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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

PTSD: MEDICATION TREATMENT

SARA HAACK, MD, MPH

UNIVERSITY OF WASHINGTON

UW Medicine
UW SCHOOL OF MEDICINE

GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

SPEAKER DISCLOSURES

✓ There are no conflicts of interest to disclose.

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OBJECTIVES

1. Review epidemiology
2. Current medications
3. Novel medications

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WHY THIS IS IMPORTANT

- Trauma is common
  - 39-90% of American adults
- PTSD is common
  - 7-12% lifetime prevalence
- Common in Primary Care
  - 6-25% of patients in primary care clinics have PTSD

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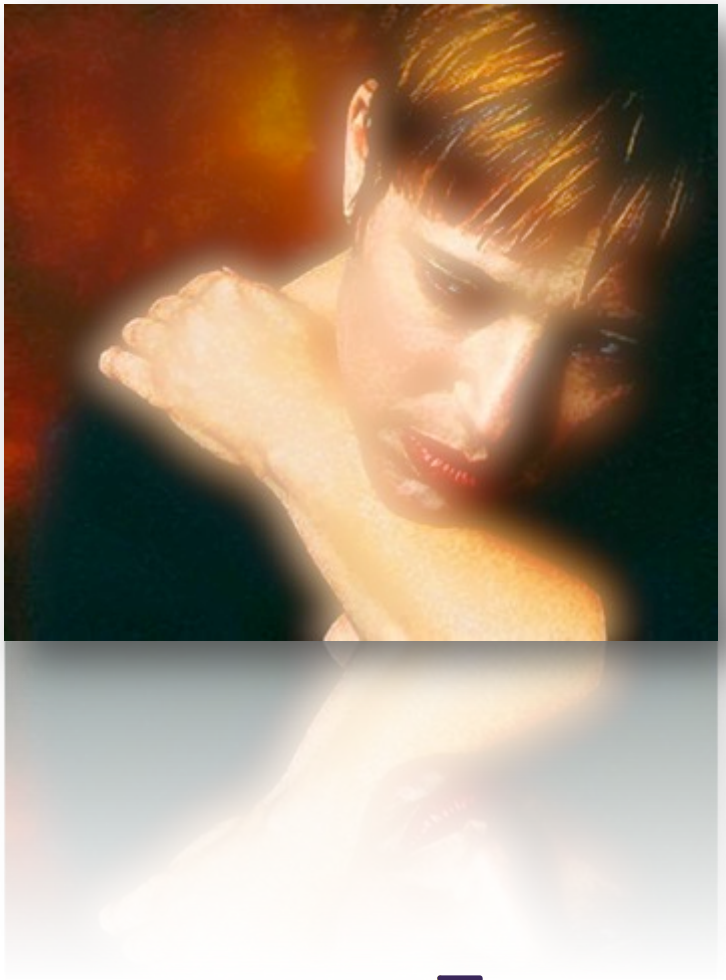
DSM-5 STRESSOR CRITERION

- Exposure to actual or threatened death, serious injury, or sexual violence:
  - Directly
  - Witnessed in person
  - Learning the event(s) occurred to close friend or family member. Actual or threatened death - event must have been violent or accidental.
- Repeated or extreme exposure to aversive details of traumatic event



