Dueling Borderline Guidelines Spark Debate in U.K.

BY BRUCE JANCIN

FROM THE ANNUAL INTERNATIONAL CONGRESS OF THE ROYAL COLLEGE OF PSYCHIATRISTS

EDINBURGH — British psychiatrists are scratching their heads over two fresh sets of sharply conflicting guidelines on the use of medications in borderline personality disorder.

On the one hand, the National Institute for Health and Clinical Excellence (NICE), which advises the National Health Service, reviewed 28 randomized controlled trials and found them sorely lacking and unconvincing. The NICE guidelines reached this unequivocal conclusion: "Do not use drug treatment specifically for borderline personality disorder or for the individual symptoms or behaviour associated with it" (BMJ 2009;338:b93).

Yet a Cochrane systematic review of the evidence base conducted at roughly the same time resulted in a raft of recommendations for a variety of drugs targeting the specific core symptom domains of borderline personality disorder [BPD] (Br. J. Psychiatry 2010;196:4-12).

"We've got two well-respected bodies reviewing virtually exactly the same evidence, employing very similar methodologies, and drawing quite markedly different conclusions," Dr. Jeremy Hall said at the meeting.

So, what's going on here? "I think it's really a question of whether you see the glass as being half empty or half full," said Dr. Hall of the University of Edinburgh.

NICE concluded that there is insufficient evidence to robustly recommend any medication for BPD. The Cochrane review concluded that there are small studies showing encouraging evidence of efficacy against some symptom domains, although not for the disorder as a whole, he explained.

Two well-respected bodies reviewed virtually the same evidence but drew markedly different conclusions.

DR. HALL

The dueling guidelines have sparked much debate among U.K. psychiatrists. Regardless of which camp one falls into, however, there can be no doubt that the literature on medications for BPD is seriously deficient.

The randomized trials are small, nearly all fewer than 50 patients. They're of short duration, with a mean length of only 12 weeks, even though borderline personality disorder is often a chronic condition. There are no standardized outcome measures, making comparisons across studies particularly challenging. Moreover, many of the trials excluded patients with comorbidities.

"Really, what we need as clinicians are results that are generalizable to the population that we see—and the population we see largely has comorbid conditions," Dr. Hall continued.

In addressing the four core symptom domains of borderline personality disorder described in DSM-IV, the Cochrane report recommended the use of mood stabilizers or second-generation antipsychotics for affective dysregulation, with the caveat that there is no evidence to support the use of carbamazepine or ziprasidone for this or any of the other symptom domains.

For impulsive-behavioral symptoms, the Cochrane report recommended mood stabilizers; for interpersonal difficulties, a mood stabilizer or second-generation antipsychotic; and for cognitive-perceptual symptoms, a second-generation antipsychotic.

The Cochrane report advised against polypharmacy for borderline personality disorder, which has shown no additional benefit in the few studies that have looked at it. Yet polypharmacy for borderline personality disorder is very common in clinical practice, Dr. Hall noted.

Dr. Hall said that although the DSM-IV criteria for borderline personality disorder allow patients with many different combinations of symptoms to be placed under the same diagnostic umbrella, his soon-to-be-published meta-analysis of all the structural brain imaging studies with control groups supports the notion that borderline personality disorder is in fact a biologic syndrome.

"The results were surprisingly consistent. The borderline personality disorder patients showed evidence of decreased left and right hippocampal volume, and left and right amygdala volume," he said.

Borderline personality disorder is associated with a very large burden of illness. Although the disorder's population prevalence is only 0.7%, affected patients account for 4.3% of primary care visits and 10% of outpatient psychiatric visits in the United Kingdom. In Scotland, borderline personality disorder is the primary diagnosis for 6% of psychiatric inpatients. Dr. Hall reported no financial conflicts. ■

PTSD Tied to a Doubling of Veterans' Risk for Dementia

BY MARY ANN MOON

FROM THE ARCHIVES OF GENERAL PSYCHIATRY

Male veterans with posttraumatic stress disorder appear to be nearly twice as likely to develop dementia as those who do not have PTSD, a study has shown.

The reason for this association is not yet known, nor is it clear whether treatment of PTSD reduces dementia risk. Until more is understood about this newly identified link, it is critical that all patients with PTSD, especially those of advanced age, be followed to screen for cognitive impairment, said Dr. Kristine Yaffe of the University of California, San Francisco, and her associates.

To their knowledge this is the first study of its kind, despite observational reports that older patients with PTSD have been found to show greater declines in cognitive performance than control subjects.

"Given that PTSD symptoms often continue late in life and that alterations in the hypothalamic-pituitary-adrenal axis often accompany PTSD, and these in turn may be associated with dementia, there is reason to believe that PTSD might be associated with accelerated brain aging," they said.

Dr. Yaffe and her colleagues performed a retrospective cohort study involving 181,093 veterans (96% males), aged 55 and older, who received their medical treatment at VA hospitals nationwide. A total of 53,155 of these patients had received a diagnosis of PTSD, while the remainder had no PTSD.

At baseline, the veterans had a mean age of 69 years and were followed for a mean of 7 years to track the development of incident dementia. This included senile dementias, vascular dementia, Alzheimer's disease, frontotemporal dementia, Lewy body dementia, and dementia "not otherwise specified."

Patients with PTSD were nearly twice as likely to develop dementia during follow-up as were those without PTSD, with a hazard ratio of 1.77. The cumulative incidence of dementia was about 11% with PTSD, compared with approximately 7% without it, Dr. Yaffe and her associates said (Arch. Gen. Psychiatry 2010;67:608-13).

The link was strong across all dementia subtypes, and it persisted when subjects with diagnoses of clinical depression, substance abuse, or head injury were excluded from the analysis.

This study was limited in that it enrolled male veterans primarily. The study was funded by the U.S. Department of Defense and the National Institute on Aging. Dr. Yaffe and her associates reported ties to Novartis, Zelos Therapeutics, Tethys Bioscience, NPS Pharmaceuticals, Actelion Pharmaceuticals, Sanofi-Aventis, Takeda, the Chatham Institute, and the Pri-Med Institute. ■