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Role of PCP & Ob-Gyn With Women at Risk for PTSD: Recognition, Screening, and Referral

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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

Dr. McIntyre:
Joe, great to be with you.

Dr. Goldberg:
Glad you're here. We're going to be discussing how primary care and obstetrics and gynecology physicians can improve their recognition and screening and referral of women whose presentation of symptoms suggest PTSD.

Roger, what can you tell us?

Dr. McIntyre:
Such a great topic, Joe. First of all, we know that PTSD is a common condition, often chronic. It tends to differentially affect women. Hence, primary care, especially, of course, OB-GYN settings, are 2 opportunities for timely detection and implementation of guideline-recommended and FDA-approved treatments for people living with PTSD.

Like most things in life, Joe, it begins with contemplation. We're busy as practitioners, we're time poor, we're trying, in fact, to take a comprehensive history from our patients, and it begins with, I think, a very cost-effective, time-sensitive question, that being, have you ever had a history of trauma? That doesn't take a lot to ask. That's a standard question. I'm amazed, Joe, how seldom that question is even asked. And of course, that's a very subjective definition of what trauma is. But asking the question, that's critical to the PTSD diagnosis.

If, in fact, you get an affirmative answer, I think that obviously then triggers a set of questions, maybe beginning to screen, and also then go through the DSM polythetic list for PTSD. Before I get to that, Joe, another point I would raise is so often in my practice I'm referred patients: query bipolar, query borderline personality, query, query, query. So, in other words, when someone comes with a psychiatric disorder, asking about trauma should be part of the intake, part of the consultation, especially in conditions that are also well known to be associated with trauma histories, not limited to, for example, personality disorder like borderline personality disorder.

I think, again, it talks about the idea is that we should be screening. One of the guiding principles of medicine is we only should screen what we have therapeutics for and the infrastructure to provide care for. Well, we do have that for PTSD. And I would say, Joe, that in my experience, again, often patients are not even asked about a trauma history.

Second, there's not a systematic probing for the symptoms of potential PTSD and maybe even the diagnosis of PTSD. So there's many different screening tools that are available, including the PCL-5, which is probably best known. There's also a primary care PTSD scale, PC-PTSD. I think many clinicians would be very familiar with depression and anxiety scales, PHQ-9 and GAD-7. They're not PTSD scales, but I think the only point being is that we are familiar with metrics that patients can complete that can be very helpful to alerting us to the presence and severity and the possibility of PTSD.

So I think for primary care and OB-GYN settings, I do think, in fact, a trauma question is a very easy question to pose. I think, Joe, to be very candid, sometimes people, as clinicians, are a little hesitant to ask the question because, oh no, what if the patient says yes, then what do I do after that? And I think that's frankly a little hesitation for some clinicians. But what I would say is that the question needs to be asked, screen for PTSD. We do have, in fact, treatments available, which would warrant this type of process in place.

Dr. Goldberg:
Terrific. I'll add just one quick pearl, which is if you're a primary care physician or ob-gyn and you're treating a patient, a woman with, say, mood symptoms and they're taking antidepressants and not getting better, there becomes a wide differential diagnosis that has to come into play before you just prescribe the next antidepressant. We won't go into that wide differential today. It is quite extensive and there may well be a point at which, after many nonresponses to treatments, referral to a mental health clinician makes sense. But be sure to include on that differential a history of trauma. It's not mutually exclusive with depression, but if it's there and if PTSD is comorbid with depression, it’s a common reason for seeing a poor response to treatments, and it really signals the need for a more concerted kind of treatment approach, so you can really catch that in patients who don't get better with initial treatment approaches.

Well, this has been a great micro discussion. I want to thank you so much, Roger, for being with us today and thank you all for joining us. We'll see you next time.

Dr. McIntyre:
Thanks, Joe. Thanks everybody.

Announcer:
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