We Need to Keep Learning from One Another

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This issue of Psychiatric Annals features five case reports. I believe that psychiatrists who are actively practicing clinical psychiatry have much to teach one another. Although placebo-controlled, randomly assigned treatment studies, case-control studies, and long-term follow-up studies are essential to the development of our knowledge base, the fact is that many of the studies available do not address and do not inform us about the individual cases we come across in the real world of clinical practice.

Another emerging reality is that clinical trials are very costly, and they are conducted almost exclusively for the purpose of qualifying a medication for a Food and Drug Administration (FDA) treatment indication. They are, in many cases, funded by industry. Financial support for these studies is almost totally commercial. Even the exceptions of treatment studies funded by the National Institutes of Mental Health (NIMH) are often not placebo controlled (eg, Sequential Treatment Alternatives to Relieve Depression, or STAR*D1). Additionally, all but one of the substudies reported from the Systematic Treatment Enhancement Program-Bipolar Disorder (STEP-BD) study2 question the role of new-generation antidepressants in bipolar depression.3

If you accept my opinion that increasingly, psychiatrists are treating patients who have failed conventional treatment with new generation antidepressant and antipsychotic medications, often prescribed by primary care physicians, where is the evidence base to guide our approach to treatment resistant/refractory depression or anxiety? Most treatment algorithms have evidence to support the first two to three levels of treatment — beyond that, the evidence is essentially expert opinion. Case reports play an important role here, as long as we keep in mind that they are just that — case reports.

Consider the discovery that the cast-off alpha 1A blocker prazosin is helpful in treating posttraumatic stress disorder (PTSD)-related nightmares, awakenings, maybe daytime symptoms, possibly agitation-aggression in Alzheimer’s dementia patients, and maybe a lot more. The 2000 report by Raskind and colleagues indicating that a small group of Vietnam veteran patients receiving prazosin experienced a marked reduction in combat PTSD-driven nightmares;4 a civilian trauma daytime distress study;5 studies in dementia-related agitation;6 double-blind, placebo-controlled trials;7 and a favorable comparison with quetiapine in combat PTSD8 took 10 years to develop. Who knows? Prazosin may be useful in some cases of difficult-to-treat comorbid anxiety in mood disorders and other primary disorders.

The jury is still out on that point in my practice. It is difficult to successfully use because low (sub-therapeutic 1 to 2 mg) test doses should be used to detect the very small proportion of people who develop orthostatic hypotension from it, requiring a week or two to reach effective doses of 4 to 20 mg. This leads patients to stop it prematurely for lack of effect (they expect immediate onset, like that with benzodiazepines). Can you imagine this development process taking this long if commercial...
interests were involved? Raskind’s initial report of four cases turned out to be very valuable to some individual patients, even if the marketing pressure has been very low.

One of the case reports in this month’s issue reports the possible value of off-label memantine in treating pathological skin picking disorder associated with depression/anxiety. Who knows? This observation may be a lead, or maybe it won’t work out. To a clinician facing a refractory case and after doing a risk-benefit analyses, it might be very useful. Keep the case reports coming, and savor the glorious fall weather.

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REFERENCES