DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar is:

Understanding Psychopharmacology Polypharmacy in Service Member and Veteran Populations

Oct. 25, 2012, 1-2:30 p.m. (EDT)

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Executive Director, Department of Veterans Affairs National Center for PTSD

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

Webinar Details

- The following continuing education (CE) and continuing medical education (CME) credit is approved for this activity:
  - 1.5 AMA PRA Category 1 Credits™
  - 1.75 CE Contact Hours Physical Therapy and Occupational Therapy
  - 1.5 Nursing Contact Hours
  - 1.5 Social Work CE Hours
  - 1.5 APA Credits for Psychologists
- For complete accreditation statements, visit the DCoE website to review CE and CME credit
- Webinar pre-registration **required** to receive CE or CME credit
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Additional Webinar Details (continued)

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Webinar Overview

Understanding Psychopharmacology Polypharmacy in Service Member and Veteran Populations

Health care providers treating service member and veteran populations with posttraumatic stress disorder, or PTSD, face a number of challenges. PTSD, itself, can be difficult to treat even when prescribed medications conform to the VA/DoD clinical practice guidelines. Furthermore, people with PTSD usually have at least one co-occurring disorder or problem that requires treatment in its own right. Most commonly these include depression, substance use disorders, traumatic brain injury, insomnia, pain, aggressive behavior or medical/surgical problems.

As a result, providers frequently interact with patients who have complex drug regimens for both physical and psychological health disorders. Prescribers need to carefully consider the implications of adding a new medication to a treatment regimen that may already include several pharmacological agents. They also need to consider discontinuing ineffective treatments that may only complicate clinical management.

Although sometimes it is necessary to prescribe a number of medications for complex patients, combinations of medications increase the occurrence of adverse drug interactions, medication misuse and medication non-compliance/adherence. Additionally, combinations of medications have been identified as a contributing factor of suicides and unintentional deaths.

Non-prescribing health care providers treating service member and veteran populations are in a unique position to identify risk of drug-drug interactions, monitor patients for adverse drug reactions, educate patients about polypharmacy and refer patients for further assessment. This webinar will:

- Review the rates of polypharmacy in service member and veteran populations with a special emphasis on psychopharmacological medications
- Identify factors leading to polypharmacy situations and the safety risks
- Describe the role of clinicians in working with patients who have complex drug regimens

Matthew J. Friedman, M.D., Ph.D.

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Geisel School of Medicine at Dartmouth

Executive Director, Department of Veterans Affairs National Center for PTSD

Required Disclosure

I have no relevant financial relationships, however, I do intend to discuss scientific evidence from clinical trials regarding the off-label use of medications not approved for the treatment of PTSD.

The following drug categories will be discussed today:

- Antidepressants
- Anti-adrenergic agents
- Anticonvulsants/Mood stabilizers
- Atypical antipsychotic agents
- Anxiolytics

Pharmacotherapy for Refractory PTSD

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Strength of Recommendation from VA/DoD 2010 Guideline

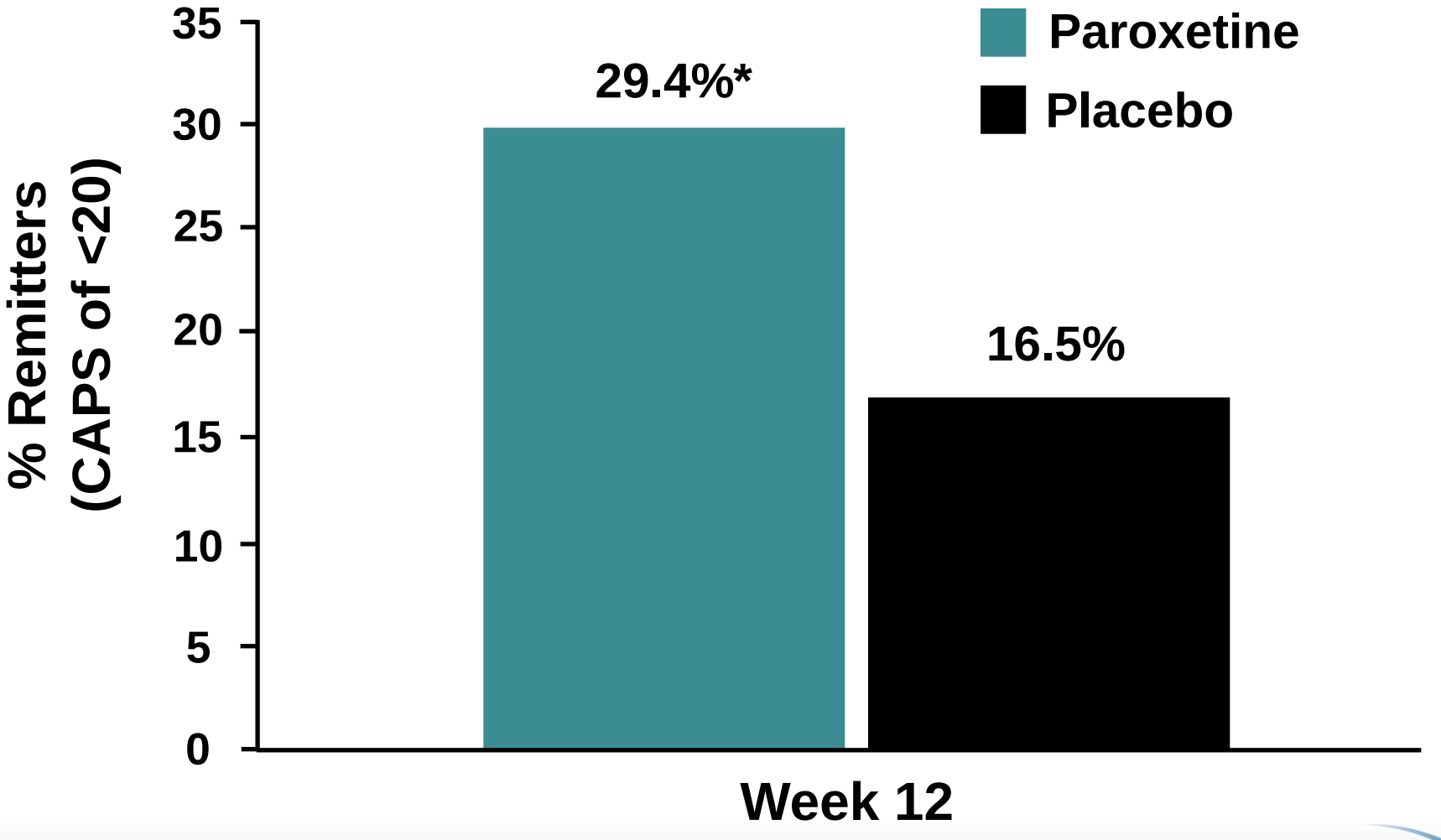
Pharmacotherapy Interventions for Treatment of PTSD: Balance of Benefit and Harm

Strength of Recommendation Rating or (SR Rating): A, B, C, D or I

A (Strong Recommendation)	B (Fair Evidence)	C (No Recommendation)	D (Ineffective or Harmful)	I (Insufficient Evidence)
Significant Benefit	**Some Benefit**	**Unknown**	**No Benefit**	**Unknown**
▪ SSRIs–Fluoxetine, Sertraline and Paroxetine ▪ SNRIs–Venlafaxine	▪ Mirtazapine ▪ Topiramate ▪ Prazosin (Use for sleep/nightmares) ▪ TCAs ▪ Nefazodone **[Use caution]** ▪ MAOIs (Phenelzine – attention to drug-drug and dietary interactions)	▪ Prazosin (For global PTSD)	▪ Benzodiazepines **[Harm]** ▪ Tiagabine ▪ Guanfacine ▪ Valproate ▪ Risperidone ▪ Citalopram	▪ Olanzapine and Quetiapine ▪ Conventional Antipsychotics ▪ Buspirone ▪ Non-Benzodiazepine sedative/hypnotics ▪ Citalopram ▪ Bupropion ▪ Trazodone (Adjunctive) ▪ Gabapentin ▪ Lamotrigine ▪ Propranolol ▪ Clonidine

