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790 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 9 Ketamine A small RCT investigating the effects of one infusion of ketamine (vs midazolam) found more improvement in socio-occupational functioning in the ketamine group at day 14.23 However, the apparent improvement in BPD may well reflect changes in underlying mood rather than change in BPD psychopathology. In treatment-resistant depression with comorbid BPD, ketamine was shown significantly to improve both depressive and borderline symptoms.24 A case report of BPD and treatment-resistant depression that was managed with citalopram and esketamine nasal spray resulted in improvement in depression, anxiety and behavioural symptoms.25 Clearly, further studies are required. Omega-3 fatty acids A 2021 meta-analysis concluded that marine omega-3 fatty acids improve symptoms of BPD, particularly impulsive behaviour and affective dysregulation, and that they could be considered as an add-on therapy.26 Botulinum toxin In an RCT comparing glabellar botulinum toxin with acupuncture, both groups showed significant reductions in symptoms, but findings did not support the superiority of any particular treatment.27 Management of crisis Medications are often used during periods of crisis when symptoms can be severe, distressing and potentially life-threatening. In BPD these symptoms can be expected to fluctuate.28 Consequently, pharmacological therapy may then be required intermittently, and with each episode the decision to prescribe needs to be informed by a careful consideration of the relative harms and benefits of medication. It is generally easy to see when treatment is required, but much more difficult to decide when modest gains are worthwhile and whether or not continuation is likely to be necessary. The use of psychotropic drugs is not without harm, so treatment should always take the form of a rigorously evaluated short-term trial. In the UK, NICE8 recommends that during periods of crisis, time-limited treatment with a sedative drug may be helpful. The anticipated side effect profile and potential toxicity in overdose should guide choice. For example, benzodiazepines (particularly short-acting drugs) can cause disinhibition in this group of patients,29 ultimately compounding problems. Sedative antipsychotics can cause extrapyramidal side effects (EPSEs) and/or considerable weight gain, and tricyclic antidepressants are particularly toxic in overdose. A sedative antihistamine such as promethazine (25–50mg) is usually well tolerated and may be a helpful short-term treatment when used as part of a co-ordinated care plan (although there is no study evidence to support this assumption). Its adverse effects (dry mouth, constipation), deleterious effects on sleep architecture and lack of clear anxiolytic effects militate against longer-term use.

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