For Some Troops, Powerful Drug Cocktails Have Deadly Results

PAIN AND DEPRESSION Senior Airman Anthony Mena in Baghdad in 2007. After his death in 2009, a toxicologist found eight prescription medications in his blood. More Photos »

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In his last months alive, Senior Airman Anthony Mena rarely left home without a backpack filled with medications.

He returned from his second deployment to Iraq complaining of back pain, insomnia, anxiety and nightmares. Doctors diagnosed post-traumatic stress disorder and prescribed powerful cocktails of psychiatric drugs and narcotics.

Yet his pain only deepened, as did his depression. “I have almost given up hope,” he told a doctor in 2008, medical records show. “I should have died in Iraq.”

Airman Mena died instead in his Albuquerque apartment, on July 21, 2009, five months after leaving the Air Force on a medical discharge. A toxicologist found eight prescription medications in his blood, including three antidepressants, a sedative, a sleeping pill and two potent painkillers.

Yet his death was no suicide, the medical examiner concluded. What killed Airman Mena was not an overdose of any one drug, but the interaction of many. He was 23.

After a decade of treating thousands of wounded troops, the military's medical system is awash in prescription drugs — and the results have sometimes been deadly.

By some estimates, well over 300,000 troops have returned from Iraq or Afghanistan with P.T.S.D., depression, traumatic brain injury or some combination of those. The Pentagon has looked to pharmacology to treat those complex problems, following the lead of civilian medicine. As a result, psychiatric drugs have been used more widely across the military than in any previous war.

But those medications, along with narcotic painkillers, are being increasingly linked to a rising tide of other problems, among them drug dependency, suicide and fatal accidents — sometimes from the interaction of the drugs themselves. An Army report on suicide released last year documented the problem, saying one-third of the force was on at least one prescription medication.

"Prescription drug use is on the rise," the report said, noting that medications were involved in one-third of the record 162 suicides by active-duty soldiers in 2009. An additional 101 soldiers died accidentally from the toxic mixing of prescription drugs from 2006 to 2009.

"I'm not a doctor, but there is something inside that tells me the fewer of these things we prescribe, the better off we'll be," Gen. Peter W. Chiarelli, the vice chief of staff of the Army who has led efforts on suicide, said in an interview.

Growing awareness of the dangers of overmedicated troops has prompted the Defense Department to improve the monitoring of prescription medications and restrict their use.

In November, the Army issued a new policy on the use of multiple medications that calls for increased training for clinicians, 30-day limits on new prescriptions and comprehensive reviews of cases where patients are receiving four or more drugs.

The Pentagon is also promoting measures to prevent troops from stockpiling medications, a common source of overdoses. For instance, the Navy, which provides medical care for Marines, has begun pill "give back" days on certain bases. At Camp Lejeune, N.C., 22,000 expired pills were returned in December.

The Army and the Navy are also offering more treatments without drugs, including acupuncture and yoga. And they have tried to expand talk therapy programs — one of which, exposure therapy, is considered by some experts to be the only proven treatment for P.T.S.D. But shortages of mental health professionals have hampered those efforts.

Still, given the depth of the medical problems facing combat veterans, as well as the medical system's heavy reliance on drugs, few experts expect the widespread use of multiple medications to decline significantly anytime soon.

The New York Times reviewed in detail the cases of three service members who died from what coroners said were toxic interactions of prescription drugs. All were classified accidents, not suicides.

Airman Mena was part of a military police unit that conducted combat patrols alongside Army units in downtown Baghdad. He cleaned up the remains of suicide bombing victims and was nearly killed by a bomb himself, his records show.

Gunnery Sgt. Christopher Bachus had spent virtually his entire adult life in the Marine Corps, deploying to the Middle East in 1991, Iraq during the invasion of 2003 and, for a short tour, Afghanistan in 2005. He suffered from what doctors called survivor's guilt and came back "like a ghost," said his brother, Jerry, of Westerville, Ohio.

Cpl. Nicholas Endicott joined the Marines in 2003 after working as a coal miner in West Virginia. He deployed twice to Iraq and once to Afghanistan, where he saw heavy combat. On

one mission, Corporal Endicott was blown more than eight feet in the air by a roadside bomb, medical records show. He came home plagued by nightmares and flashbacks and rarely left the house.

Given the complexity of drug interactions, it is difficult to know precisely what killed the three men, and the Pentagon declined to discuss their cases, citing confidentiality. But there were important similarities to their stories.

