



PALLIATIVE CARE CASE OF THE MONTH

“PTSD in seriously ill Patients: A difficult conundrum”

by

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Case #1: The patient is a 66-year old man who was admitted to the CCU after a cardiac arrest. He has a two-year history of recurrent v-tach, despite taking multiple anti-arrhythmics and AICD placement. Over the last 18 months, the AICD has gone off more than 20 times. He was admitted to the CCU to determine whether surgical procedures might help with his v-tach. His only reported symptom is severe anxiety; he is continually worried about his AICD firing. When he feels his heart skip a beat, he becomes very watchful and anxious. He is nervous to go anywhere and ruminates about previous episodes of his AICD firing (Interestingly his wife has similar symptoms).

Case # 2: The patient is a 75-year old man who was admitted to the hospital with metastatic lung cancer. Palliative care was asked to see him because he was having nightmares and talked about being afraid of dying. In taking his history, he describes untreated PTSD since he was in Vietnam over 50 years ago. He has recurrent nightmares about fighting in the jungle; he cannot stop thinking about the people who died and wondering why he did not die, and experiences flashbacks to the jungle when he is short of breath.

Discussion: Posttraumatic stress disorder (PTSD) has been described as the complex somatic, cognitive, affective, and behavioral effects of trauma. It is characterized by intrusive thoughts, nightmares, flashbacks of traumatic events, avoidance of reminders of the trauma, hypervigilance and sleep disturbances.¹ By some estimates, 84% of people encounter a traumatic event during their lives; 15-24% of them develop post-traumatic stress disorder, leading to 6-9.2% of Americans experiencing PTSD during their lifetimes.² While many different types of trauma may precipitate PTSD, some data suggest a heightened prevalence of PTSD in patients with life-threatening or terminal illnesses. For example, some data suggest that between 10-30% of individuals with AICD will suffer from PTSD, and the prevalence of PTSD in patients who have survived an intensive care unit stay is roughly 20%.^{3,4} PTSD is also more common in certain populations. For example, veterans, particularly those with combat injuries, have higher rates of PTSD. Of Vietnam theater veterans, 15.2% of males and 8.1% of females were currently diagnosed with PTSD in one study.⁵

Several clinicians and researchers have recommended that all seriously ill patients should be screened for PTSD. There are no evidence based measures to screen palliative care patients; however, several brief tools, with favorable psychometric properties, have been used in primary care to screen for and monitor symptoms of PTSD.

The four item Primary Care PTSD Screen tool carries a positive likelihood ratio of 6 and the negative likelihood ratio of 0.3.⁶ Given that patients have high rates of co-occurring psychiatric and physical illness, patients with PTSD should be screened for depression, substance use disorders, and traumatic brain injury.

General methods for mitigating symptoms of PTSD include pharmacotherapy and psychotherapy. Among medication therapies, selective serotonin reuptake inhibitors (SSRIs) are the first line of treatment for PTSD. In meta-analysis, patients treated with SSRIs were more likely to experience improvement in symptoms and function than those who received placebo.⁷ After a drug is started it is titrated to a maximal dose, and failures are typically only determined after 2-3 months of treatment.

Psychotherapies used to treat PTSD include exposure therapy, cognitive therapy, and eye movement desensitization and reprocess, a form of cognitive behavioral therapy that incorporates saccadic eye movements during exposure. The theory underlying all these treatments is that the meanings we impose on the traumatic events contribute to our emotional reaction to them. In addition, patients develop strategies to avoid the distressing emotional reactions that often interfere with processing the event and developing more functional strategies. The above treatments help people reassess the events and change how they think about them. Multiple studies, including meta-analysis have found all three treatments are effective for PTSD.⁸

Despite the availability of effective therapies, treatment of posttraumatic stress disorder at the end of life is complicated. First, these treatments require more time than is usually available in palliative care or hospice settings. Unless the patient is treated relatively early during the illness, it often takes 6-12 weeks to alleviate symptoms. In fact, initially symptoms may worsen. Second, typical psychotherapeutic sessions are 50-90 minutes which may tax seriously ill, frail patients. Third, for patients whose traumatic event is AICD going off or getting chemotherapy or being in the ICU the stress is not in the past, it is current and ongoing. Therefore, the corrective information that is often provided in cognitive behavioral therapy may not be relevant. While there is data for trauma-focused cognitive behavioral treatment for the treatment of acute stress, these studies have been conducted in the domain of civilian trauma rather than on-going medical conditions.^{9,10}

These considerations underscore the value, for seriously ill patients with PTSD, of referral to a therapist who has experience with cancer or other life limiting illness.¹⁰

Personal details in the case published have been altered to protect patient privacy.

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 647-7243, pager # 8511, Shadyside, 647-7243, pager # 8513, Perioperative/Trauma Pain, 647-7243, pager # 7246, UPCI Cancer Pain Service, pager 644-1724, Interventional Pain 784-4000, Magee Women's Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children's pager 958-3844.

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(Discussion Continued)

Recently therapists have begun to develop new models to care for patients at the end of life who have PTSD. One such model entitled, "The Stepwise Psychosocial Palliative Care Approach," relies on step-wise employment of cognitive behavior therapies to maximize quality of life in every therapeutic intervention. (10) Sadly, there is not sufficient data to conclude whether such therapies are useful. It does, however, highlight the complexity of treating PTSD in patients with severely limited life expectancies.

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