Published in final edited form as:

J Am Geriatr Soc. 2013 June ; 61(6): 1044–1045. doi:10.1111/jgs.12290.

Unexpected suicidality in an older emergency department patient

Marian E. Betz, MD, MPH¹, Robert Schwartz, MD², and Edwin D. Boudreaux, PhD³

¹Assistant Professor, Department of Emergency Medicine, University of Colorado School of Medicine, Aurora, Colorado

²Professor and Chair, Division of Geriatric Medicine, Department of Medicine, University of Colorado School of Medicine, Aurora, Colorado

³Departments of Emergency Medicine, Psychiatry, and Quantitative Health Sciences, University of Massachusetts Medical School, Worcester, Massachusetts

To the Editor

Depression and suicidal ideation (SI) are unfortunately common among older adults,¹ with suicide rates peaking among older men.^{2, 3} However, clinicians under-diagnose and under-treat these conditions among older adults,^{3, 4} in part because of erroneous ideas that hopelessness or thoughts of death are a part of “normal aging.”⁵ Non-traditional presentations and concurrent cognitive impairment can also complicate diagnosis, especially when there is not an established provider-patient relationship.

Case Report

A 66 year-old white male presented to an emergency department (ED) with a foot wound that he sustained the previous day from stepping on a nail while gardening. The nail punctured through the sole of his shoe, and he was concerned about infection because of his type 2 diabetes mellitus. His past medical history also included hypertension, hyperlipidemia, depression and prostate cancer. He denied using tobacco, alcohol or drugs. He had not seen a provider or taken any medications in over a year because of insurance issues, but he had become eligible for Medicare just two days before his ED visit. He was affable and in no obvious physical or emotional distress, with normal vital signs other than a mildly elevated blood pressure. On examination, he had a shallow puncture wound on the sole of his right foot with mild surrounding erythema but no swelling, crepitus, or fluctuance. A radiograph was normal. The patient received a dTAP booster and was started on a course of oral antibiotics.

Corresponding Author: Marian E. Betz, MD, MPH, University of Colorado Denver, 12401 E. 17th Ave B-215, Aurora, CO 80045, Telephone: (720) 848-6777, Fax: (720) 848-7374, marian.betz@ucdenver.edu. Alternate Corresponding Author: Robert Schwartz (Robert.schwartz@ucdenver.edu).

Presentations: None

Conflict of Interest: None of the authors has any conflicts of interest to report.

Author Contributions: MEB participated in case identification and manuscript preparation, and she takes responsibility for the manuscript as a whole. EDB and RS participated in manuscript preparation.

As part of a newly instituted ED protocol, the patient's nurse asked him standard screening questions concerning recent depression and SI. To the care team's surprise, the patient responded affirmatively, and he matter-of-factly reported a detailed suicide plan designed to look like an accident so his sister would receive his life insurance benefit. On supplementary questioning, the patient revealed multiple recent social stressors, including the one-year anniversary of his partner's death and an impending eviction from his home with the loss of his beloved garden. The patient was evaluated by the ED's mental health team and admitted to a psychiatric hospital. Upon discharge, he was on a stable dose of sertraline, had reestablished contact with his primary care provider and had no further SI.

Discussion

In 2007, there were over 7.6 million ED visits related to mental health conditions; 25% of these visits were by older adults, and total and mental health-related ED visits by older adults are increasing.⁶ However, there could be as many as 13 million ED patients with SI per year, based on an estimated prevalence of SI among all ED patients of up to 11%,⁷ and some figures suggest up to 20% of older ED patients have depression.⁸ Almost half of suicide victims visit an ED in the year before their death, often for non-psychiatric reasons, and they are more likely to have multiple recent ED visits than those who die by other causes.⁹

Most EDs rely on targeted SI questioning triggered by clinician concern, but some have begun standard screening all patients, in part due to Joint Commission patient safety goals related to suicide prevention. Although widespread SI screening has the potential to identify patients who might otherwise be missed, it is also controversial because of concerns about ED crowding, wait times, provider time constraints, and the lack of evidence for a benefit from such screening.¹⁰

Regardless of screening practices, clinicians should be aware of suicide risk factors among older adults. These include: male gender; white race; alcohol abuse; social isolation; a prior history of mental illness; particular kinds of social stressors (including bereavement or loss of social supports); access to firearms and other lethal means; physical illness; cognitive deficits; and functional impairment.^{2, 3} Of these, mood disorders appear to play the strongest role,³ highlighting the importance of their appropriate recognition and treatment.

Suicide prevention for older adults poses unique challenges because older suicidal individuals are more likely to employ advance planning and less likely to directly ask for help,³ with a suicide attempt to completion ratio among older adults of approximately 4:1, compared to up to 200:1 among young adults.³ SI among older adults is also more likely to stem from chronic medical or social issues rather than abrupt crises,³ so there may be a longer available period for intervention. Better mental health treatment, suicide interventions, and chronic disease management during this contemplative period might reduce morbidity and mortality.² However, there remains a need to improve the identification of SI/SA among older adults,⁴ and systematic screening protocols may be beneficial in selected clinical environments.

ACKNOWLEDGMENTS

Funding Sources: This work was supported by the American Foundation for Suicide Prevention and by Award Number U01MH088278 from the National Institute of Mental Health. No sponsor had any direct involvement in manuscript preparation.

REFERENCES

1. Gonzalez O, Berry JT, McKnight-Eily LR, et al. Current Depression Among Adults-United States, 2006 and 2008. *MMWR*. 2010; 59:1229–1235. [PubMed: 20881934]
2. Lapierre S, Erlangsen A, Waern M, et al. A systematic review of elderly suicide prevention programs. *Crisis*. 2011; 32:88–98. [PubMed: 21602163]
3. Conwell Y, Van Orden K, Caine ED. Suicide in Older Adults. *Psychiat Clin N Am*. 2011; 34:451–468.
4. Erlangsen A, Nordentoft M, Conwell Y, et al. Key Considerations for Preventing Suicide in Older Adults Consensus Opinions of an Expert Panel. *Crisis*. 2011; 32:106–109. [PubMed: 21616757]
5. Szanto K, Gildengers A, Mulsant BH, et al. Identification of suicidal ideation and prevention of suicidal behaviour in the elderly. *Drug Aging*. 2002; 19:11–24.
6. Larkin GL, Claassen CA, Emond JA, et al. Trends in US Emergency Department visits for mental health conditions, 1992 to 2001. *Psychiat Serv*. 2005; 56:671–677.
7. Boudreaux ED, Cagande C, Kilgannon H, et al. A Prospective Study of Depression Among Adult Patients in an Urban Emergency Department. *Prim Care Companion J Clin Psychiatry*. 2006; 8:66–70. [PubMed: 16862229]
8. Meldon SW, Emerman CL, Schubert DS. Recognition of depression in geriatric ED patients by emergency physicians. *Ann Emerg Med*. 1997; 30:442–447. [PubMed: 9326858]
9. Morrison KB, Laing L. Adults' use of health services in the year before death by suicide in Alberta. *Health Rep*. 2011; 22:15–22. [PubMed: 22106785]
10. Screening for suicide risk: A systematic evidence review for the US Preventive Services Task Force. Agency for Healthcare Research and Quality; 2004. [Online] <http://www.ahrq.gov/downloads/pub/prevent/pdfser/suicidser.pdf>. [Accessed December 14, 2012]