All the men had been deployed multiple times and eventually received diagnoses of P.T.S.D. All had five or more medications in their systems when they died, including opiate painkillers and mood-altering psychiatric drugs, but not alcohol. All had switched drugs repeatedly, hoping for better results that never arrived.

All died in their sleep.

Psychiatry and Warfare

The military medical system has struggled to meet the demand caused by two wars, and to this day it still reports shortages of therapists, psychologists and psychiatrists. But medications have always been readily available.

Across all branches, spending on psychiatric drugs has more than doubled since 2001, to $280 million in 2010, according to numbers obtained from the Defense Logistics Agency by a Cornell University psychiatrist, Dr. Richard A. Friedman.

Clinicians in the health systems of the Defense and Veterans Affairs Departments say that for most patients, those medications have proved safe. “It is important not to understate the benefit of these medications,” said Dr. Robert Kerns, the national director of pain management for the Department of Veterans Affairs.

Paradoxically, the military came under criticism a decade ago for not prescribing enough medications, particularly for pain. In its willingness to prescribe more readily, the Pentagon was trying to meet standards similar to civilian medicine, General Chiarelli said.
But the response of modern psychiatry to modern warfare has not always been perfect.

Psychiatrists still do not have good medications for the social withdrawal, nightmares and irritability that often accompany post-traumatic stress, so they mix and match drugs, trying to relieve symptoms.

“These decisions about medication are difficult enough in civilian psychiatry, but unfortunately in this very-high-stress population, there is almost no data to guide you,” said Dr. Ranga R. Krishnan, a psychiatrist at Duke University. “The psychiatrist is trying everything and to some extent is flying blind.”

Thousands of troops struggle with insomnia, anxiety and chronic pain — a combination that is particularly treacherous to treat with medications. Pairing a pain medication like oxycodone, a narcotic, with an anti-anxiety drug like Xanax, a so-called benzodiazepine, amplifies the tranquilizing effects of both, doctors say.

Similarly, antidepressants like Prozac or Celexa block liver enzymes that help break down narcotics and anxiety drugs, extending their effects.

“The sedation is not necessarily two plus two is four,” said Cmdr. Rosemary Malone, a Navy forensic psychiatrist. “It could be synergistic. So two plus two could be five.”

Commander Malone and other military doctors said the key to the safe use of multiple prescriptions was careful monitoring: each time clinicians prescribe drugs, they must review a patient’s records and adjust dosages to reduce the risk of harmful interactions. “The goal is to use the least amount of medication at the lowest doses possible to help that patient,” she said.

But there are limits to the monitoring. Troops who see private clinicians — commonly done to avoid the stigma of seeking mental health care on a base — may receive medications that are not recorded in their official military health records.

In the case of Sergeant Bachus of the Marines, it is far from clear that he received the least amount of medication possible.

He saw combat in Iraq, his brother said, and struggled with alcoholism, anxiety, flashbacks, irritability and what doctors called survivor’s guilt after returning home.

“He could make himself the life of the party,” Jerry Bachus recalled. “But he came back a shell, like a ghost.”

Sergeant Bachus received a diagnosis of P.T.S.D., and starting in 2005, doctors put him on a regimen that included Celexa for depression, Klonopin for anxiety and Risperdal, an antipsychotic. In 2006, after a period of stability, a military doctor discontinued his medications. But six months later, Sergeant Bachus asked to be put on them again.

According to a detailed autopsy report, his depression and anxiety worsened in late 2006. Yet for unexplained reasons, he was allowed to deploy to Iraq for a second time in early 2007. But when his commanders discovered that he was on psychiatric medications, he was sent home after just a few months, records show.

Frustrated and ashamed that he could not be in a front-line unit and unwilling to work behind a desk, he applied in late 2007 for a medical retirement, a lengthy and often stressful process that seemed to darken his mood.

In early March 2008, a military doctor began giving him an opiate painkiller for his back. A few days later, Sergeant Bachus, 38, called his wife, who was living in Ohio. He sounded delusional, she told investigators later, but not suicidal.

“You know, babe, I am really tired, and I don’t think I’ll have any problems falling asleep tonight,” he told her. He was found dead in his on-base quarters in North Carolina nearly three days later.

According to the autopsy report, Sergeant Bachus had in his system two antidepressants, the opiates oxymorphone and oxycodone, and Ativan for anxiety. The delirium he experienced in his final days was “most likely due to the interaction of his medications,” the report said.

Nearly 30 prescription pill bottles were found at the scene, most of them recently prescribed, according to the report.

Jerry Bachus pressed the Marine Corps and the Navy for more information about his brother’s death, but received no further explanations. “There was nothing accidental about it,” he said.

