Co-occurring Conditions Toolkit: Executive Summary of Changes

The Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health, second edition, is an update to the version published by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in March 2011. A working group consisting of representatives from DCoE, U.S. Department of Veterans Affairs (VA), U.S. Army Medical Command (MEDCOM), and Defense and Veterans Brain Injury Center (DVBIC) was convened in September 2011. The working group's objective was to revise the tool kit to reflect the current changes in the VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress (VA/DoD PTS CPG; updated in 2011). The working group addressed changes in pharmacotherapy treatment recommendations for acute stress disorder (ASD) and post-traumatic stress disorder (PTSD), as well as updated the tool kit to reflect current evidence. The most significant changes are summarized below.

BENZODIAZEPINES FOR THE TREATMENT OF ASD AND PTSD

In the previous edition, benzodiazepines were recommended for 5-7 days as a sleep aid. The new version is consistent with the VA/DoD CPG for PTS and recommends against the use of benzodiazepines for PTSD or for the prevention of ASD. Relevant sections throughout the tool kit were revised and the new language reads as follows:

- There is evidence against the use of benzodiazepines in PTSD management, as it may cause **HARM**. Strongly recommend against the use of benzodiazepines for prevention of ASD or treatment of PTSD.

ATYPICAL ANTIPSYCHOTICS FOR THE TREATMENT OF ASD AND PTSD

In the previous edition, atypical antipsychotics were considered to have a good overall quality of evidence for use in PTSD. The new version reflects the current evidence and does NOT support the use of atypicals as monotherapy for PTSD. Relevant sections throughout the tool kit were revised and the new language reads as follows:

- VA/DoD PTS CPG states that the evidence does NOT support the use of atypical antipsychotics as monotherapy for PTSD.
- The VA/DoD PTS CPG recommends against the use of risperidone as an adjunctive medication for PTSD; there is insufficient evidence to recommend for or against other atypical antipsychotics as an adjunctive treatment for PTSD.

TYPICAL ANTIPSYCHOTICS AND PTSD

In the previous edition, it was stated that there was poor quality of evidence for the use of typical antipsychotics in PTSD. The new version strengthens this language. Relevant sections throughout the tool kit were revised and the new language reads as follows:

- Insufficient evidence to recommend use of typical antipsychotics in PTSD and ASD; risks could outweigh benefit.

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS) AND PTSD

In the previous edition, all SNRIs were stated to be an effective first line treatment for PTSD. The new version reflects a closer examination of the evidence. Only venlafaxine is an effective first line treatment for PTSD and duloxetine has not been studied for use in PTSD. Relevant sections throughout the tool kit were revised and the new language reads as follows:

- Venlafaxine is an effective first line treatment for PTSD. During titration phase, venlafaxine may increase anxiety, nightmares and fatigue.
- Duloxetine has not been studied for use in PTSD.

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SMOKING CESSATION AIDS

The previous edition of the tool kit provided information on varenicline (Chantix) only. The new edition reflects the most recent VA/DoD guidance on smoking cessation, reserving varenicline for use only after first line medications have failed. First-line medications include: nicotine patch, nicotine gum, nicotine lozenge, bupropion and combination therapy.

THE FOLLOWING TABLE PROVIDES A LIST OF PAGES THAT WERE EDITED AS PER THE ABOVE SUMMARIES:

Topic Updated	Page # in Updated Tool kit
BENZODIAZEPENES and PTSD/ASD	Pgs. 2, 15, 82-84
ATYPICAL ANTIPSYCHOTICS FOR THE TREATMENT OF ASD AND PTSD	Pgs. 21, 93-95
TYPICAL ANTIPSYCHOTICS and PTSD	Pgs. 89-92
SNRIs and HEADACHE AND PTSD	Pg. 45
SMOKING CESSATION AIDS	Pgs. 102-103