few suitably trained radiologists. The results of the United Kingdom Coordinating Committee on Cancer Research breast screening frequency trial which is designed to identify the optimum interval for screening should become available next year.

The existence of a properly funded national quality assurance programme with a comprehensive feedback system has ensured that, although the preliminary results from the United Kingdom's national programme seemed satisfactory, the occurrence of a higher than expected rate of interval cancers has been recognised early. Immediate steps are being taken to identify the reasons why and implement corrective action.

S FIELD
Consultant radiologist

Kent and Canterbury Hospitals NHS Trust,
Canterbury CT1 3NG

M J MICHELL
Consultant radiologist

King's Healthcare NHS Trust,
London SE5 9RS

M G W WALLIS
Director

Breast Screening Unit,
Coventry and Warwickshire Hospital,
Coventry CV1 4FH

A R M WILSON
Director

Breast Screening Training Centre,
City Hospital NHS Trust,
Nottingham NG5 1PB

Dr Field is the radiology representative on the Department of Health's advisory committee for breast cancer screening. Dr Michell is chairman and Drs Wallis and Wilson are regional representatives on the National Breast Screening Radiology Quality Assurance Committee.

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What general practitioners should do about breast screening

Employ more staff, set priorities, and delegate

See p 229

Despite evidence that the national breast screening programme is working well, primary health care teams could do still more to improve uptake.[1,2] Why, for example, are rates of breast screening in Grampian lower than those of childhood immunisation and cervical screening (as reported in this week's journal, p 229[3])?

General practitioners are well placed to encourage women to attend for breast screening, and they have received guidelines on improving the quality and uptake of the screening programme and on ensuring that women receive information and counselling.[4] Yet their wholehearted commitment seems doubtful,[5,6] and Rudiman and colleagues have tried to find out why.[3] The factors that they identify include scepticism about the value of breast screening, lack of involvement with the local breast screening centre, lack of financial incentives to reach targets for breast screening, and lack of time.

One of the difficulties is that breast screening units provide a specialised service, often at some distance from the practice, whereas primary care teams do cervical screening and childhood immunisations themselves. General practitioners may also be sceptical about the value of breast screening in reducing the morbidity of and mortality from breast cancer.[7-9]

Introducing payments for achieving targets in cervical screening and childhood immunisation has improved uptake[10] but this may have adversely affected general practitioners' morale. Extending targets to breast screening might increase dissatisfaction and also, more importantly, lead some general practitioners not to comply solely for financial reasons.

To create more time for screening, general practitioners should improve managerial support in their practices and delegate to other members of the primary health care team. Practice managers should have a relevant qualification in practice management to attract partial reimbursement of their salaries. Managed practices could then set priorities, identify the resources needed to achieve these priorities, and audit their performance. Practices would have to know the cost effectiveness of their screening and health promotional activities. This approach would enable general practice to undertake any new screening programmes, improve the functioning of the practice team, and give general practitioners more time to concentrate on clinical tasks.

Vocational training for practice managers could improve practice management in the same way that vocational training improved the quality of general practice. This training could be based around the core skills that have recently been identified by the Association of Managers in General Practice.[11]

Practice nurses do most of the health promotion and screening in general practice. The staff reimbursement scheme for general practice has become cash limited since 1990 and general practitioners wanting to employ extra nurses may be unable to do so unless they pay for any extra nurses themselves. If screening programmes in general practice are to achieve their full potential the salaries of practice nurses should be fully reimbursed, provided that practices can prove the cost effectiveness of extra nurses.

General practice cannot keep absorbing more work without more resources. Recent reports suggest that the second round of breast screening may not have reached the same proportion of eligible women as the first.[12] Only with the right allocation

of resources can general practice in Britain deliver highly effective national screening programmes.

PAUL A CREIGHTON
General practitioner

Broomhill Health Centre,
Morpeth NE65 0SR

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Suicide and antidepressants

Controversies on prevention, provocation, and self poisoning continue

See pp 221, 215

Antidepressants are mostly prescribed for depression and its complications. Foremost among these is suicide, but, despite these drugs having been available for over 35 years, no unequivocal evidence that they prevent suicide exists. Ironically, some antidepressants have been alleged to provoke self destructive behaviour, and patients sometimes kill themselves with the drugs prescribed to treat their depression.

