possible mental disorder, scores from 1.70 to 2.46, and (iii) individuals at risk of suicide, scores higher than 2.46. Nevertheless, the authors accept that the S-PLE performs less well in differentiating individuals with a mental disorder and no history of AS and patients with a history of AS, although the area under the curve (AUC) of the receptor operative characteristic (ROC) remains acceptable (0.756).

Our group tried to replicate these earlier results in an independent sample of 197 patients [35.5% men; average age (SD) = 54.15 (10.54) years old], diagnosed with mood disorder [unipolar depression (74.6%); bipolar depression (8.1%) and dysthymia (17.3%)] with clinical severity of depression at the time of evaluation measured using the Hamilton Depression Rating Scale (HDRS)[6] of 18.56 (5.95), which is equivalent to moderate to severe depression. 38.6% (n = 76) of the patients had a history of AS. The patients with a history of AS were significantly younger [51.79 (10.70) vs 55.64 (10.21); Student t-test = 2.526; p = .012] and they scored significantly higher in the S-PLE [2.10 (0.48) vs 1.79 (0.46); Student t-test = −4.424; p = .000], while they were similar in terms of sex and their average score on the HDRS.

When the precision of the scale was evaluated by means of ROC analysis, an AUC of 0.675 was obtained, which is lower than the AUC figure reported by the authors. When the cut-off point they proposed to differentiate individuals with a mental disorder without a history of AS from those with a history of AS/(scores higher than 2.46), we found a sensitivity of 17.10% and specificity of 95.90%, i.e., there are a high number of false negatives. If it is wished to use this scale as a screening tool, we believe it would be prudent to suggest a modification of the cut-off point to reduce the large number of false negatives, at the least when the aim is to detect the risk of suicide in patients with mental disorders. After evaluating our results we suggest that a more suitable cut-off point for the evaluation of the risk of suicide would be 1.70. With this cut-off point, at least in our sample, a major increase in sensitivity is achieved (85.5%), although specificity falls by 32.2%. Nevertheless, given the severity of the consequences of the event we wish to predict and the possibility of using the S-PLE in screening for the risk of suicide in situations where time is lacking, such as hospital emergency or primary care departments, we consider it to be clear that good sensitivity has to take priority over specificity.

We believe that the S-PLE may be a useful clinical instrument for detecting the risk of AS, although it is necessary to set a more precise cut-off point for the tool and determine

☆ Please cite this article as: Fernández-Peláez AD, Rodríguez-Revuelta J, Abad I, Velasco Á, Burón P, García-Portilla MP, et al. A propósito de la utilidad de la Escala Abreviada de Personalidad y Acontecimientos Vitales (S-PLE) en la detección de las tentativas de suicidio. Rev Psiquiatr Salud Ment (Barc). 2017;10:218–219.

its predictive capacity in prospective studies such as those currently underway in our research group.

Acknowledgements

This study was financed by the Spanish Government fund ''Fondo de Investigación Sanitaria'' FEDER (PI14/02029) and the Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM).

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2173-5050/

Safety in the use of antidepressants: Vortioxetine-induce hyponatremia in a case report☆

Seguridad en el uso de antidepresivos: hiponatremia inducida con vortioxetina a propósito de un caso

Dear Editor,

Hyponatremia, defined as a level of sodium in the serum below 135 mmol/l, is in practice the most common hydroelectric disorder. It is a known side effect of antidepressants, antipsychotics and mood stabilisers.[1] The mechanism may be mediated by stimulation of the production of antidiuretic hormone by serotoninergic actions or dopaminergic blocking, which may be aggravated by polydipsia or xerostomia. It may manifest with general symptoms (nausea, fatigue, cramps and headache) or severe neuropsychiatric symptoms of cerebral oedema (confusion, agitation, altered gait, lethargy, convulsions and coma). Even mild forms are associated with increased morbimortality.[2]

The frequency with which hyponatremia is induced by antidepressants varies from 0.06% to 70%, and it has the following risk factors: a history of hyponatremia, advanced age, female sex, low weight, cirrhosis, heart or kidney failure and the use of diuretics, ACE inhibitors or laxatives. The risk seems to be greater with ISRS and venlafaxine than it is with mirtazapine and some tricyclics.[1] The risk cannot be established in other groups due to the lack of epidemiological data. This is striking, given that monitoring is extremely simple (biochemistry with ions) and that it is found in the recommendations of guides and agreements on monitoring the physical health of patients with depression.[3] However, the outstanding finding is that it is hard for the recommendations contained in guides to be put into practice in the absence of resources and strategies aimed at implementing them.[4]

In connection with this risk, in our hospital we witnessed a fatal case of hyponatremia associated with the use of vortioxetine. A 72-year-old woman was evaluated in March 2016 in the Mental Health department due to low mood, loss of interest, anhedonia, tiredness, lack of concentration and reduced activity, with a history of recurring depressive disorder from the age of 55 years old and several previous hospitalisations due to severe hyponatremia associated with several psychopharmaceuticals (fluoxetine, amitriptiline, mirtazapine and asenapine) without SIADH being proven. The current treatment was maprotiline 75 mg/d, with which she had not suffered any severe new hyponatremia in the past year. In the current episode vortioxetine was proposed as the treatment, in a crossed change strategy, with a 5 mg dose of vortioxetine and a reduced dose of maprotiline (37.5 mg/d) and, after 4 weeks, 10 mg/d vortioxetine had to be maintained. Nevertheless, 26 days afterwards she was admitted to the ICU from the Emergency Department after suffering a convulsion. In spite of recovering sodium values

☆ Please cite this article as: Pelayo-Terán JM, Martínez-Pérez MM, Zapico-Merayo Y. Seguridad en el uso de antidepresivos: hiponatremia inducida con vortioxetina a propósito de un caso. Rev Psiquiatr Salud Ment (Barc). 2017;10:219–220.