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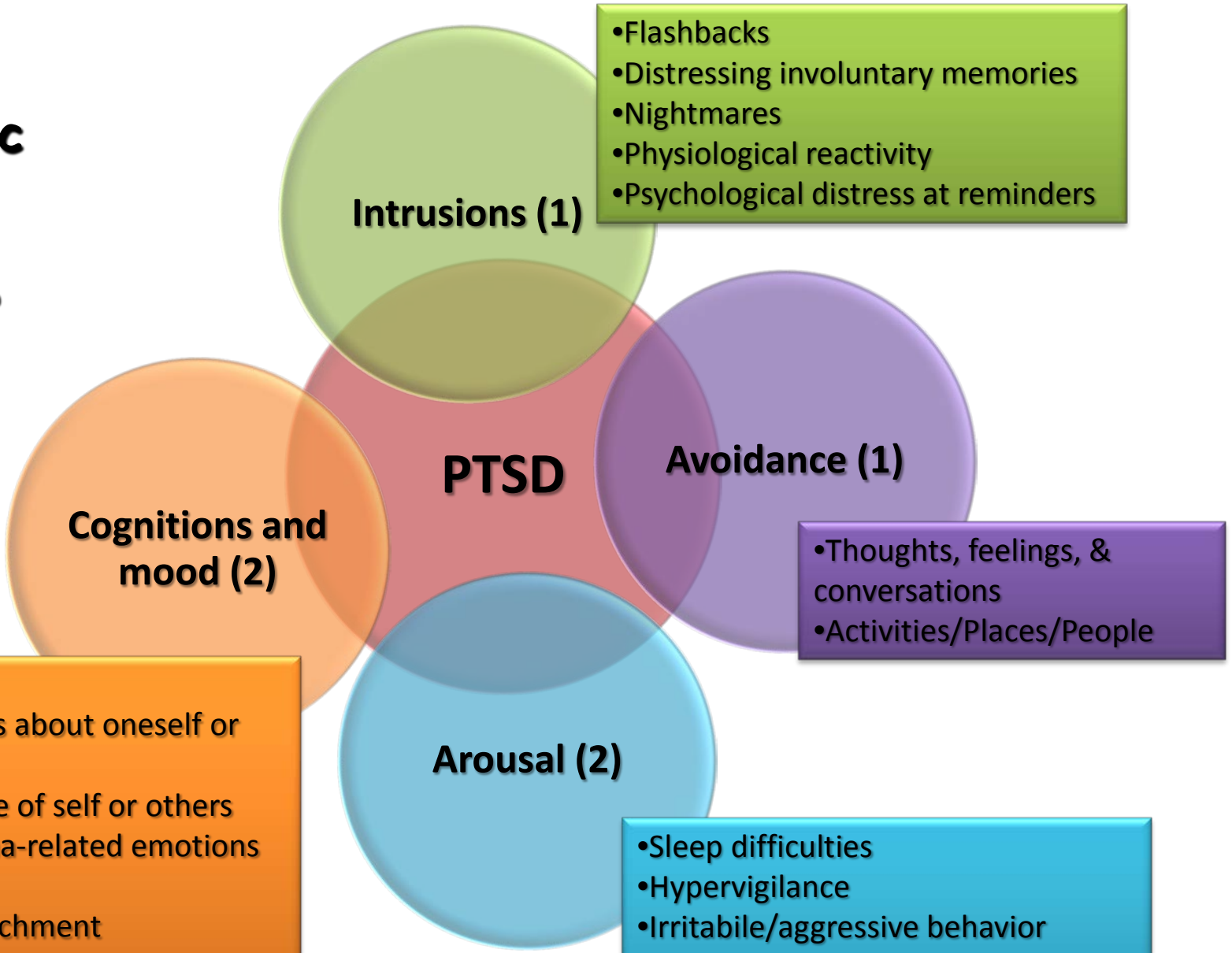
