PRACTICAL PSYCHOPHARMACOLOGY

Medication for PTSD: A Leap of Faith?

Conflicting reports about the efficacy of pharmacologic therapy for posttraumatic stress disorder leave clinicians in limbo, with more questions than answers on the subject.

Two selective serotonin reuptake inhibitors (SSRIs)—paroxetine (Paxil) and sertraline (Zoloft)—are the only medications approved in the United States specifically to treat posttraumatic stress disorder (PTSD).

SSRIs are considered the first choice among pharmacologic therapies in 2004 clinical practice guidelines issued separately by the American Psychiatric Association (www.psychiatryonline.com/pracGuide/pracGuideTopic_11.aspx) and the Veterans Administration/Department of Defense (www.oqpmed.va.gov/cpg/PTSD/PTSD_Base.htm).

In 2005, however, the British National Institute for Clinical Excellence (NICE) guidelines on management of PTSD backed away from SSRIs after considering several negative studies published after the 2004 guidelines (www.nice.org.uk/CG26). The NICE guidelines suggested using medication only in patients who are unwilling or unable to receive psychotherapy (which had better evidence for efficacy than drug therapy), adding that there is some evidence from nonrandomized trials of benefits from paroxetine, the noradrenergic and specific serotonergic antidepressant mirtazapine (Remeron), the tricyclic antidepressant amitriptyline (Elavil), and the MAO inhibitor phenelzine (Nardil).

The Australians weighed in with 2007 recommendations that considered studies published after the NICE guidelines (www.nhmrc.gov.au/publications/synopses/mh13syn.htm). Although they still listed SSRIs as the first choice in pharmacologic treatment, they noted that the four SSRI studies conducted after the NICE guidelines all failed to provide evidence that these drugs help either PTSD symptoms or depression in patients with PTSD.

Finally, an assessment by the Institute of Medicine (IOM) in 2008 (books.nap.edu/openbook.php?record_id=11955) of randomized, controlled trials of medications for PTSD concluded that no drugs have adequate data showing efficacy, including SSRIs, the α-adrenergic blocker prazosin, anticonvulsants, the atypical antipsychotics olanzapine (Zyprexa) and risperidone (Risperdal), benzodiazepines, the MAO inhibitors phenelzine and brofaromine (Consonar), other antidepressants, and drugs such as naltrexone or inositol.

Only cognitive-behavioral therapy (CBT) had solid evidence behind it, but many people with PTSD are either unable or unwilling to pursue psychotherapy. What's a clinician to do?

"It's kind of depressing, isn't it?" asked Dr. Thomas C. Neylan, director of the PTSD program at the University of California, San Francisco, and the San Francisco Veterans Affairs (VA) Medical Center. One of the problems is that there are fewer than 40 randomized, controlled studies of pharmacotherapy for PTSD (compared with hundreds of studies for depression).

That said, there are good data showing that paroxetine and sertraline work well for PTSD in civilian women, he added. Fewer benefits are seen in combat veterans given SSRIs for PTSD, but two randomized controlled trials reported that combat veterans with PTSD benefited from treatment with prazosin, a generic antihypertensive. The VA soon will start a large study to definitively answer whether prazosin is effective for PTSD symptoms.

Another large randomized trial underway within the VA system is studying augmentation of antidepressant therapy using atypical antipsychotic agents. Some studies have shown modest effects from augmentation with risperidone for PTSD.

Dr. Neylan has been a consultant for or received research funds from Actelion Pharmaceuticals Ltd., Forest Pharmaceuticals Inc., Jazz Pharmaceuticals Inc., Sanofi-Aventis, Sepracor Inc., and Takeda Pharmaceuticals, some of which make drugs used for PTSD.

Although the data on antidepressants for PTSD are mixed, "there's enough evidence to justify using these drugs," said Dr. Jonathan R. Davidson, emeritus professor of psychiatry at Duke University, Durham, N.C., and former head of the anxiety and traumatic stress program there. At least one study each showed efficacy for paroxetine, sertraline, fluoxetine, and the serotonin-norepinephrine reuptake inhibitor venlafaxine (Effexor), he noted.

Prazosin may be particularly helpful for veterans with nightmares. "It's possible there are subgroups in the PTSD population where particular drugs are of more benefit," he added.

The biggest hole in PTSD treatment data relates to pharmacotherapy for children, where PTSD often begins, Dr. Davidson noted. The few existing pediatric studies report conflicting results.

