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Correspondence

Pharmacotherapy for anxiety

Sir: Nutt & Bell (1997) have included a section about the drug treatment of post-traumatic stress disorder (PTSD). They state that "there have been no properly controlled trials" for the pharmacological treatment of PTSD. This statement is incorrect since there have been at least eight randomised, double-blind, controlled trials of the drug treatment of PTSD using: phenelzine (Frank *et al*, 1988; Shestatzky *et al*, 1988; Kosten *et al*, 1991), amitriptyline (Davidson *et al*, 1990), desipramine (Reist *et al*, 1989), imipramine (Frank *et al*, 1988; Kosten *et al*, 1991), fluoxetine (Van Der Kolk *et al*, 1994), alprazolam (Braun *et al*, 1990) and brofaromine (Baker *et al*, 1995; Katz *et al*, 1994/1995).

Nutt & Bell also recommend the addition of a benzodiazepine for more enduring cases. I would caution against this, since there is evidence that benzodiazepines are ineffective in PTSD (Braun *et al*, 1990) and may lead to a severe exacerbation of PTSD symptoms following withdrawal from long-term use (Risse *et al*, 1990).

Our own experience and that of the National PTSD Centre in the USA (Friedman, 1996) is that the addition of an α_2 adrenergic agonist such as clonidine to a selective serotonin reuptake inhibitor is particularly beneficial in some of the more severe, resistant cases of PTSD, and this is consistent with evidence demonstrating abnormalities of noradrenergic neuronal regulation specific to PTSD patients (Southwick *et al*, 1993).

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Authors' reply: Dr Neal emphasises that our statement "there have been no properly controlled trials for the pharmacological treatment of PTSD" is incorrect. As he mentions, there have been eight randomised, double-blind, controlled trials of drug treatment in PTSD, but these have been of different design duration and have studied people from different backgrounds. These studies have not been replicated using dose-ranging, multi-centre studies and as such, at the present time, would not meet criteria for any of the drugs being licensed for PTSD. Having said this, however, we would not like to imply that pharmacological treatment of PTSD should not be tried.

Our statement that it is our practice to use benzodiazepines in addition to antidepressant treatment for the more enduring cases. The position with benzodiazepines in PTSD is complicated. Open studies have suggested efficacy, although as Dr Neal states, the one double-blind trial there has been was not positive. The possible reasons for this include the choice of a short half-life drug