National Center for PTSD
Posttraumatic Stress Disorder

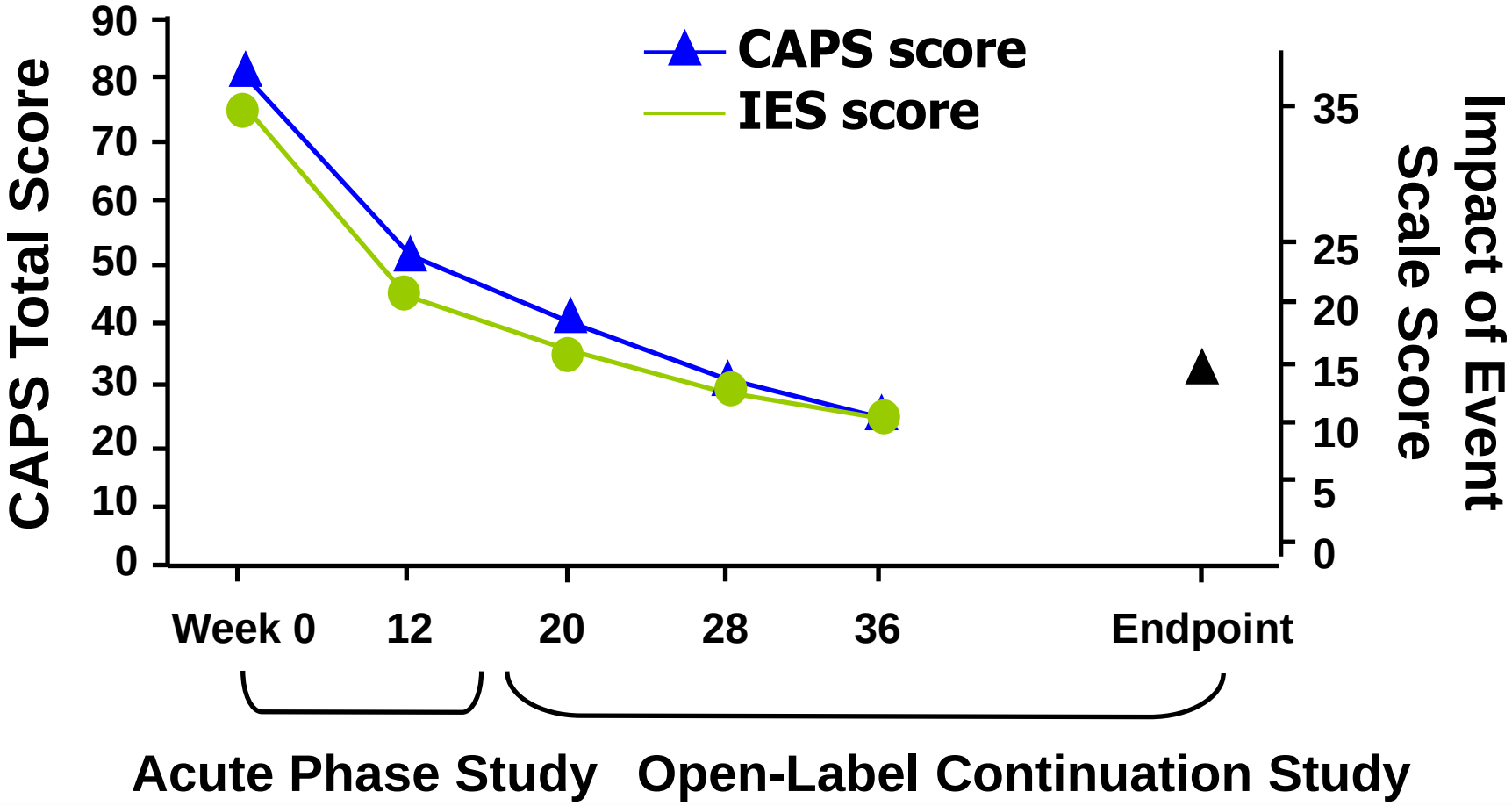
PTSD Remission Analysis



** ITT/LOCF data set; Odds ratio = 2.29; * p = 0.008; Tucker et al 2001; n=307*

National Center for PTSD
Posttraumatic Stress Disorder

Sertraline Continuation Treatment in PTSD



Londborg et al 2001

Important Medication Developments

- Venlafaxine (SNRI)
  - At least as effective as SSRIs in civilian trials
- Prazosin (alpha$_1$ adrenergic antagonist)
  - Cooperative Study underway; effective in treating nightmares, allows improved sleep
- Augmentation with atypical antipsychotics
  - Negative Cooperative Study with Risperidone

Important Medication Developments

- Mirtazapine (alpha$_2$ agonist/5-HT blocker)
  - Positive Randomized Controlled Trials
- Nefazadone (SSRI + 5-HT$_2$ antagonist)
  - Very effective
  - Monitor LFTs because of hepatotoxicity
- Bupropion (blocks presynaptic NE/DA uptake)
  - No evidence for efficacy in PTSD

Important Medication Benefits

- Clonidine, Guanfacine (alpha$_2$ agonists)
  - Not shown to be effective
- Propranolol (beta adrenergic antagonist)
  - Has not proven to be an effective preventative agent, but reduces arousal
- Naltrexone (opiate antagonist)
  - Reduced drinking, but no direct benefit for PTSD
  - Compatible with SSRIs and TCAs

Antiepileptic Drugs in the Treatment of PTSD

- Antiepileptic drugs promising, but currently not approved for PTSD
- Positive RCTs with Topiramate
- Negative RCTs:
  - Divalproex
  - Tiagabine
  - An equivocal finding: Lamotrigine

Note: Randomized Clinical Trials (RCTs)

Atypical Antipsychotics Not Recommended for Adjunctive Treatment of PTSD

- Four small positive trials:
  - Risperidone – Three (mostly in Veterans)
  - Olanzapine
- One small negative trial:
  - Olanzapine
- One large negative multisite trial:
  - Risperidone; n=247

Bartzokis et al 2005; Hamner et al 2003; Monnelly et al 2003; Stein et al 2002; Krystal et al 2011; Butterfield et al 2001

Benzodiazepine Basics

- Multiple RCTs demonstrate efficacy in anxiety disorders including:
  - Generalized Anxiety Disorder (GAD)
  - Panic Disorder (PD)
  - Social Anxiety Disorder (SAD)
- Effective treatments for short-term relief of anxiety symptoms or an “as-needed” basis
- Have a rapid onset of action, helps stabilize

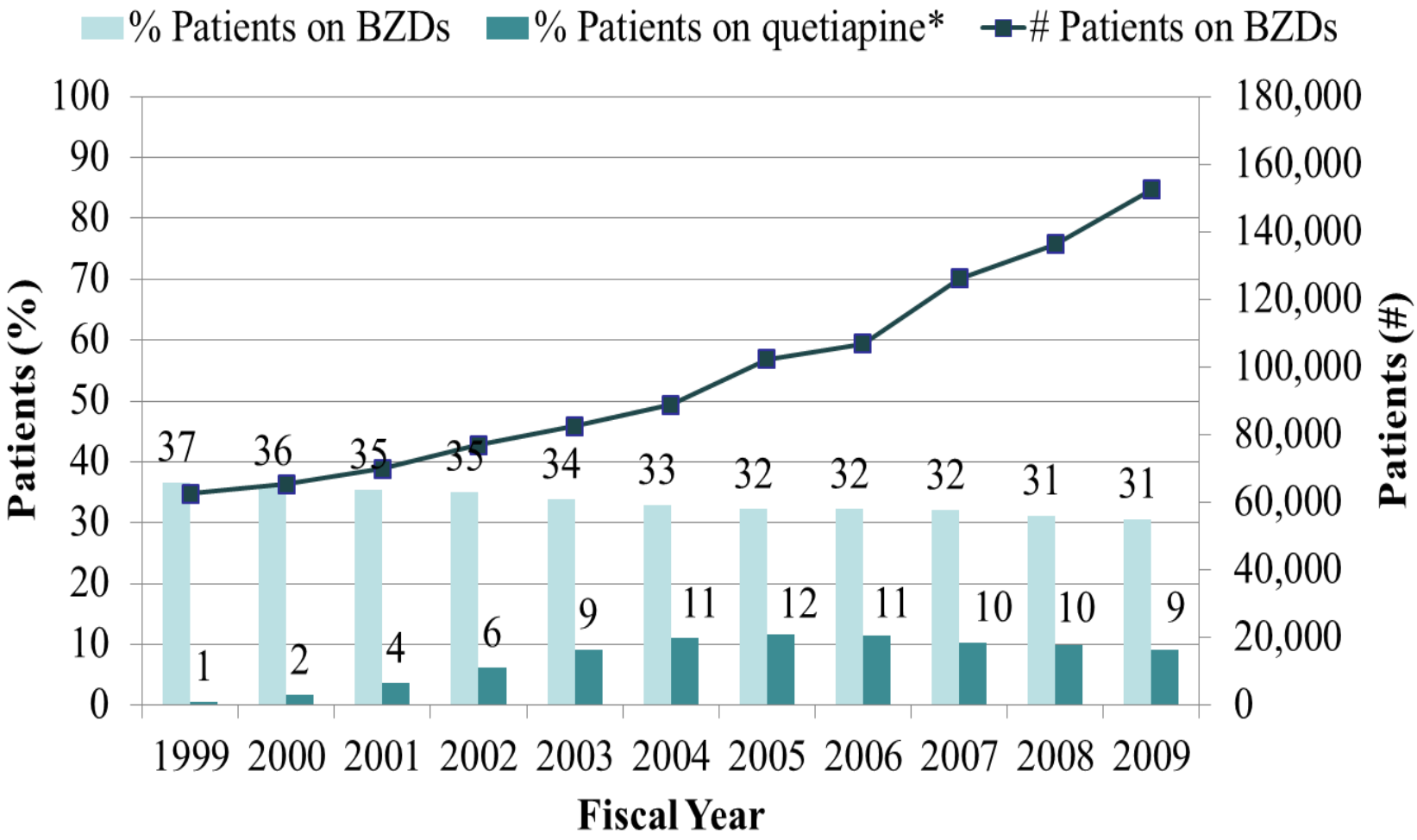
(Nutt, 2005); Note: Randomized Clinical Trials (RCTs)