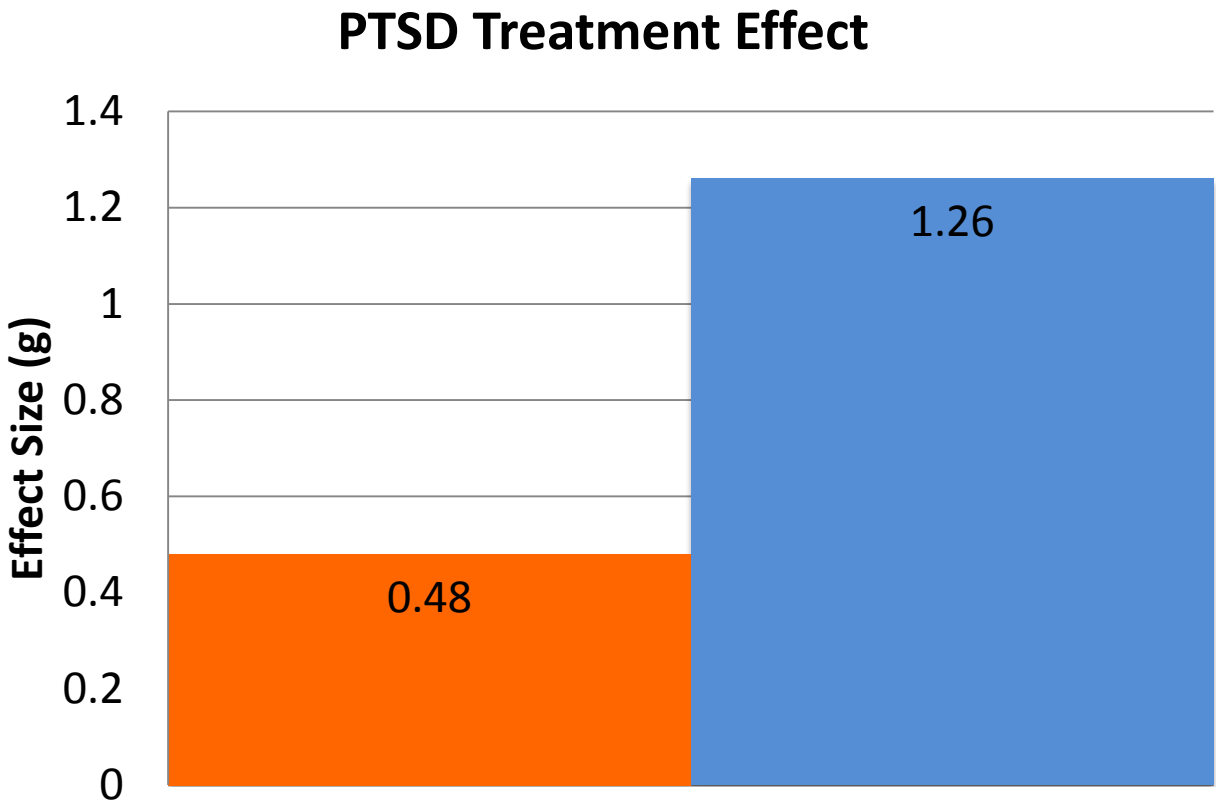
Post Traumatic Stress Disorder



