Table 7: Summary of Recommendations in Included Guidelines

Supporting Evidence	Recommendations	Strength of Evidence and Recommendations
VA/DoD, 2017[21]		
"Major depression frequently co-occurs with PTSD. Feder et al. evaluated the efficacy of a single intravenous (IV) sub-anesthetic dose of ketamine in patients with PTSD since preliminary evidence suggests that sub-anesthetic doses of IV ketamine has rapid antidepressant effects in treatment-resistant depression. The study compared ketamine versus midazolam in 41 patients with PTSD in a two-week crossover, low quality RCT.[165] Ketamine administration significantly reduced self-rated PTSD symptoms at 24 hours, but not seven days after the infusion. Furthermore, clinician-rated PTSD symptom severity was also not significantly different between subjects given ketamine or midazolam one week after administration. Additionally, there was no significant difference between ketamine and midazolam with respect to the severity of depressive symptoms. Individuals who received ketamine had greater rates of blurred vision, dry mouth, restlessness, nausea and vomiting, headache, and poor coordination compared to midazolam. In the context of limited information on the efficacy of ketamine in PTSD combined with its significant side effects and potential for abuse, we recommend against the use of ketamine for the primary treatment of PTSD in a clinical setting. Future, well-designed studies could help shed light on the efficacy of ketamine on clinician-rated PTSD and depressive symptoms." (p. 57)	**"**We recommend against treating PTSD with divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone, or D-cycloserine, as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.**"** (p. 56)	Quality of Evidence: Very low Recommendation: Strong Against

PTSD = posttraumatic stress disorder.