Benzodiazepines – Not Indicated

- There are concerns in prescribing benzodiazepines (BZDs) for PTSD anxiety-related symptoms
  - Questionable beneficial effects will be short-lived
  - They may interfere with CBT treatment
  - Persistent withdrawal or craving exacerbates symptoms
  - May exacerbate coexisting substance use conditions
  - May exacerbate TBI-related cognitive impairment
  - May disinhibit aggressive behavior
    - BZDs use associated with suicidal behavior

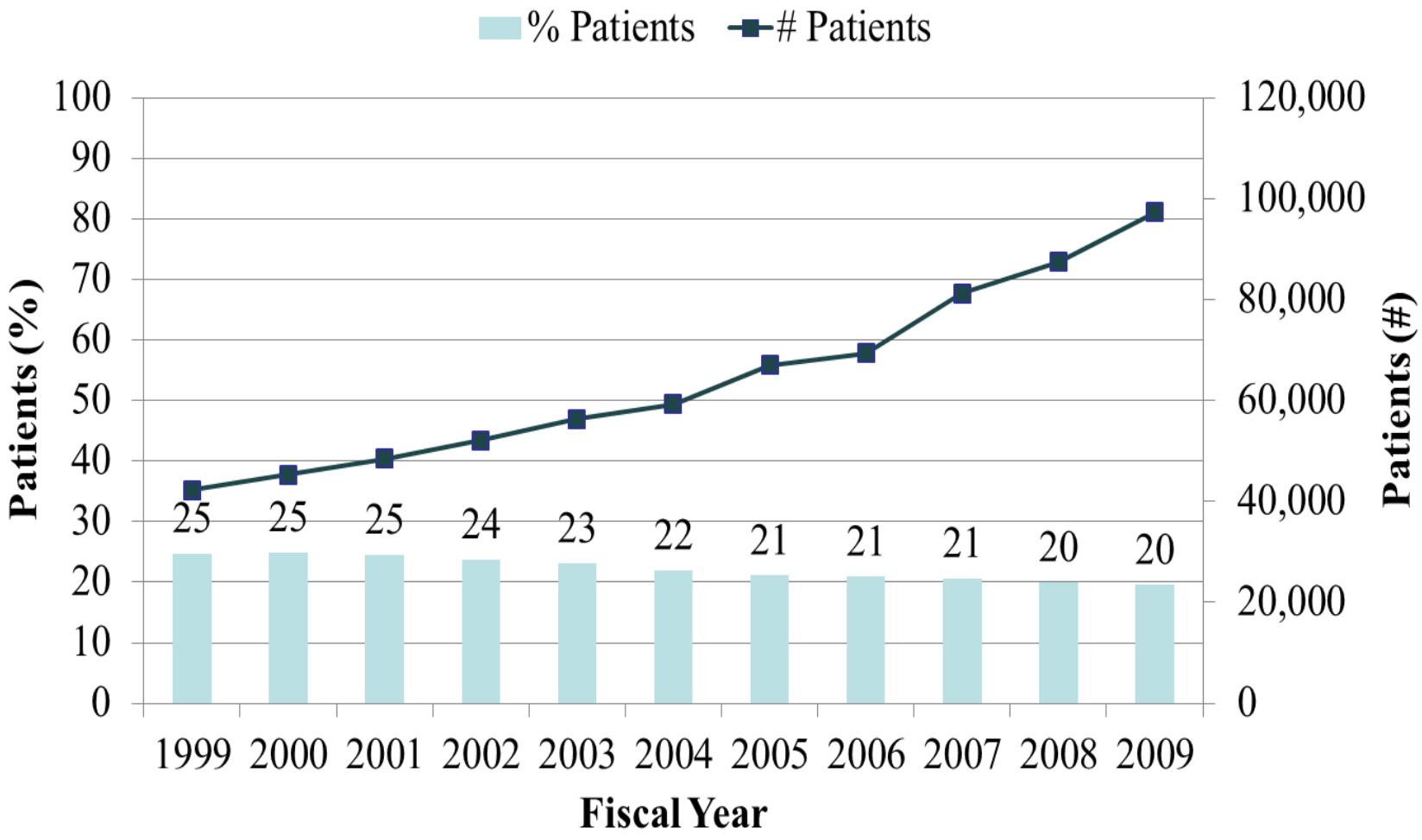
Note: Cognitive Behavior Therapy (CBT)

Benzodiazepines (BZDs)