DSM V

WHAT ARE WE LOOKING AT?



Watts et. al. 2013

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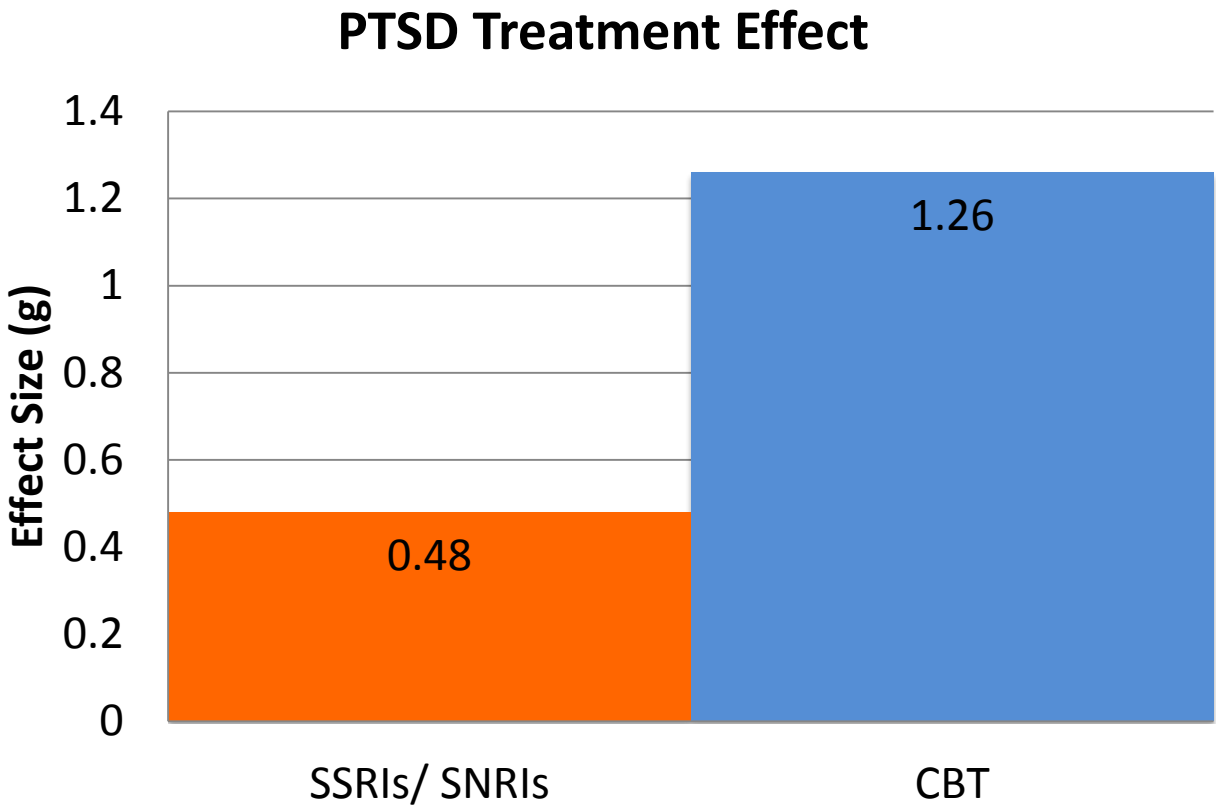
COMPARING THERAPY AND MEDS



Watts et. al. 2013

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GUIDELINES

	APA	VA/ DOD	ISTSS	WHO	NICE	Uptodate
Therapy and meds both 1st line tx	Yes	Yes	Yes	TF-CBT> meds	TF-CBT> meds	TF-CBT> meds

WHICH MEDICATIONS HAVE THE MOST CONSISTENTLY ROBUST EVIDENCE FOR TREATING PTSD?

1. citalopram, fluoxetine
2. sertraline, venlafaxine
3. Seroquel, mirtazapine
4. cannabis, ketamine

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GUIDELINES

	APA	VA/ DOD	ISTSS	Uptodate
1st line Medications	SSRIs	SSRIs, SNRIs	Sertraline, paroxetine, fluoxetine, venlafaxine, mirtazapine, nefazodone, prazosin	SSRIs, SNRIs

SSRIs

- Most studied, recommended
- Hit all 3 symptom clusters
- Best evidence
  - Sertraline, paroxetine, fluoxetine
- Less evidence
  - Citalopram, escitalopram
- Veterans with combat-related PTSD
  - Evidence less robust, but still recommended

SNRIs

- Venlafaxine most studied
- ~=sertraline in head-to-head comparison
- 1st line
  - VA/DOD
  - ISTSS
  - Uptodate
- 2nd line
  - APA (2004)

HOW TO PRESCRIBE

- Similar to treating MDD
  - Dosing
  - Time to effect
  - Side effects
- Discontinuation
  - Relapse appears higher than MDD
  - Davidson et al 2001: relapse 6x as likely with d/c
  - 1 year- indefinitely

GUIDELINES

	APA	VA/ DOD	ISTSS	Uptodate
Optimal duration of treatment	indefinitely ?	Until remission	Trial of at least 8-12 weeks, 36 weeks is better	6 m- 1 yr after achieving remission

True or false: There is evidence that adding medication to psychotherapy results in greater PTSD symptom reduction than therapy alone.

True or false: Adding medications to trauma focused psychotherapy has been shown to significantly improve overall PTSD symptom reduction versus trauma-focused psychotherapy alone.

