Pharmacotherapy in PTSD

Dr Penny Burns: So today we'll be talking about pharmacotherapy for post-traumatic stress disorder and as a GP in rural areas I think we have a lot more need to understand how to manage this medication due to the limited access to mental health care support in those areas more, but it's also as an urban GP, it's also nice to understand how management is progressing for patients.
So I guess the first question I have John is - when should pharmacotherapy be considered in the treatment of PTSD? Because I know earlier on in a previous podcast you're talking about it being a second line treatment following psychological treatment. So when should we be thinking about actually introducing pharmacotherapy?
Dr John Cooper: So I think there are a few elements to consider, one is patient preference another is the availability of the psychological treatments and then we have the situation where maybe the psychological treatments are available and have been used but haven't been as effective as we would like.
There's also the other related issue particularly with more chronic presentations of PTSD, is that there are often a range of comorbidities and one of the most common comorbid conditions to PTSD is depression along with other anxiety disorders and occasionally substance abuse.
So we also need to be thinking about managing and treating those comorbidities and if there was comorbid depression that might make us think about using medication earlier than we might otherwise.
There are also situations where there is an acute presentation associated with significant risk. For example, of suicide, where a person's symptoms are very severe, disabling and distressing and they could preclude the patient from being able to participate in psychological treatment. And that would be another reason to start thinking about medication treatment.
Dr Penny Burns: So we've decided we're going to start this patient on medication, which of the many medications should I be choosing and is there evidence behind choosing a particular medication?
Dr John Cooper: So the class of medication that we should be choosing from in the first instance is an antidepressant medication the evidence tells us that SSRIs are supported with randomized control trials with significant sample sizes. However a number of the other antidepressants simply haven't been researched from a perspective of their effectiveness with PTSD. So the three SSRIs have had the best research done are sertraline paroxetine and fluoxetine. In the Australian treatment guidelines for PTSD we've generally recommended the class of SSRIs and we base this on clinical practice and evidence that we're able to obtain from other conditions such as depression.
We know clinically however, that there are some predictable side effects associated with both SSRIs and SNRI antidepressants and often we're choosing an antidepressant based on potential side-effects as well as the confidence that we might have in its effectiveness.
So for general practitioners, my advice is to start with your preferred SSRI the antidepressant that you're most comfortable prescribing. For me that would be sertraline or escitalopram but for others it might be fluoxetine or maybe citalopram for example. If you're looking for a different side effect profile then there are other medications to consider, that have been shown from clinical practice to be effective but aren't necessarily supported as well with an evidence base. And they are antidepressants such as mirtazapine or moclobemide and we also have up our sleeves the option of the older antidepressants such as tricyclics and the male inhibitors that have also shown some benefits for PTSD.
Dr Penny Burns: So John if I was looking for something to help my patients sleep because that was particularly something that they were having problems with and we know that sleep is often disrupted as well in general after disasters, but for PTSD I have a number of patients that have trouble with sleeping, what sort of medication side effects would you be looking for there, which medication would you be considering?
Dr John Cooper: That's a complicated question Penny because the sleep problems that present are often multifactorial in terms of their cause. If you assess that the insomnia is a direct symptom of the PTSD or depression, then you would expect with any of the antidepressants as they take effect on improving the severity of the PTSD and depression that sleep will improve. To contradict myself it's also worth noting that the SSRIs and SNRIs do have negative effects upon sleep particularly in the initial phases of use and they can be associated with more broken sleep. That might cause somebody to start thinking about mirtazapine as an antidepressant option if the sleep issue is critical. Otherwise, in terms of short prescriptions of medication that might help sleep we would, I would, recommend that GPs use their own clinical experience in deciding whether to use hypnotics, benzodiazepines or the z hypnotics or some of the other sedating medications that are used understanding that they're not supported with good evidence. They don't necessarily improve PTSD in the longer term and there are all of the caveats of concern about using these sorts of medication with respect to side-effects dependency and so forth.
Dr Penny Burns: And of course as GPs we're pretty good with the sleep hygiene aspects as well that we would add in there. So my next question would be - how is using antidepressants to treat PTSD different to using them to treat depression for example?