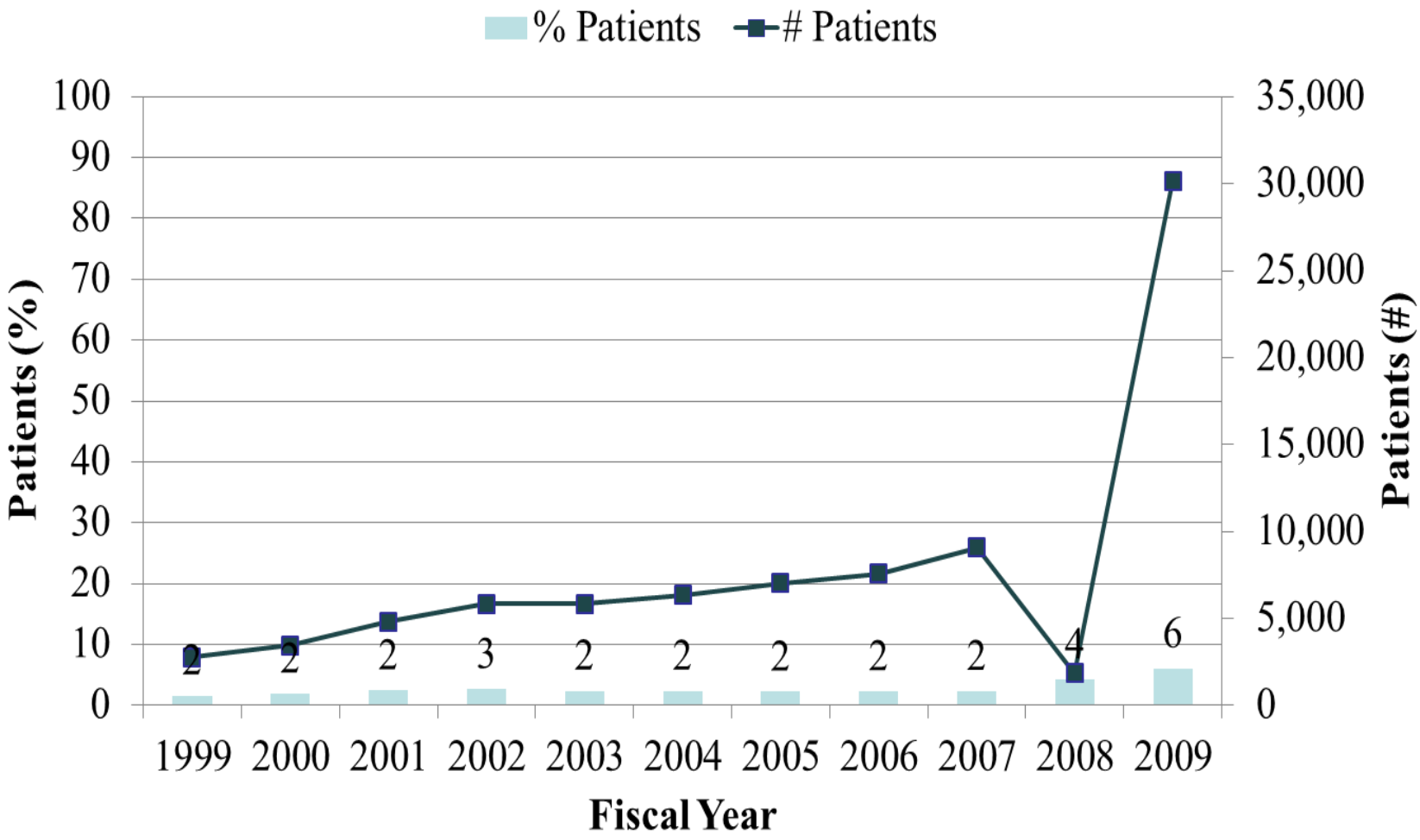
** Dose <=200 mg/day*

Chronic Benzodiazepines*



* > 90 days of continuous use in the fiscal year

Chronic Non-Benzodiazepine Hypnotics*



** > 90 days of continuous use in the fiscal year*

D-Cycloserine: PE Augmentation

- How it works
  - NMDA receptors enhanced
  - Mediates learning and memory
- Current research
  - Shown to be effective for other anxiety disorders
  - Faster extinction than exposure alone
  - Research with PTSD patients underway

PTSD Treatment Pharmocotherapy
Balance = Benefit - Harm

SR	SUBS.	SOMEWHAT	UNKNOWN	NONE or HARM
A	• SSRIs • SNRIs			
B		• Mirtazapine • Topiramate • Prazosin (Use for sleep /nightmares) • TCAs • Nefazodone **[Use Caution]** • MAOIs (Phenelzine)		
C			• Prazosin (for global PTSD)	
D				• Benzodiazepines- **[Harm]** • Risperidone • Tiagabine • Guanfacine • Valproate

A = Strong Recommendation; B = Fair Evidence; C = No Recommendation; D = Ineffective or Harmful

*(SR = Strength of recommendation ** Potential harm Full Guideline, p. 149)*

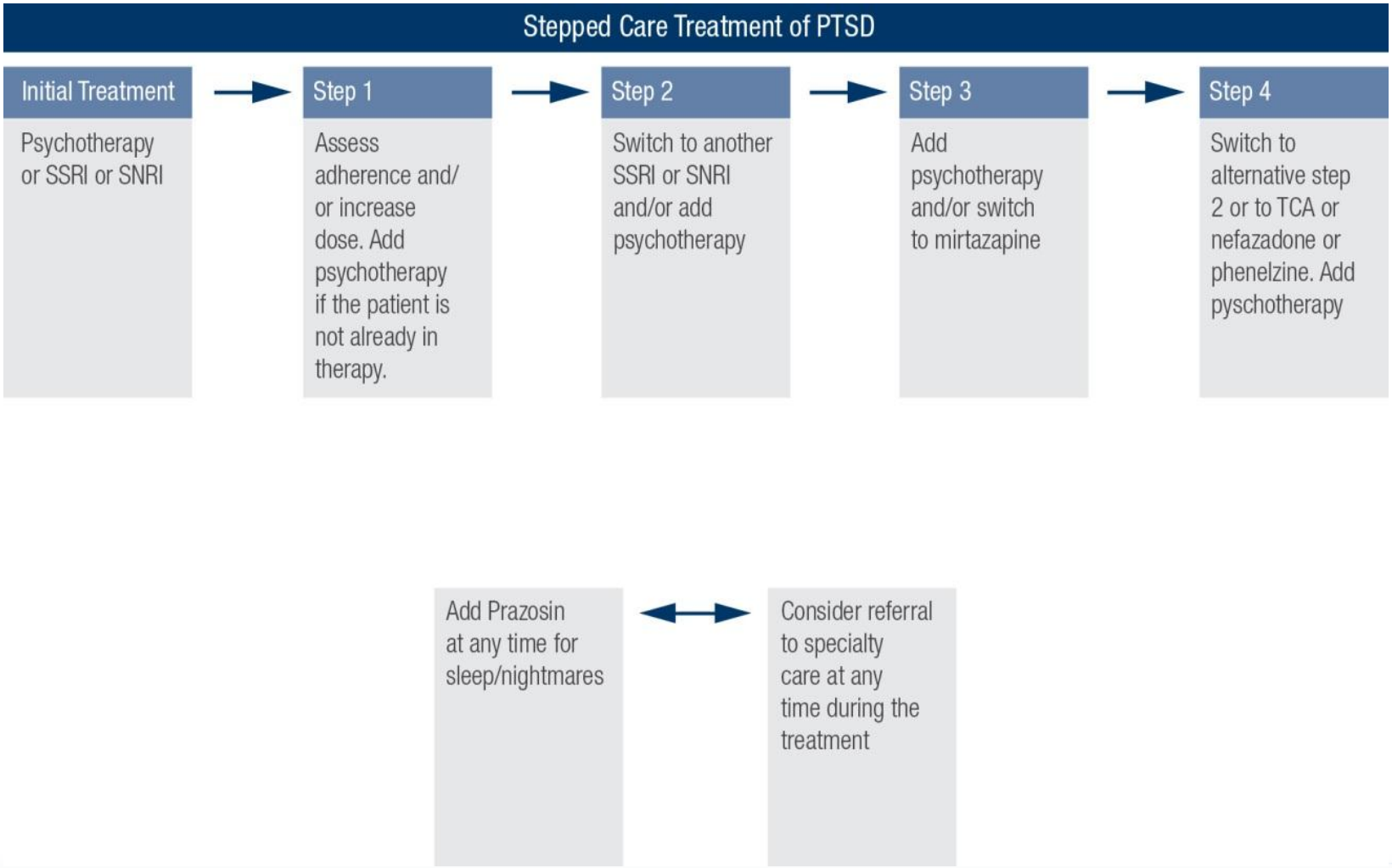
PTSD Treatment Pharmocotherapy
Balance = Benefit - Harm

SR	SUBS.	SOMEWHAT	UNKNOWN	NONE or HARM
I			▪ Atypical antipsychotic (mono- & adjunctive therapy) ▪ Conventional antipsychotics ▪ Buspirone ▪ Non-benzodiazepine hypnotics ▪ Citalopram ▪ Bupropion ▪ Trazodone (adjunctive) ▪ Gabapentin ▪ Lamotrigine ▪ Propranolol ▪ Clonidine	

