

tobacco industry. As noted in the article, the names of the SAB members, as well as the institutions funded by CTR, have been paraded before juries by industry lawyers in an attempt to persuade jurors that scientists still question whether smoking causes disease. Surely this is an abuse of science, and of individual scientists, of the first order. It is one that a single public statement could end. Why does the SAB not issue such a statement? Does it fear, perhaps with reason, that the tobacco industry would cease funding research if it could no longer use the mere existence of the funding process to raise doubts about the dangers of smoking?

Finally, for the information of the readership of the *American Journal of Public Health*, including Dr. Sterling, the editor of the *Journal* intended to publish "both sides" of the CTR story in the Public Health Policy Forum. He had secured the agreement of a physician involved in the CTR program to write an article to accompany mine. That individual failed to deliver his paper. □

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**Mass Media as Drug Users' Key Information Source on Overdoses**

Although cocaine has captured public attention, heroin continues to create severe health problems. Heroin overdoses occur unpredictably<sup>1</sup> and present numerous management problems for health personnel.<sup>2</sup> In San Francisco an unusually potent heroin mixture triggered 50 overdoses and 3 deaths one weekend in 1989. Overdose

victims arrived at the county hospital hourly, compared with a usual rate of 1 to 2 per day.<sup>3,4</sup> Little is known about how drug users learn about health threats. A national study found that the highest proportion of female sexual partners of drug users gleaned AIDS information from television, and 84% of those female partners who were injection drug users cited television as an information source.<sup>5</sup> We interviewed San Francisco patients in drug treatment to determine whether and how they had learned of the overdoses that occurred the one weekend in 1989.

Subjects were 115 patients in three San Francisco drug treatment programs. Programs included outpatient heroin detoxification (n = 55), methadone maintenance (n = 35), and a multimodality outpatient clinic (n = 25). Interviews were conducted within two weeks of the weekend overdoses. Subjects averaged 21 years of injection drug use and had been in drug treatment a mean of five times.

Ninety-six percent knew of the overdoses by the time of the interviews. Thirteen percent knew someone affected by the overdoses, and 4% had been personally affected. The mass media was the initial information source for 54% (Figure 1). Specifically, 34% first learned of the overdoses from television, 13% from newspapers, and 7% from radio. Another 37% heard the news from other people, including 18% "on the street," 14% from friends, and 5% from their drug dealers. Only 9% learned first at a health program, including 7% from a hospital and 2% at their drug treatment program. When asked whether they had heard of the overdoses *at all* from various information sources, the patients replied that the most

frequent sources were television (54%), "on the street" (46%), newspapers (40%), and friends (37%).

These data are the first known to us about addict reactions to an overdose epidemic. Our study is limited: Methods were speedily developed to capture reactions to the emergency, and results depended on a single self-report from an in-treatment sample. We caution further that public warning messages could have the unintended effect of increasing some drug users' interest in acquiring dangerously potent heroin. Nevertheless, the mass media—especially television—may be a vital information source when overdoses occur.

We recommend that public health planners collaborate with the media. Perhaps as standard procedure emergency-room administrators could notify both the media and drug treatment programs when such problems appear. □

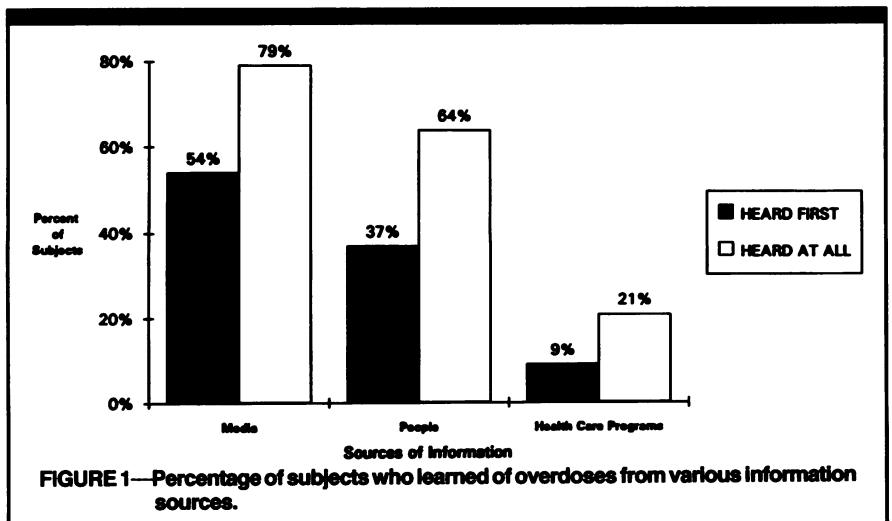
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## Trend in Suicide Rates Since Fluoxetine Introduction

