Introduction

• Posttraumatic stress disorder (PTSD) is a condition that can occur after exposure to potentially traumatic event(s).
• PTSD has a lifetime prevalence of 6.8% with prevalence about three times more common in females than males.1
• The lifetime prevalence of PTSD was found to be highest in Black/African Americans, followed by Caucasians, Hispanics, and Asians.2
• Rates of depression and substance use disorders (SUDs) are higher in patients with PTSD than those without.1,3
• Psychotherapy remains the mainstay treatment recommendation within PTSD guidelines. Consistency of pharmacotherapy treatment recommendations is lacking.

Objectives

• Primary objective: The intent of this retrospective study is to explore PTSD pharmacotherapy prescribing patterns at a federally qualified health center (FQHC).
• Secondary objectives:
  • To assess the prevalence of major depressive disorder (MDD) and SUDs in patients with PTSD at this FQHC.
  • To compare the prevalence of these co-occurring disorders in patients with PTSD in males versus females.
  • To compare the prevalence of these co-occurring disorders in patients with PTSD in different races and ethnicities.

Methods

• IRB approval was obtained from SIUE’s and the FQHC’s IRB Review Boards.
• Study Design: Retrospective Chart Review
• Data Source: FQHC’s Electronic Health Record
• Study Period: July 12, 2020 – July 12, 2021
• Inclusion Criteria: Any patient treated at this FQHC with a diagnosis of PTSD (ICD-10 code F43.1) during the study period
• Data Collected: One year of prescribing data, prescriber, ICD-10 diagnosis codes for depression (F33) and SUDs, and patient demographics (race, ethnicity, sex, birth year).
  • Prescribers were split into one of two categories: behavioral health (BH) or non-BH providers.
  • SUDs included: alcohol (F10), opioid (F11), cannabis (F12), sedative/hypnotic/anxiolytic (F13), cocaine (F14), stimulant (F15), hallucinogen (F16), nicotine (F17), inhalant (F18), and other psychoactive substances (F19).
• Data Analysis: Descriptive Statistical Analysis

Results

Co-Occurring Conditions by Race and Sex

Rx Written by Non-BH Providers

Rx Written by BH Providers

Discussion

• Escitalopram and citalopram lack efficacy evidence in PTSD, but these were often used by non-BH providers.
• Due to the set up of this FQHC, BH providers more often saw patients with more refractory symptoms, which was shown in their more frequent prescribing of mirtazapine, bupropion, duloxetine, and trazodone.
• Benzodiazepines are not recommended for use in PTSD due to lack of evidence and increased risk of SUDs
• Limitations: Unable to account for previously trialed medications and efficacy of medications used from the data pulled for this study
• Lack of time available to delve into chart notes
• Inconsistency and lack of diagnosis codes attached to prescriptions and patient profiles

Moving Forward

• Encouraging use of SSRIs with more evidence for efficacy in PTSD (sertraline, fluoxetine, and paroxetine)
• Encouraging use of atypical antipsychotics for refractory symptoms
• Reinforce the de-prescribing of benzodiazepines, particularly in patients with PTSD
• Encourage routine screening for trauma exposure and PTSD
• Encourage more frequent routine screening for depression and SUDs in patients with PTSD