I = Insufficient Evidence

*(SR = Strength of recommendation ** Potential harm Full Guideline, p. 149)*

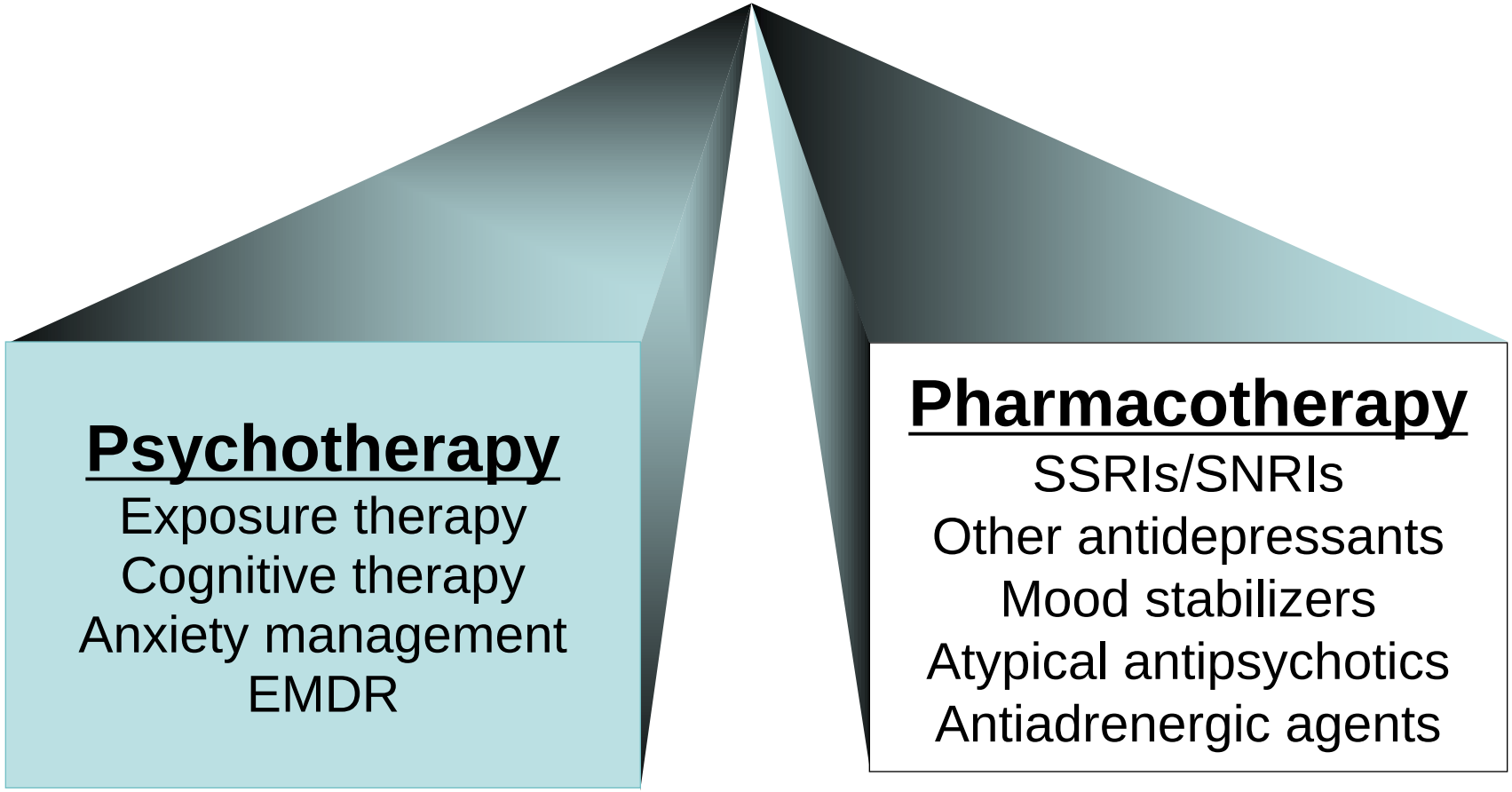
Algorithm for Stepped Care Approach



Evidence for Augmentation

- As of yet, no RCTs comparing ET with pharmacotherapy. However, there have been two augmentation trials:
  - ET plus 10 weeks of Sertraline resulted in reduction in relapse and symptom reduction in patients who did not respond to Sertraline (Rothbaum, 2006)
  - Augmentation with Paroxetine for patients who partially responded to six ET sessions did not result in additional benefit (Simon, 2007)

PTSD Treatment Options



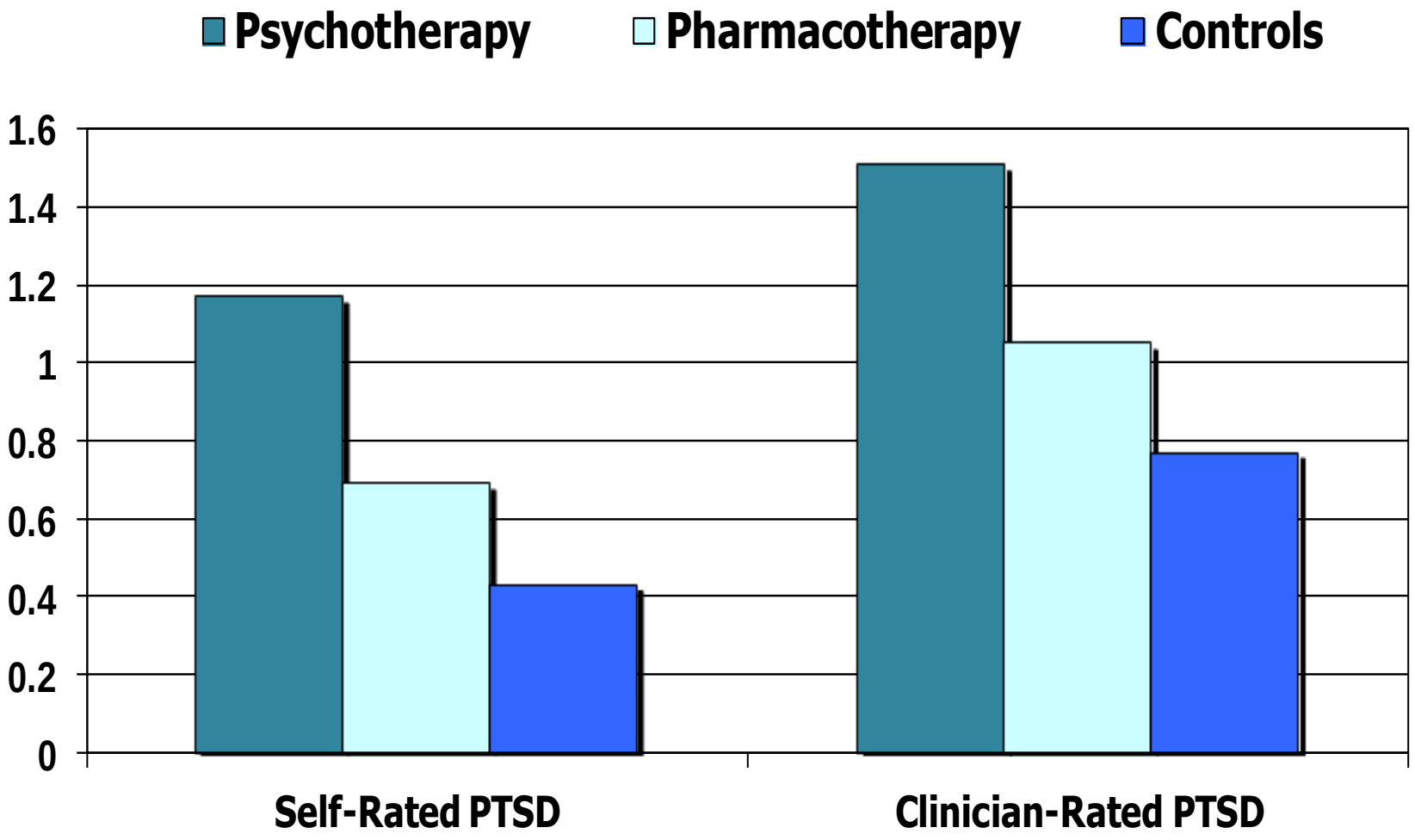
Note: Eye Movement Desensitization and Reprocessing (EMDR)

VA/DoD Clinical Practice Guidelines

- First Line Treatments: Psychotherapy
  - Cognitive-Behavioral Therapy
    - Cognitive Processing Therapy
    - Prolonged Exposure
  - Eye Movement Desensitization and Reprocessing
- Pharmacotherapy Treatments
  - Selective Serotonin Reuptake Inhibitors
  - Venlafaxine
  - Response rates to SSRIs, however, rarely exceed 60%
- Options for non-responders are needed