Antidepressant drugs are more effective than placebo in treating acute episodes of affective disorders, and they may help prevent relapses and recurrences of depression. Although they also decrease the score on the "suicide item" on the Hamilton rating scale for depression, this is not a valid measure of suicidal intent or a predictor of future self destruction. Suicide is rare, and small differences in suicide rates during treatment with different antidepressants could be due to chance or unsatisfactory matching between groups. Thus, saying that antidepressants prevent suicide could be more a statement of faith than of fact.

Depression has long been considered to be an uncommon paradoxical adverse reaction to antidepressants.[1] Maprotiline has been thought to provoke suicide in some patients because a controlled trial found that more suicides occurred in patients receiving the drug than in those receiving placebo (although the difference was not significant).[2] Significantly more suicidal attempts or gestures occurred in the group given maprotiline, but populations who show such behaviour are different from those who commit suicide. Fluoxetine has similarly been suspected of provoking suicidal behaviour because violent self destructive thoughts were reported in six patients treated with the drug.[3] Reviews suggested that the suicidal ideation was more likely to have been due to the disorders being treated,[4] while a meta-analysis found that suicide was not significantly more common during treatment with fluoxetine than with tricyclic antidepressants or placebo.[5] More recently, prescription event monitoring has not found a higher incidence of suicide during treatment with fluoxetine than with fluvoxamine, another selective serotonin reuptake inhibitor.[6] Thus no totally convincing evidence exists that antidepressants either provoke or prevent suicide.

What is more certain, however, is that people kill themselves by taking overdoses of antidepressants and that tricyclic drugs introduced into practice before 1970 are more lethal than those introduced since. A study of deaths from self poisoning between 1976 and 1984 showed that the older drugs have a higher fatal toxicity index (the number of deaths due to overdose per million prescriptions).[7] The research, updated to 1987, showed that fluvoxamine also has a low fatal toxicity index,[8] while the most recent update (to 1992) showed that fluoxetine, paroxetine, and sertraline similarly have low lethality in overdose (p 221).[9] Despite the limitations of the methodology, especially uncertainty over the causes of death, the quantities of drugs and other substances taken, and the medical condition of the patients, the results provide strong circumstantial evidence that death due to overdoses of antidepressants is more likely to occur in those prescribed older tricyclic drugs than those prescribed newer antidepressants. This is consistent with the known cardiotoxic effects of the older drugs and recent work showing that overdoses of dothiepin are more likely than those of other antidepressants to cause seizures and cardiac arrhythmias, which are regarded as intermediate outcome measures.[10]

In view of these observations and the knowledge that patients survive large overdoses of selective serotonin reuptake inhibitors, some commentators have suggested that prescribing older tricyclic drugs for depressed patients while safer drugs are available is unethical and irresponsible. To do so, they say, would justify any claim for negligence that ensued. It is necessary, however, to see the risks in a clinical and epidemiological perspective.

Firstly, although the lifetime prevalence of suicide in patients with major depression is high, a much smaller proportion take their lives during the relatively short period when they are prescribed antidepressants as first line treatment than at other times. More important than the choice of drug in most non-suicidal patients is a thorough assessment of suicidal risk. Although there are no accurate predictors of suicide in the long term, patients known to be at high risk in the short term should be targeted for special care. The ethical and medicolegal questions that should be asked therefore are not only which antidepressant was prescribed but how competently the risk of suicide was assessed; what support, supervision, and treatment other than an antidepressant were given; and why that particular antidepressant was prescribed for the patient at that time. Merely handing a patient a prescription for an antidepressant (however safe in overdose it might be) without a proper assessment and care plan could be regarded as negligent.

Secondly, only about 4% of all suicides are due to overdoses of single antidepressants.[11] It is not known what proportion of these overdoses is taken during treatment—that is, when choice is more relevant—and statistics on deaths due to overdoses of antidepressants include those due to accidental overdoses and overdoses of other people's supplies, often taken by people without psychiatric disorders.

Thirdly, it is not known whether different suicide rates in