The choice of medication often depends on individual patient factors, such as comorbidities, tolerance for specific side effects, or medication interactions, he added. Dr. Davidson participated in an expert consensus panel that produced PTSD treatment algorithms in 2005 for various kinds of patients, available free at www.ipap.org from the International Psychopharmacology Algorithm Project.

He and Dr. Neylan both advised persistence in treatment of PTSD. If there are side effects, back off on a dosage and then gradually increase it. If an adequate trial of one drug doesn't work, try another.

Dr. Davidson has been a speaker or adviser for or received research funds from Solvay Pharmaceuticals, Pfizer Inc., GlaxoSmithKline, Wyeth-Ayerst Laboratories, Forest Laboratories Inc., Eli Lilly & Co., Ancile Pharmaceuticals, Roche, Novartis, Organon USA Inc., Boehringer Ingelheim GmbH, UCB Pharma, Pharmacia Corp., Johnson & Johnson, Bristol-Myers Squibb Co., Pure World Inc., and Allergan Inc., some of which make drugs used for PTSD.

Sometimes, the best strategy to address PTSD is not to focus initially on the PTSD, said Dr. Douglas F. Zatzick of the University of Washington, Seattle, and a member of the APA's guidelines committee. He and associates presented a study recently at the International Society for Traumatic Stress Studies showing that even though pharmacotherapy was less effective than CBT, a care-management intervention succeeded in getting many more onto medications.

The intervention helped patients address their immediate concerns: Will they ever be able to use damaged limbs again? Where are the children who were in the same auto crash but were taken to different hospitals? Once those concerns are addressed, patients are more open to considering therapy.

"We reached more patients, and at the population level did more good in terms of reducing PTSD," said Dr. Zatzick, who has no conflicts of interest related to PTSD.

He called the IOM report "very conservative." He still uses SSRIs for PTSD but admits to being "a bit torn," because he respects the methodology used for the NICE guidelines.

"We're following the APA guidelines and not throwing them out, despite the IOM guidelines," he said. "That may be a statement of faith." ■

By Sherry Boschert, San Francisco Bureau

Low Socioeconomic Patients Able, Willing to Use E-Mail

BY ROBERT FINN
San Francisco Bureau

HONOLULU — The "digital divide" separating society's haves and have-nots may not be as deep as many fear, according to a study of 120 parents of adolescent patients and the patients themselves.

In a survey, more than 60% of parents and adolescents of low socioeconomic status (SES) from one Boston pediatric practice indicated a willingness to contact physicians via e-mail if given the option, according to Dr. Tarissa Mitchell of Boston Medical Center.

Among the survey respondents, 66% stated that they had access to e-mail and/or computers at home. But only 19% of the parents had their health care provider's e-mail address, and only 3% of them had ever used e-mail to contact their provider.

Dr. Mitchell and Dr. Shikha G. Anand of the Whittier Street Health Center, Roxbury, Mass., conducted a convenience sample survey of 120 parents of adolescent patients and the adolescent patients who were above the age of 13 at an urban community health center in Boston over a 4-month period. At that center, five pediatric providers serve 3,876 low SES children, 84% of whom are publicly insured and 82% of whom self-identify as black or Hispanic.

Sixty-six percent of respondents had access to e-mail, but only 19% had their provider's e-mail address and 3% said that they had ever used e-mail to contact their provider.

Compared with respondents without e-mail availability at home, those with home e-mail availability were significantly more willing to contact their physicians: 77%, compared with 33%. And respondents who used e-mail more frequently also were significantly more willing to contact their provider this way.

For example, among respondents whose e-mail was always on, 89% were willing to e-mail their physicians. This declined to 60% among respondents who used e-mail only weekly and to 43% of those who used e-mail monthly or less frequently than that, Dr. Mitchell and Dr. Anand wrote in a poster presented at the annual meeting of the Pediatric Academic Societies.

Only 13% of the respondents stated that they would never use e-mail to communicate with their provider.

The most common reason that they gave was a desire to telephone the office, but they also cited lack of access to e-mail, difficulty with the English language, concerns over bothering the doctor with e-mails, and an expectation of slower response time.

In addition, 33% of the entire survey population expressed concern that e-mail may not be private and could be reviewed by individuals other than their health care provider.

Dr. Mitchell and Dr. Anand stated that they had no conflicts of interest related to this presentation. ■