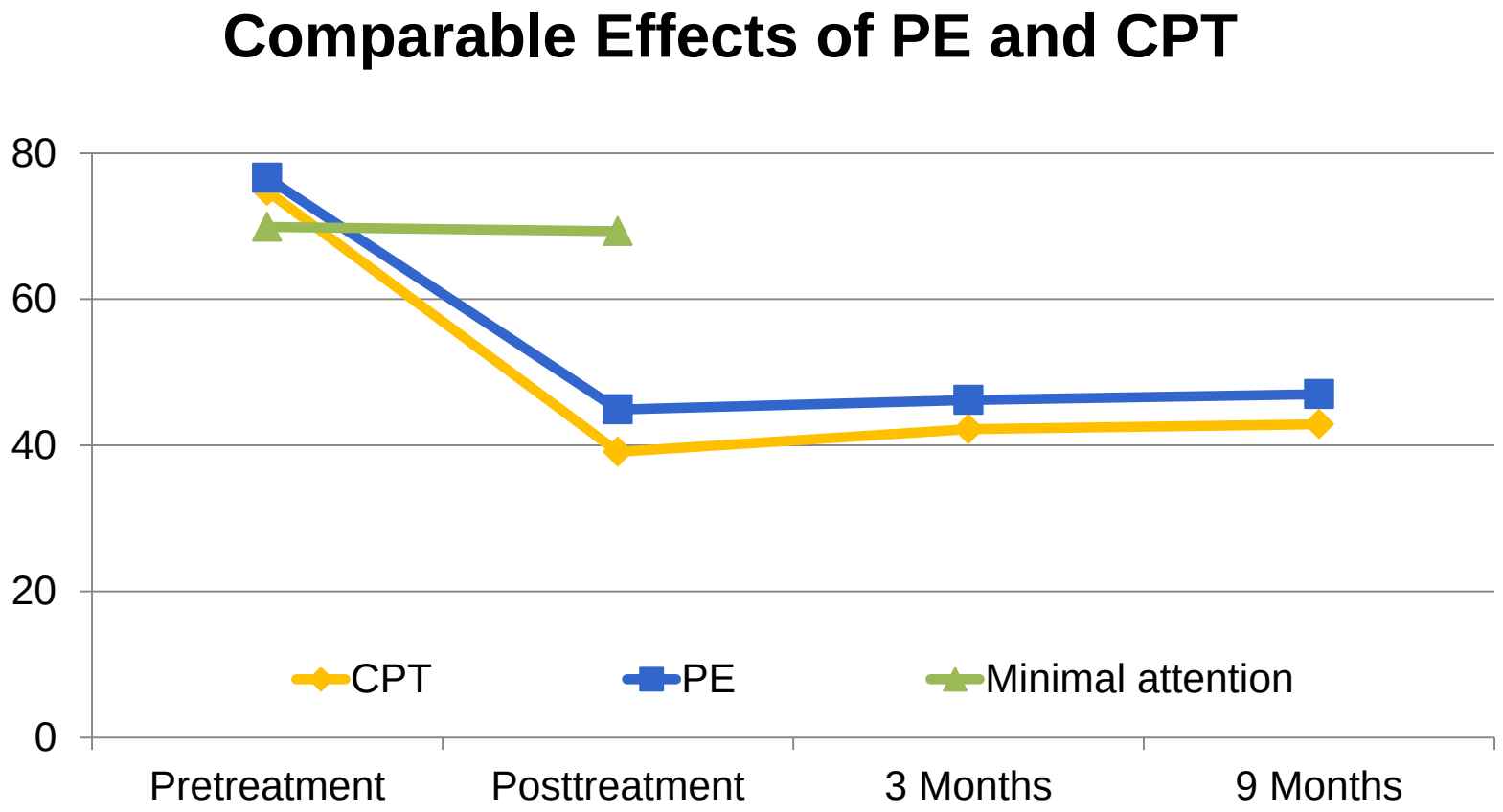
Van Etten & Taylor, 1998

Meta-Analysis of PTSD Treatments



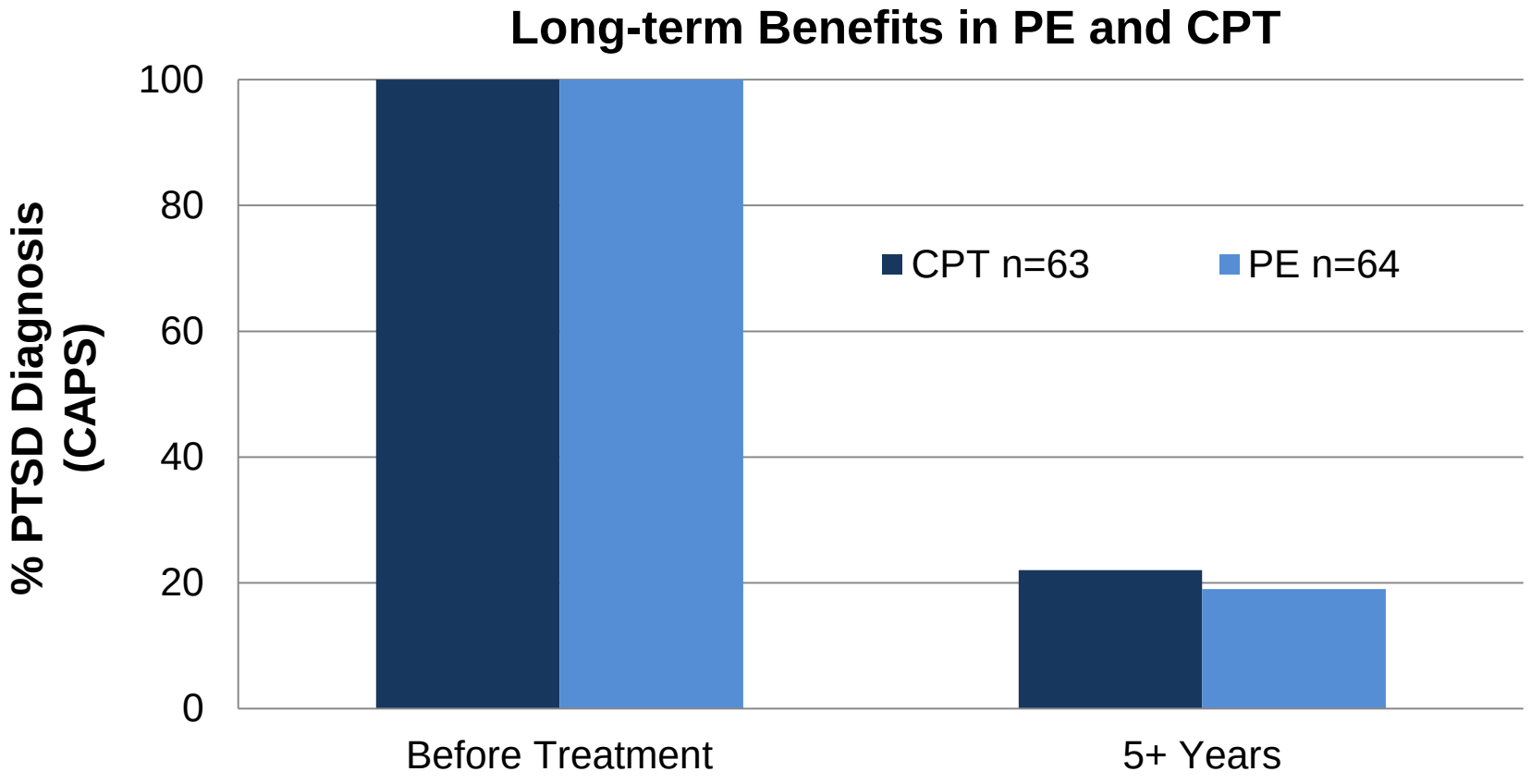
Van Etten & Taylor, 1998

CAPS PTSD Scores in Women Treated with PE versus CPT



Resick et al 2002; n=171

PTSD Diagnosis Before Treatment and at 5+ Years in CPT and PE



Resick et al, in press (2011)

CBT Instead of Medication

There is some emerging evidence that, given a choice, patients would rather have CBT than medication.

Note: Cognitive Behavior Therapy (CBT)

Key Questions About Treatment

- How should one choose among treatment modalities?
- What can one expect from treatment and how does one define realistic goals?
- How can one combine various treatment techniques?
- How does one approach complex clinical pictures and comorbid conditions?
- How long should a treatment be followed?
- How does one make sense of clinical difficulties and assess failure?