False

OTHER MEDICATIONS

- Some evidence of benefit
  - TCAs
  - Mirtazapine
  - Atypical antipsychotics (adjunct & monotherapy)
  - Prazosin (global symptoms)
- Little evidence
  - Anticonvulsants
  - Bupropion
  - Propranolol, α2-agonists
  - Benzodiazepines (Harm)

INSOMNIA TREATMENT

- Sleep hygiene
- Trazodone
  - Difficulty with sleep initiation
- Prazosin
  - Difficulty with nightmares
  - α1-antagonist
  - Some evidence of improvement in global symptoms

PRAZOSIN DOSING

If a random patient walked into your office and stated, “I’m on prazosin for my PTSD nightmares,” what is the most likely dose of their prazosin?

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IN STUDIES, WHAT IS THE EFFECTIVE DOSE RANGE OF PRAZOSIN?

1. 1-3 mg/ night
2. 3-6 mg/ night
3. 3-15 mg/ night
4. 12-20 mg/ night

INSOMNIA TREATMENT

- Sleep hygiene
- Trazodone
  - Difficulty with sleep initiation
- Prazosin
  - Difficulty with nightmares
  - α1-antagonist
  - Some evidence of improvement in global symptoms
  - 3-15 mg in studies, VA recommends 6 mg

ANGER AND IRRITABILITY

RECOMMENDATIONS (BASED ON CONSENSUS OF THE WORKING GROUP CLINICAL EXPERTS)

1. Assess the nature of symptoms, severity, and dangerousness. Consider using standardized Anger Scales, such as Spielberger's State-Trait Anger Expression Inventory, to quantify.
2. Explore for cause of symptoms and follow-up to monitor change.
3. Consider referral to specialty care for counseling or for marital or family counseling as indicated. Offer referral for:
    a. Anger Management therapy
    b. Training in exercise and relaxation techniques
4. Promote participation in enjoyable activities - especially with family/ loved ones.
5. Promote sleep and relaxation.
6. Avoid stimulants and other substances (caffeine, alcohol).
7. Address pain (see pain management).
8. Avoid benzodiazepines.
9. Consider SSRIs/SNRIs
    a. If not responding to SSRIs/SNRIs and other non-pharmacological interventions, consider low-dose anti-adrenergics or low-dose atypical antipsychotics (risperidone, quetiapine).
    b. If not responding or worsening, refer to specialty care.

CHILDREN AND ADOLESCENTS

- Trauma-focused psychotherapy is 1st line
- Medications can be used in conjunction with therapy
  - Severe or prolonged symptoms
  - Comorbid conditions
- Small body of evidence
  - SSRI trials non-significant (AACP says “can consider SSRI treatment”)
  - α2-agonists, α1-antagonists, SGAs, AEDs supported
  - Target most impairing symptoms

Source: Keeshin & Strawn 2014

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NOVEL MEDICATIONS

- MDMA
- Ketamine
- Cannabis

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MDMA-AP

Original Paper

The safety and efficacy of ±3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic stress disorder: the first randomized controlled pilot study

Michael C Mithoefer[1], Mark T Wagner[2], Ann T Mithoefer[1], Lisa Jerome[3] and Rick Doblin[3]