Since mid-1990, there has been intensive and at times sensational media attention to a possible association of suicidality (suicidal acts and ideation) and the antidepressant drug fluoxetine (Prozac). Review of data from US controlled, blinded fluoxetine clinical trials in depression has documented a lack of such an association,<sup>1</sup> as has a comparative analysis.<sup>2</sup>

Fluoxetine was marketed in the United States in January 1988. From its introduction through December 1991, an estimated 3.7 million US patients had been treated with fluoxetine. A review of final US mortality data for the years 1984 through 1989 (4 years preceding and 2 years following introduction of fluoxetine) showed fluctuation in both the total number of suicide deaths per year and the suicide death rates per 100 000 population.<sup>3-5</sup> For the years 1984 through 1989, suicide deaths (all ages) were, respectively, 29 286, 29 453, 30 904, 30 796, 30 407, and 30 232. For the same years, suicide death rates (unadjusted) per 100 000 population were, respectively, 12.4, 12.3, 12.8, 12.7, 12.4, and 12.2. For the same 6-year time frame, age-adjusted suicide death rates were 11.6, 11.5, 11.9, 11.7, 11.4, and 11.3.

Provisional mortality data for suicide rates for 1990 and 1991 support the trends noted through 1989.<sup>6</sup>

There has been a modest decline in the number of suicide deaths during the first 2 years since fluoxetine has been marketed. With more than 6 million fluoxetine prescriptions dispensed in the United States in 1989 (*National Prescription Audit*, IMS America, Ltd), both the crude and the age-adjusted suicide death rates for 1989 (12.2 and 11.3 per 100 000 population, respectively) were the lowest in the 6-year time frame. However, one must be cautious in interpreting trends in aggregate mortality data. Many factors could be associated with the decrease in the annual number of suicide deaths. For example, during this time frame, a major public education effort (Depression Awareness, Recognition, and Treatment Program) was initiated by the National Institute of Mental Health. Nonetheless, these mortality data do not support claims of increased suicide risk subsequent to the marketing of fluoxetine in the United States.

Suicidality is one of several cardinal features of major depression.<sup>7</sup> All clinicians involved in the care of patients with depression must be alert for the possible emergence or intensification of suicidal thoughts and possible suicidal behaviors during either pharmacologic or nonpharmacologic treatment of the illness. Clinicians should be especially alert for such thoughts and behaviors in patients who are poorly compliant, demonstrate lack of response to a treatment regimen, experience adverse intercurrent life events, have substance abuse disorders, or experience other factors adversely impacting the course of depression. □

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## Native American vs All-Races Infant Mortality

The November 1991 article by James Hsu and Scott Williams, "Injury Prevention Awareness in an Urban Native American Population,"<sup>1</sup> references four publications that the authors claim indicate Native American 1- to 4-year-old injury deaths are occurring "at nearly three times the rate of the same age group among the general population in the United States."

As a public health analyst specializing in American Indian and Alaska Native data, I take exception to this claim. I have recently been analyzing 3 years (1986 to 1988) of Native American infant mortality data that I collected from 10 states in collaboration with L. S. Honigfeld and D. W. Kaplan, who are associated with the American Academy of Pediatrics. Our data (which are carefully verified with complete medical and social record reviews) indicate that 4% of the infant deaths were attributable to injuries or accidents (intentional as well as unintentional). For the same 3 years nationally, 6% of US all-races infant deaths were attributed to the same causes.

Hsu and Williams reference Honigfeld and Kaplan's 1987 *Pediatrics* article, "Native American Postneonatal Mortality."<sup>2</sup> By definition the mortality rates in the *Pediatrics* article are those of infants who are between 28 and 365 days old; they have no bearing on rates of death among children who are between 1 and 4 years old, Hsu and Williams' population. In the authors' first reference, the 1988 *Indian Health Service Chart Series Book*, I have been unable to find any data that specify cause of death for the age group 1 to 4 years old. Instead, for cause of death in children, the *Series* breaks down age as (1) under 1 year and (2) 1 to 14 years of age.

Hsu and Williams' third reference is to 15- to 20-year-old data compiled by the US Department of Health, Education, and