Criteria for Choosing Treatment for PTSD

- Expected efficacy for amelioration of PTSD severity
- Associated disorders and problems
- Difficulties, side effects, negative effects
- Acceptability and consent
- Cultural appropriateness
- Length, cost and availability of resources
- Legal, administrative and forensic implications
- Accessibility and acceptability to the family

Realistic Goals

- Remission is always the goal, unless proven otherwise
- Many chronic patients who have failed to respond to other therapies have benefited significantly from CBT or new medications
- If remission is not a realistic goal, maintenance of optimal function is the desired endpoint (e.g., recovery)

Combining Treatments

- Introduce treatments one at a time
  - Take into account: treatment efficacy, patient's choices and clinician's experience
- Conduct adequate clinical trial to determine effectiveness
- Discontinue if ineffective or intolerable side effects
- For partial response: introduce second treatment (prescription or CBT) without discontinuing first (e.g., Prazosin, atypicals, Mirtazapine)
- If response is adequate, try to discontinue first treatment
  - Try to eliminate all unnecessary medications

Polypharmacy

- The usual reason for polypharmacy is a partial response
- A clinical tendency is to add additional medications when one or more medications are only partially effective
- Because of compliance, side effects and drug interactions, one should always strive to eliminate ineffective medications whenever possible

Combined Treatments

- Combined treatments are common but data limited
  - Prolonged Exposure (PE) improved outcomes in partial responders to an SSRI
  - SSRI did not improve outcomes in partial responders to PE
  - D-cycloserine improved outcomes of PE in patients with anxiety disorders

Rothbaum et al 2006; Simon et al 2008; Norberg et al 2008

Treating Comorbid Conditions

- Vast majority of patients will have >1 comorbid disorder
- Crises and urgent conditions must be treated first
  - Suicidal/homicidal behavior
  - Severe alcohol/chemical dependency
  - Incapacitating depression
  - Marital/family/vocational crisis

Management of Co-occurring Disorders

- Providers should screen/assess for medical disorders/symptoms, mental disorders and psychosocial problems that commonly co-exist with PTSD
  - Depression, other psychiatric disorders, substance use patterns (i.e., alcohol, nicotine, prescribed drugs and illicit drugs), TBI, chronic pain, sleep patterns, associated high-risk behaviors (e.g., HIV and hepatitis risk)

Management of Co-occurring Disorders

- Little evidence exists for treatment recommendations for co-occurring disorders and PTSD
- Strategy is to follow the other VA/DoD Guidelines for the co-occurring disorder
  - www.healthquality.va.gov

Management of Co-occurring Disorders – PTSD and SUD

- Recommendation is to offer coordinated treatment and **concurrent** care when possible
- Addiction-focused pharmacotherapy should be offered, when appropriate
- Several psychotherapy options in SUD guideline; preliminary evidence for PTSD CBT treatments
- Assess response to treatment and monitor biological indicators

Treating Comorbid Conditions

Few Randomized Clinical Trials:

- PTSD and SUD
  - Seeking safety - Five RCTs
  - Sertraline - One RCT
  - Naltrexone/Disulfiram - One RCT
- PTSD and psychotic symptoms
  - Risperidone - One RCT

Najavits et al 2006; Najavits et al 2005; Hein et al 2004; Zlotnick et al 2003; Cohen et al 2006; Brady et al 2000; Petrakis et al 2006; Hamner et al 2003

Evidence-Informed Strategies for Comorbid Conditions

- PTSD and Depression or Anxiety
  - FIRST LINE: SSRI/SNRI -- good for both
  - Augment with Mirtazapine, TCA
  - Augment with Prazosin/atypicals (for depression)
- For co-occurring major depression, recommendation is to treat the PTSD and MDD which will typically improve (if severe, refer to specialty care)

Evidence-Informed Strategies for Comorbid Conditions

- PTSD and Hyperarousal/Dissociation/Aggression
  - SSRI/SNRI
  - Prazosin, Clonidine/Guanfacine, Propranolol
  - Benzodiazepines may disinhibit aggressive behavior

CPG Recommendations for Insomnia

- Behavior/Lifestyle Changes
  - Sleep hygiene
  - Less caffeine
  - Stop smoking
  - Aerobic exercise
- Psychotherapy (CBT-I)
- Medication

First, Make the Diagnosis

- Consider non-PTSD causes of insomnia
- First, screen for substance use disorders and depression
  - Alcohol
  - Nicotine
  - Stimulants
  - Major depression
- Refer to the VA/DoD CPG on SUD at www.healthqualityva.gov for the SUD and MDD guidelines and any of the other available CPG documents

Second, Primary Sleep Disorders

- Restless Legs (RL)
- Periodic Limb Movements of Sleep (PLMS)
- Obstructive Sleep Apnea (OSA)

Evidence-Informed Strategies for Comorbid Conditions

PTSD and Insomnia

- FIRST LINE: Prazosin
- Augment with Trazadone (i.e., Hydoxyzine or Diphenhydramine)
- Augment with SSRI/SNRI for co-occurring depression

Evidence-Informed Strategies for Comorbid Conditions

- PTSD and Psychotic/Hypervigilance
  - SSRI/SNRI and atypical antipsychotics
- PTSD and Bipolar Disorder
  - SSRI/SNRI and mood stabilizer

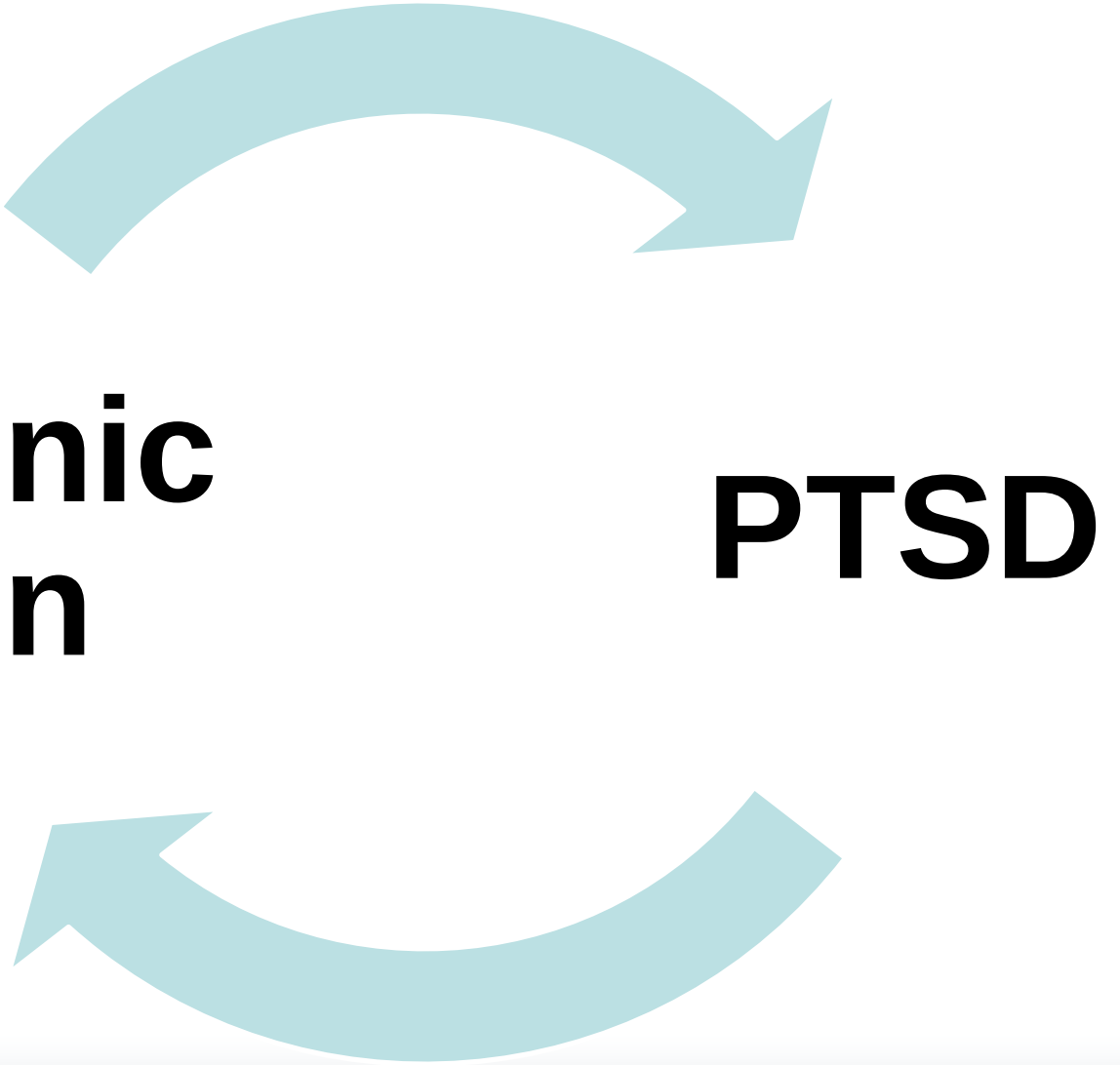
Treating Comorbid Conditions

PTSD and Cognitive Impairment (mTBI)

- Start low, go slow
- Avoid Anticholinergics
- Avoid Benzodiazepines
- Consider stimulants
- Consider CBT (for mTBI)