Dr John Cooper: In the first instance I would say that there isn't a difference, that in terms of the choice of agent, the dosing regimen, the idea of starting low, going slow, having a methodical approach to adjusting the dose educating patients to expect some delay in the onset of benefits, giving patients good information about the likely side-effects and the possible situation that they'll have side effects before they'll have a therapeutic effect. There is some evidence to suggest that with PTSD the dosing may need to be a little bit more robust than if we're treating straightforward depression. So GPs may need to be prepared to go up to middle to high doses within the dose range of the particular agent in order to get the optimal effect.

Dr Penny Burns: And how would we know if they weren't working? So when would we understand that okay we've gone up a bit higher but there's really no effect? We've got no access, we've got the psychiatrist on the phone that we can obviously talk to but when would be starting to suspect that.
Dr John Cooper: If there's absolutely no indication of any symptomatic improvement within the first two weeks I would have gentle alarm bells ringing. We know that the full effect of an antidepressant can take much longer than that, four six or even eight weeks. Our ability to wait that long with our patients will depend upon the severity of their symptoms the level of their distress and any associated risks for suicide for example you might condense the time frames if your decision making if any of those factors are present.
If you've taken the antidepressant up to a moderate to high dose within a four to six week period and there's no evidence of improvement at all then you would be thinking about changing to a second line antidepressant and for me I'd be thinking about using an antidepressant from a different class but the algorithm that you use, there are some there are some guidance from the evidence I would tend to bring to bear my practice in treating depression even if there was no depression in a patient with PTSD and there's also a decision that will need to be made along that path particularly if there is a partial response about introducing an augmentation strategy where you might use a second medication to try and get additional benefits. And so can you give us an example of that? So your first preference is sertraline what would you be then looking at and how would you augment that?
If I had some response from the sertraline it would then depend upon the residual symptoms and their severity but if there were there were symptoms such as distressing nightmares and associated insomnia then the first additional agent I would begin to think about is prazosin, which is an old-fashioned anti-hypertensive medication with an adrenergic effect. There's reasonably good evidence that added to an antidepressant it can improve those symptoms of PTSD, particularly nightmares and sleep disturbance. A lot of people with more severe PTSD or persisting symptoms of PTSD end up on atypical antipsychotics for example quetiapine. Now in my practice, I have a reluctance to go down this path because I'm not always confident of the risk benefit profile. The evidence of helpfulness from research is there but it's not strong. And we know that some of these medications have quite significant side effects particularly in the metabolic realm but also some of the neurological side-effects of antipsychotic agents. So in my practice I reserve them for patients whose PTSD is at the more severe and complex end of the spectrum.
Dr Penny Burns: Fantastic, thank you. So my final question would be that once you've got the patient established on a helpful regime what should the GP be looking at in providing ongoing monitoring and review?
Dr John Cooper: With a good response to medication my advice to a patient is to stick with the dose that helped, for at least a 12 month period and depending upon circumstances and symptom response may be longer. That would then require regular review with the GP to monitor effect and side-effect to provide the prescriptions to support compliance and to be looking at all of the other important aspects of treatment beyond the pharmacotherapy.
If circumstances permit, for example, there are no major life stresses there are no other medical problems going on, a patient has done well, may be whilst taking the medication they've had access to good psychological treatment. Tthen the GP and the patient might then have an active discussion about is it time to come off the antidepressant If the answer to that question is ‘yes’ then my advice is to do it very slowly, methodically, and have the patient aware that there could be a deterioration of their symptoms, some of the symptoms might return, and if that happens either with sufficient severity or if it persists for more than a week or two, then that might be answering the question about whether or not the medication is still needed and an obvious option there is to go back on the previous effective dose. In some instances we are able to take a patient right off their medication and they remain well, and then the longer they go off the medication after an effective course the more confident that I'm going to be that they're not going to need to go back on the medications.
Dr Penny Burns: Fantastic anything, sorry, keep going.
Dr John Cooper: There would be a small group of patients who will end up on antidepressant medication for much longer periods of time. I would caution GPs against setting and forgetting. I think it does, every time a prescription is written the question should be asked with the patient. Is this an important part of your treatment regimen? And if the historical evidence supports the need for the ongoing antidepressant, it's being well tolerated, then sometimes patients with chronic PTSD end up on their medication for you know much longer than 12 months, you know 5 years, 10 years sometimes.
Dr Penny Burns: Fantastic, thanks very much John. Well I think that's a really good snapshot of how to look at medication in PTSD and hopefully that will be useful to a lot of GPs out there.
Dr John Cooper: Thanks Penny.