Despite the cynicism of others, the FDA and the BMJ should be congratulated on brining to the attention of a wider medical community the age related relationship between suicidality and SSRI antidepressants.

Despite the disadvantages of this type of study, as pointed out in both the paper and in the accompanying editorial, the fact that younger people are clearly at greater risk than adults, is an important message. If for no other reason it should act as a warning that SSRIs should be used with a great deal of caution in adolescents and that younger adults should have increased surveillance. All doctors who wish to prescribe SSRIs to these patients should clearly follow, in the interests of safety, at least the recommendations of the manufacturers concerning their use by suitably qualified professionals, their use at the lowest possible dose, frequent assessment in the early stages of treatment and a consultation with someone other than the patients, especially in adolescents, to warn them to look for any signs of increasing suicidality. In adolescents, they should probably be used after a trial of psychotherapy and in conjunction with it.

If this publication does no more than take this message to one physician, good will have been done.

I have provided support to parents of children admitted to the Capio Hospital's Adolescent Mental Health Unit while there was early debate on the risks to children and to have such clear evidence of an age relationship is helpful to them in deciding if they wish their children to be prescribed such drugs. Reinforcement by clinicians to parents and other carers of the risks and the need to closely observe their loved ones has to be encouraged.

As many have pointed out, this is only the start of answering many questions in relationship to this matter. These of course include '*Are there differences between the various SSRIs?*' and 'How *do we distinguish prospectively those patients who will have decreased suicidal ideation and those who may have increased suicidal ideation when prescribed these drugs?'*

As important is further work to ascertain the risk benefit ratio when SSRIs are prescribed clinically to those whom are actively excluded from GCP conducted registration quality studies. They are clearly a different sub-population due to inclusion bias by investigators, the protocoled exclusion of those with severe depression and suicidality and their age range.

Of equal importance to suicidality, is the question as to whether SSRI drugs induce patients to behave aggressively, violently or to commit homicide. I wonder whether there were enough cases of violence in the FDA database to begin to answer this question. There are unlikely to be anywhere near the number of homicides required.

The accompanying editorial by Geddes et al contains some important observations; however, it is disappointing that they used their status and the opportunity to write an editorial on an important subject to quote their own work and to promote the use of Sertraline over and above other SSRIs.

It is to be regretted that they were allowed to state without reference to other SSRIs that '*the odds of suicidal behaviour on Sertraline for example is around half that on*

placebo' without giving any reference or even noting the populations studied, or without looking for an age relationship as was clearly shown by the FDA. Such statements cannot move forward such a complex area which has needed the study of over 100,000 patients by the FDA. Whether or not Sertraline is better tolerated was not the point of the FDA review and thus comments on this were completely inappropriate in the editorial, even if this is true, which many would dispute.

Competing interests

Dr Malcolm VandenBurg has given many medico legal opinions to UK courts in legal cases in which SSRIs were implicated, instructed by both defence and prosecution.

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