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Inconsistent Outcomes: How Ignoring Guidelines Leads to Unpredictable Results

Announcer:
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Dr. McIntyre:
This is CME on ReachMD, and I'm Dr. Roger McIntyre. Here with me today is my good friend and colleague, Dr. Joe Goldberg.

Welcome, Joe.

Dr. Goldberg:
Thank you, Roger. Hello, everybody.

Dr. McIntyre:
It is clear that many patients with PTSD are often not being treated as recommended in current guidelines. Very common. While there are many valid reasons for not adhering to a PTSD treatment guideline, doing so not only comes with potential adverse consequences for patients, but no guarantee of good quality or improved outcome.

Joe, how do we address this issue?

Dr. Goldberg:
So guidelines are helpful as guidelines. They're not cookbooks. They don't tell you do this, then that, then that, but they kind of sketch out parameters. And for something such as PTSD, which is often under recognized, not even screened for, and there's phenomenon that many clinicians may not even have full awareness of, guidelines are a helpful thing to be aware of.

There are a few that are contemporary. There's the VA Department of Defense Practice Guidelines that came out in 2023, the International Society for Traumatic Stress Studies, the ISTSS guidelines, and the American Psychiatric Association also has guidelines. And I think there's a couple of common threads that are useful.

So first and foremost is just an awareness of what is PTSD and to ask about it, particularly in situations where there's reason to be concerned that someone may have been exposed to some traumatic event. So guidelines would emphasize screening as a starting point. And having screening tools can be helpful. We talk about this in other settings, but things like the CAPS-5 is a 20-item questionnaire the patient can fill out, which gets at some of the core dimensions of symptoms of PTSD such as sleep disruptions or nightmares, re-experiencing, reliving, mood changes, avoidant behaviors.

The clinical interview itself has to follow these things up. So just an awareness of the 4 domains, intrusive thoughts, autonomic hyperarousal and startle, the avoidant behaviors, and the mood and cognitive symptoms are things that guidelines would tell us the clinician should be aware of.

We know that trauma does not equate to PTSD. So just because a patient says, well, I did experience a physical assault, the response

isn't you must have PTSD. It's more, let's find out if that awful event that occurred for you has led to something like PTSD and to destigmatize it, to normalize it, that it is a pathological response that our brain does after an event. Right? So it wouldn't just be anybody who's experienced an aversive experience gets PTSD.

Now, guidelines do talk about treatments. We have only 2 FDA-approved treatments for PTSD at the moment, that is sertraline and paroxetine. And guidelines also call out the drug venlafaxine. That's off-label use of an SNRI that has some data in PTSD. The impactfulness, or the effect sizes, of those treatments as acknowledged in guidelines, is not humongous, and so it's a starting point. But then guidelines talk about the degree to which there is or isn't evidence for other supportive kinds of things. And here we can be a bit critical of some of the guidelines. For instance, briefly, alpha-antagonists, such as prazosin or trazodone, are sometimes thought to be helpful for nightmares and flashbacks, and there's mixed data on that. Alpha-agonists, like clonidine or guanfacine, are sometimes used for the fight-or-flight components, the hyper-responsivity and hypervigilance. But again, the data are mixed there. Atypical antipsychotics, such as quetiapine, some newer data with brexpiprazole as an augmentation of sertraline, don't get called out in guidelines so much drug by drug, as if to say we don't know enough at the moment about atypical antipsychotic, but there's an emerging database.

Guidelines also suggest certain things are just new and provisional. So much interest in psychedelic drugs, the drug MDMA, which the FDA recently asked for more data before rendering an opinion on, are, I would say, cutting-edge kinds of treatments. And then I'd say most important of all are behavioral interventions, such as exposure therapy or EMDR, eye movement desensitization reprogramming. So again, guidelines focus on proper screening, recognition of evidence-based treatments, both pharmacologic and behavioral, and recognizing limitations, as we look to hopefully newer and better treatments ahead in the future.

Dr. McIntyre:
Joe, that was wonderful. And I completely agree. Clinical practice guidelines do provide an opportunity for consistency, for appropriateness, acceptability, and perhaps also quality and cost-effectiveness advantages for our patients. This all sounds great. They're not cookbooks, as you said, Joe, but certainly provide a framework for guidance to inform our decisions at the point of care to help our patients.

So thanks so much, Joe. It's been a great discussion. Thanks to you all for listening.

Dr. Goldberg:
Thank you all.

Announcer:
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