PTSD and TBI
Three Important Medication Groups

- Dopaminergic Agonists
  - Amantadine and Memantine
  - Ropinirole and Pramipexole
- Anticholinesterase Inhibitors
  - Galantamine
  - Donezepil
  - Rivastigmine
- Stimulants
  - Methylphenidate
  - Dextroamphetamine
  - Amphetmine


Chronic Pain
PTSD

Migraine Headaches

Acute Migraine Treatment

- Triptans (Serotonin Agonists)
  - Faster-acting: Sumatriptan, Zolmitriptan, Rizatriptan, Almotriptan and Eletriptan
  - Slower-acting: Naratriptan and Frovatriptan
  - Synergy: Combination Triptan/NSAID (i.e., Sumatriptan/Naproxen Sodium)
- Ergots (Dihydroergotamine - DHE)
  - Injection and nasal spray
  - Use in those who do not tolerate Triptans, failed Triptan therapy, or in those with prolonged attacks

Treatment Strategies for Back Pain

Exercise	Return to Activity	Medications	Other Interventions
Flexibility exercises	Return to activity	NSAIDS	Surgery
Range-of-motion exercises	Return to activity	Acetaminophen	Spinal cord stimulation
Aerobic exercises	Return to activity	Tramadol	Breathing techniques; Relaxation
Muscle strengthening exercises	Return to activity	Opioid analgesics	CBT
	* Harder to rebuild after deconditioning	Antidepressants (primarily for patients with comorbid depression)	

Treatment Strategies for Neuropathic

Anticonvulsants	Opiates	Antidepressants	Other Meds	Interventions
Gabapentin 900-3,600mg/day	Methadone 5-100mg/day	Amitriptyline 25-200mg/day	Topical Capsaicin	Transcutaneous Electrical Nerve Stimulation (TENS)
Carbamazepine 600-1,200mg/day	Tramadol 50-400mg/day	Nortriptyline 25-150mg/day	Topical Lidocaine	Sympathetic Nerve Blocks
Valproic Acid 750-2,500mg/day Topiramate 100-200mg/day		Desipramine 25-200mg/day	Lidocaine patch 5% (max 3 patches in 12 hour period)	Hypnosis, biofeedback, relaxation training
Clonazepam 0.5-3mg/day		Venlafaxine XR 150-225mg/day		
Lamotrigine 200-400mg/day		Duloxetine 60-120mg/day		
Pregabalin 300-600mg/day				

Treatment Strategies for Tension Headaches

Abortive Treatments	Prophylactic Treatments	Other Treatments
NSAIDS	TCAs (Amitriptyline, Nortriptyline)	Dental referral
Acetaminophen	SSRIs	Stress management
Aspirin	Venlafaxine	Biofeedback
		Relaxation training
		CBT

Opioid Pain Management

- For patients with moderate to moderately severe pain
  - Oxycodone
  - Methadone
  - Hydrocodone
  - Fentanyl
  - Morphine
- Goal to provide sustained analgesia and improvements in sleep quality, adherence, quality of life
- Careful screening of patients being considered for long-term opioid therapy to identify patients who may have difficulties in managing opioids
- These patients should NOT be denied access to opioid therapy, but they do require focused monitoring; increased frequency and intensity
- During therapy prescribers MUST focus on the four A's:
  - Analgesia
  - Activities of daily living
  - Adverse effects (sedation, cognitive impairment, constipation)
  - Aberrant drug-related behaviors

Opioid Management for Chronic Pain Patients

- Clearly explain risks and benefits as part of informed consent process
- Dependence and tolerance are physiological responses to opioids
- Medication should not be abruptly stopped and must be tapered
- Withdrawal symptoms may occur
- Opioid agreement
- Adherence measures: urine drug screens as needed; pill counts
- Discuss treatment goals with patient -- expected degree of pain relief with treatment
- Provide enough medication needed until next evaluation
- Establish one provider, one pharmacy relationship
- Opioid therapy is a component of the overall treatment plan that should include:
  - Referral for physical and behavioral therapy
  - Life-style modifications
  - Consult specialists as needed

How long should a treatment be continued?

- Most published follow-up < 1 year
- Discontinuation of successful pharmacotherapy usually (but not always) followed by relapse
- Need to periodically assess necessity for continuing medication
- Since PTSD patients are vulnerable to relapse following complete remission, it would be good to investigate the utility of maintenance prophylaxis

How to Understand Treatment Resistance

- Inadequate dosage
- Side effects
- Drug interactions
- Poor compliance
- Adverse life events
- Ongoing or retraumatization
- Loss of social support

Reasons for Nonadherence

- Intentional
  - Choosing not to follow the prescribed treatment
  - Choosing not to engage in treatment
  - Choosing to avoid the side effect(s) of treatment
- Nonintentional
  - Forgetting the instruction(s) for treatment
  - Confusion about the instructions for treatment
  - Lack of finances to pay for treatment
  - Deny the illness and thus, deny its treatment
  - Fear of addiction and thus, reduce treatment
  - Pressure from significant others; change treatment

PTSD and Nonadherence Risk

- Depression severity
- PTSD severity
- A sense of foreshortened future
- Feelings of detachment
- Avoiding reminders of the treatment event
- Cognitive deficits in memory and attention
- Desire to self-medicate

Key Concepts to Build Rapport

- Acknowledge readjustments after returning
- Recognize self-reliance and self-sufficiency
- Admire resilient temperament
- Question denial as a defense
- Combat stigma
- Explore ambivalences about treatment
- Establish hope for the future

Strategies to Enhance Adherence to Treatment

- Build rapport
- Reduce patient burden
- Discuss/Minimize side effects
- Show optimism about the treatment
- Engage patient in treatment decisions
- Respond to treatment related complaints or ambivalence
- Pay attention to anger or frustration towards patient whom is not adherent or is not improving in treatment

New Recommendations for the Management of Specific Symptoms

- Specific management of symptoms of sleep disturbance, chronic pain and anger is provided and aimed to assist primary care:
  - Initially use CBT to address sleep; consider Prazosin adjunctive pharmacotherapy for nightmares
  - Consider CBT to address pain; balance benefits of pain control with adverse medication effects
  - Explore for causes of anger; promote well-being and consider SSRI/SNRI; **avoid Benzodiazepines**

Implications of Recommendations

- In addition to specifics about treatment recommendations, important to advise clinicians on how to best use the guideline
- The move to integrated care models has several advantages including all issues addressed in one setting by multidisciplinary team
- In general, refer to specialty care if a patient with PTSD has comorbid mental disorders that are severe or unstable

Determination of Optimal Setting

- Consider local availability of necessary services (mental health, primary care, Vet Centers, others)
- Level of provider comfort and experience in treating psychiatric comorbidities
- Veteran-centered care -- patient preferences
- Need to maintain a coordinated continuum of care for chronic comorbidities
- Availability of resources and time in engaging in the necessary treatment(s)

Roles of Primary Care

- Routinely provide the following services for all patients with PTSD, especially those who are reluctant to seek specialty mental health care:
  - Continued discussion about specialty care
  - Address specific symptoms as reviewed in guidelines
  - PTSD-related education
  - Regular follow-up and monitoring of symptoms

Assessment in Primary Care

- Thorough assessment if
  - Presumed to have symptoms of PTSD
  - Positive for PTSD screen
- Consider using well-validated, self-administered symptom checklists (e.g., PCL)
  - Ensures systematic, standardized review of symptoms and trauma history exposure
  - Allows monitoring of treatment response and progress

Continuity of Care

- For patients referred to specialty care, important to preserve continuity of care by ensuring ongoing communication with the primary care provider
- Primary care providers should continue to be involved in treatment and provide a collaborative multidisciplinary treatment approach
- All PTSD patients should have a specific primary care provider assigned to coordinate overall health care

Conclusions and Challenges

- Promoting evidence-based treatment ultimately enhances and optimizes treatment outcomes
- Clearly, we have a ways to go to give providers tools that they can easily use
- Outcome measures will ensure that the guideline has a useful impact on practice and well-being
- Use the current gaps in knowledge as a map for future research/improvements

Thank You – Questions?

Question-and-Answer Session

- Submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
- The question box is monitored and questions will be forwarded to our presenter for response.
- We will respond to as many questions as time permits.

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- Did you pre-register on or before Monday, **Oct. 22**, 2012?
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- Did you pre-register between Tuesday, **Oct. 23**, 2012, and now?
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Save the Date

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Nov. 15, 2012
1-2:30 p.m. (EDT)

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