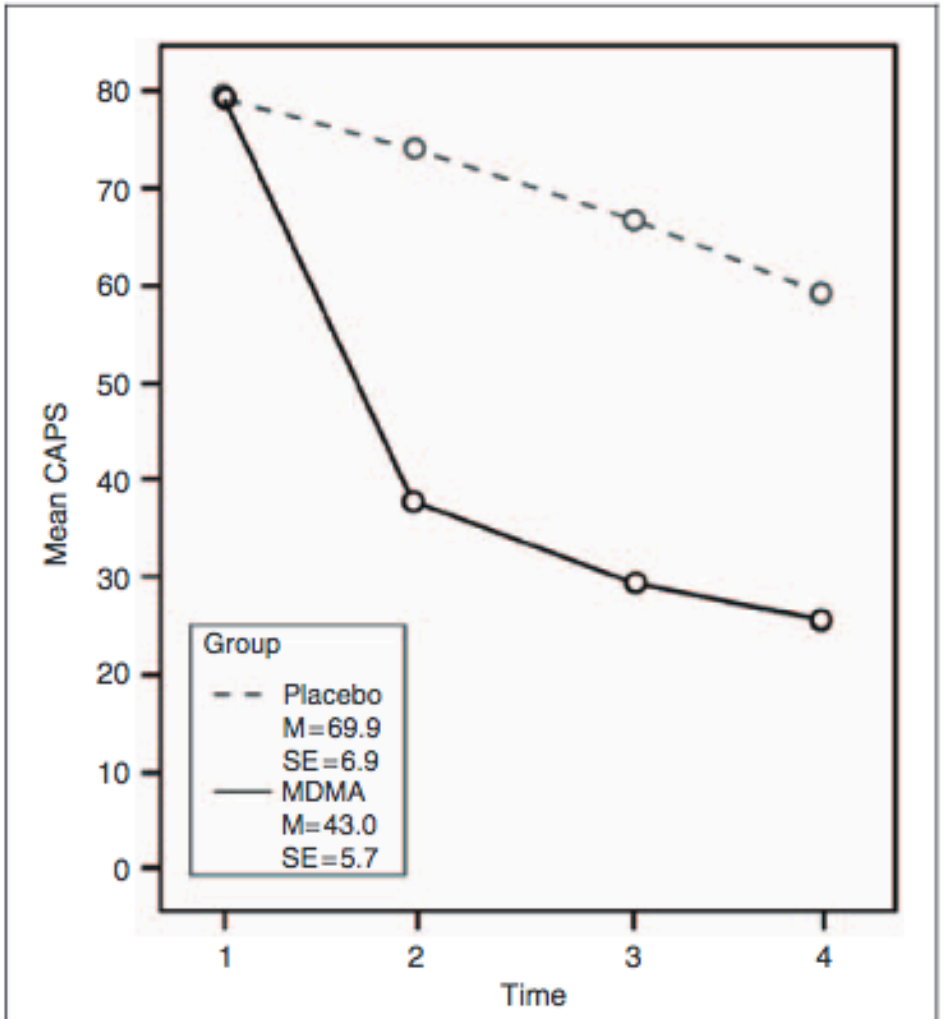
Psychopharm

Journal of Psychopharmacology
25(4) 439–452

DOI: 10.1177/0269881110378371
jop.sagepub.com
SAGE

MDMA-AP

- Clinical response was 83% vs 25%



Time 1: Baseline < 4 weeks before first experimental session and after discotinuing any psychotropic medications
Placebo=79.6 (8.1), MDMA=79.2 (6.6)

Time 2: 3-5 days after first experimental session
Placebo=74.1 (10.3), MDMA=37.8 (8.4)

Time 3: 3-5 days after second experimental session
Placebo=66.8 (8.0), MDMA=29.3 (6.5)

Time 4: 2 months after second experimental session
Placebo=59.1 (9.4), MDMA=25.5 (7.7)

KETAMINE

Efficacy of Intravenous Ketamine for Treatment of Chronic Posttraumatic Stress Disorder

A Randomized Clinical Trial

Adriana Feder, MD[1]; Michael K. Parides, PhD[2]; James W. Murrough, MD[1,3]; et al

