Management of Nightmare disorders in adult patients with Post Traumatic Stress Disorder (PTSD)

Note: Prazosin and trazodone are IMOC Amber 2 category – initiation by the sleep centre followed by maintenance prescribing in primary care. GPs are not expected to initiate these treatments but may be asked to take on prescribing in line with IMOC recommendations

Agomelatine is IMOC RED category (hospital only) – initiation and ongoing prescribing will be by the sleep service

Patient enters the tertiary specialist sleep service

Initial assessment and management

- Screen patients for underlying causative factors of PTSD (including but not limited to substance misuse).
- Optimise lifestyle factors such as exercise and sleep routine. *See Appendix 1*
- Optimise treatment of any underlying comorbidities including physical and mental health.
- Image Rehearsal Therapy (IRT) for at least three months*.

Image Rehearsal Therapy:
Behavioural guidance and or therapy will be undertaken at the Sleep Disorder Centre under the clinical team

*If a patient cannot engage with IRT or there are compelling clinical reasons as to why pharmacological treatment should not be delayed, pharmacological treatment may be initiated before IRT on a case by case basis via a multidisciplinary team discussion

For all medications:
-If remains symptomatic despite dose titrations as described in the table (page 2) then stop treatment and commence next line.
-A response is anticipated to be observed within first 6 months, but duration of treatment should be individualised based on trajectory of response and any adverse events.
-If no efficacy observed at 6-months despite optimal stable dose then consider gradual discontinuation of medication.
-Minimum effective dose to be used.

If no significant improvement at 3 months with IRT:

First line pharmacological therapy:
Prazosin - off label (nightmares & disturbed awakenings)
Second line pharmacological therapy:
Trazodone (sleep initiation disturbed)
Third line pharmacological therapy:
Agomelatine (sleep initiation disturbed)
Red - hospital prescribing only

For Trazodone and Agomelatine:
Used only in patients with insomnia comorbid with depression, so can be considered within product licence

For Trazodone:
For patients already on Trazodone for comorbid depression, this can be augmented with adding Prazosin if nightmares present

General principles of patient management in the Sleep Disorder Centre

- Patients will remain under the consultant that initiated treatment and after the initial reviews will have consultant reviews at 3, 6 and 12 months, then annually.
- Follow up consultations with the sleep pharmacist are available when necessary.
- Patients are counselled on initiation, including when to dose titrate, and when to stop treatment if not tolerated/effective. This detail is clearly communicated to GPs in the clinic letter.
- The initial prescription from the specialist team will be a minimum of 3 months' supply. Patient will be stabilised on medication (with baseline investigations undertaken) before transfer to GP
- When treatment is no longer required (e.g. not effective/tolerated), the GP will be informed via a clinic letter, including any detail of treatment tapering if required
- For further advice please contact: gst-tr.thesleeppharmacistgstt@nhs.net

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South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System: NHS South East London (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust

Management of Nightmare Disorders in Adult Patients

Drug	Starting dose	Titration instructions	GP Monitoring	Additional comments
Prazosin tablets AMB 2	0.5mg at bedtime	Generally, the dose may be increased gradually in steps of 0.5mg fortnightly increments up to maximum of 10mg at night if needed and well tolerated. The sleep disorder Centre may use quicker up-titration methods as determined by the severity of symptoms, and response to treatment.	-Annual BP, HR, renal function & LFTs	- Blood pressure to be taken at baseline by Sleep Disorders Centre, and following each dose increment until stable -Patients to be advised for first dose effects. - First dose may cause collapse due to hypotensive effect (therefore should be taken on retiring to bed). - More frequent blood pressure monitoring may be required and dose adjusted accordingly if any concurrent antihypertensives, cardiovascular comorbidities, or hepatic/renal impairment. -Prazosin is indicated for hypertension, and benign prostatic hyperplasia -Prazosin is an alpha-1 adrenergic receptor antagonist that reduces CNS sympathetic outflow throughout the brain. -Several CNS phenomena implicated in the pathogenesis of PTSD are regulated by alpha-1 adrenergic receptors including a number of sleep/nightmare phenomena. -If there are changes to symptoms or monitoring parameters the GP should contact the Sleep Disorders Centre for further advice -discontinue if: symptomatic postural hypotension or risk of precipitating syncope SEL formulary recommendation
Trazodone capsules AMB 2	50mg at bedtime	Generally, the dose may be increased by 50mg every 2-4 weeks up to 150mg at bedtime, if needed and well tolerated. The sleep disorder Centre may use quicker up-titration methods as determined by the severity of symptoms, and response to treatment.	-Repeat ECG if dose changes or prescribed new QTc prolonging medication -Annual BP & HR -Annual renal function, FBCs & LFTs	-Baseline ECG by Sleep Disorders Centre if cardiovascular history or taking QTc prolonging medications. -Trazodone is also indicated for depression. -Depression is associated with PTSD-related nightmares. -Trazodone may be used to manage nightmare disorders when prazosin has failed and patient continues to report sleep initiation insomnia despite improved sleep disturbances. - Trazodone may be used in patients with comorbid insomnia with depression without PTSD-related nightmares at doses up to 300mg at bedtime -If there are changes to symptoms or monitoring parameters

				the GP should contact the Sleep Disorders Centre for further advice -discontinue if: symptoms of liver disorder, or suicidal ideation SEL pathway Comorbid insomnia in adults SEL formulary recommendation
Agomelatine tablets 	25mg at bedtime	Increase dose to 50mg at bedtime after 2-4 weeks if needed and well tolerated.	GP monitoring not applicable. For Specialist monitoring. -Specialist team to perform LFT monitoring at baseline and thereafter -LFTs before treatment and after 3, 6, 12 and 24 weeks of treatment, and then regularly thereafter when clinically indicated* (restart monitoring schedule if dose increased). -Annual BP & HR -Annual renal function	- Agomelatine is also indicated for depression. -Depression is associated with PTSD-related nightmares. - Agomelatine may be used to manage nightmare disorders when prazosin and trazodone have failed and patient continues to report sleep initiation insomnia despite improved sleep disturbances. - Agomelatine may be used in patients with comorbid insomnia with depression without PTSD-related nightmares -discontinue if serum transaminases exceed 3 times the upper limit of reference range or symptoms of liver disorder * when clinically indicated includes (but not limited to) where dose adjustments may be required due to: (i) worsening nightmare disorder and/or insomnia symptoms, (ii) drug interactions, (iii) smoking started or stopped during treatment, or (iv) concurrent use of drugs associated with hepatic injury SEL pathway Comorbid insomnia in adults SEL formulary recommendation

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Appendix 1 – Non-pharmacological recommendations

Lifestyle optimisation measures

Stimulus control

- Bed/bedroom use only for sleep, sex and getting dressed (not reading, resting, phone, watching TV etc.)
- Get out of bed if not sleeping after 15-20 min (especially if agitated)

Sleep scheduling

- Limit the time in bed to the average time actually spent sleeping (best achieved via sleep diaries).
- Avoiding daytime and evening naps
- Getting into bed only when sleepy tired
- Getting up at the same time every day, including weekends

Naps

- Discouraged because they reduce sleep drive
- If naps cannot be avoided, then try to limit them to 20 minutes (setting an alarm), and ideally not in the 5 hours before the main episode of sleep

Additional

- Avoid caffeine after 12pm midday; switch to decaffeinated drinks
- Avoid alcohol, at the very least in the 2 hours before bed
- Daily exercise, ideally outside to gain exposure to natural day light
- Other sleep hygiene advice via the Sleep Foundation

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