» Author Affiliations | Article Information

JAMA Psychiatry. 2014;71(6):681-688. doi:10.1001/jamapsychiatry.2014.62

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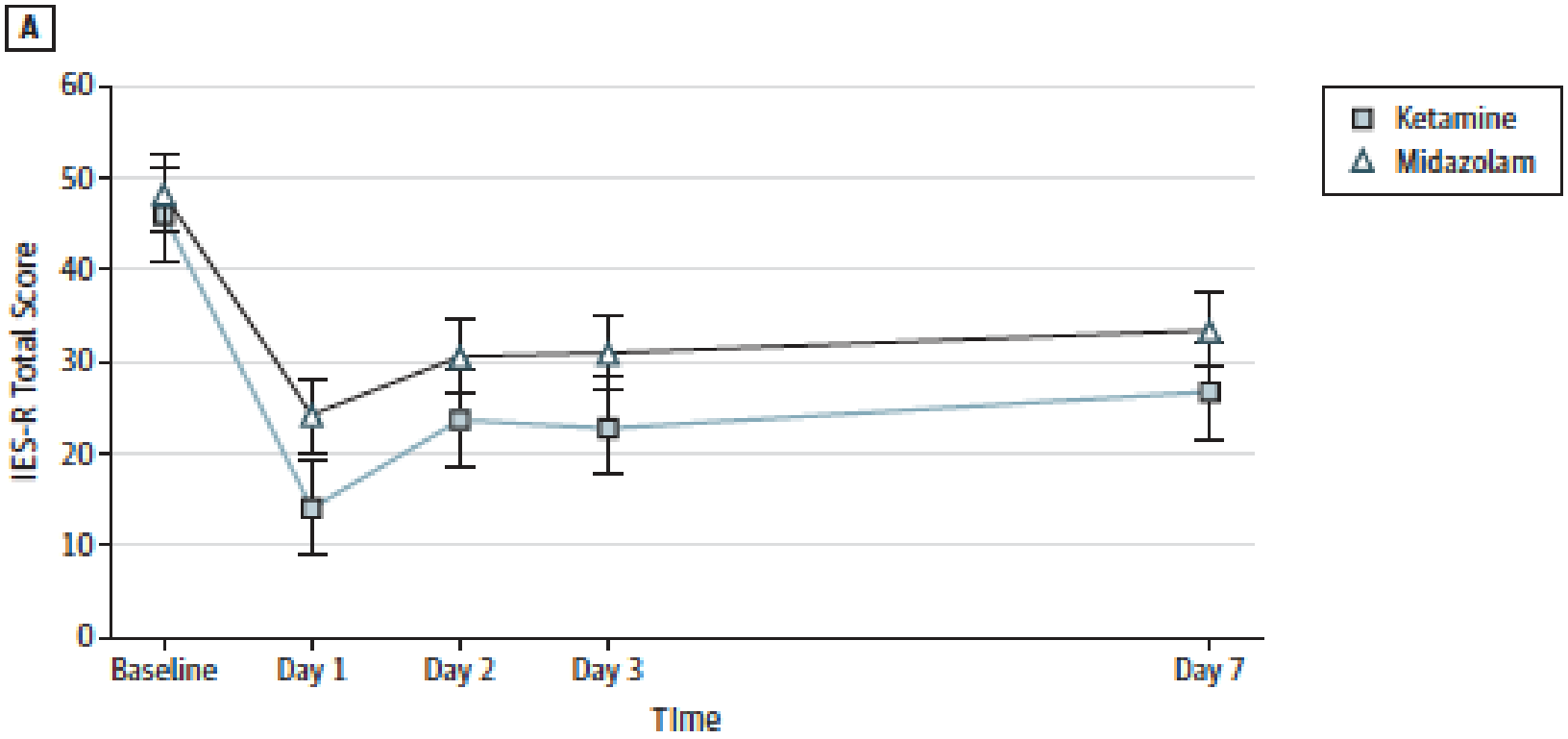
KETAMINE



CANNABIS

Clin Drug Investig (2014) 34:587–591
DOI 10.1007/s40261-014-0212-3

SHORT COMMUNICATION

Preliminary, Open-Label, Pilot Study of Add-On Oral Δ^9-Tetrahydrocannabinol in Chronic Post-Traumatic Stress Disorder

Pablo Roitman · Raphael Mechoulam · Rena Cooper-Kazaz · Arieh Shalev

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