“It was inevitable.”

Self-Medicating

The widespread availability of prescription medications is increasingly being linked by military officials to growing substance abuse, particularly with opiates. A Defense Department survey last year found that the illegal use of prescription drugs in the military had tripled from 2005 to 2008, with five times as many troops claiming to abuse prescription drugs than illegal ones like cocaine or marijuana.

The problem has become particularly acute in specialized units for wounded troops, where commanders say the trading of prescription medications is rampant. A report released last month by the Army inspector general estimated that up to a third of all soldiers in these Warrior Transition Units are overmedicated, dependent on medications or have easy access to illegal drugs.

Some of that abuse is for recreational purposes, military officials say. In response, the Army has taken several steps to tighten the monitoring of troops on multiple prescriptions in the transition units.

But in many cases, wounded troops are acquiring drugs improperly because their own prescriptions seem ineffective, experts say. They are self-medicating, sometimes to death.

“This is a huge issue, and partly it’s due to the availability of prescription drugs among returning troops,” said Dr. Martin P. Paulus, a psychiatrist at the University of California, San Diego, and the V.A. San Diego Medical Center. “Everyone knows someone who’ll say, ‘Hey, this worked for me, give it a try.”

Corporal Endicott, for instance, died after adding the opiate painkiller methadone to his already long list of prescribed medications. His doctors said that they did not know where he got the narcotic and that they had not authorized it.

Corporal Endicott, who survived a roadside bomb explosion, was in heavy fighting in Afghanistan, where he saw other Marines killed. After returning from his third deployment, in

2007, Corporal Endicott told doctors that he was having nightmares and flashbacks and rarely left his house. After a car accident, he assaulted the other driver, according to medical records. Doctors diagnosed P.T.S.D. and came to suspect that Corporal Endicott had a traumatic brain injury.

Over the coming year, he was prescribed at least five medications, including the antidepressants Prozac and Trazodone, and an anti-anxiety medication. Yet he continued to have headaches, anxiety and vivid nightmares.

"He would be hitting the headboard," said his father, Charles. "He would be saying: 'Get down! Here they come!' "

On Jan. 29, 2008, Corporal Endicott was found dead in his room at the National Naval Medical Center in Bethesda, Md., where he had checked himself in for anger management after another car accident. He was 26.

A toxicologist detected at least nine prescription drugs in his system, including five different benzodiazepines, drugs used to reduce anxiety or improve sleep. Small amounts of marijuana and methadone — a narcotic that is particularly dangerous when mixed with benzodiazepines — were also found in his body.

His death prompted Marine Corps officials at Bethesda and Walter Reed Army Medical Center to initiate new procedures to keep Marines from inappropriately mixing medications, including assigning case managers to oversee patients, records show.

Whether Corporal Endicott used methadone to get high or to relieve pain remains unclear. The Marine Corps concluded that his death was not due to misconduct.

"He survived over there," his father said. "Coming home and dying in a hospital? It's a disgrace."

Trying to Numb the Pain

Airman Mena also returned from war a drastically changed man.

He had deployed to Iraq in 2005 but saw little action and wanted to go back. He got the chance in late 2006, when sectarian violence was hitting a peak.

After coming home, he spoke repeatedly of feeling guilty about missing patrols where a sergeant was killed and where several platoon mates were seriously wounded. Had he been driving on those missions, he told therapists, he would have avoided the attacks.

"On my first day, I saw a total of 12 bodies," he said in one psychological assessment. "Over there, I lost faith in God, because how can God allow all these dead bodies?"

By the summer of 2008, he was on half a dozen medications for depression, anxiety, insomnia and pain. His back and neck pain worsened, but Air Force doctors could not pinpoint a cause. Once gregarious and carefree, Airman Mena had become perpetually irritable. At times he seemed to have hallucinations, his mother and friends said, and was often full of rage while driving.

In February 2009, he received an honorable discharge and was given a 100 percent disability rating by the Department of Veterans Affairs, meaning he was considered unable to work. He abandoned plans to become a police officer.

Now a veteran, his steady medication regimen continued — but did not seem to make him better. His mother, Pat Mena, recalls him being unable to sleep yet also listless, his face a constant shade of pale. Shocked by the piles of pills in his Albuquerque apartment, she once flushed dozens of old prescriptions down the toilet.

Yet for all his troubles, he seemed hopeful when she visited him in early July 2009. He was making plans to open a cigar store, which he planned to call Fumar. His mother would be in charge of decorating it.

The night after his mother left, he put on a new Fentanyl patch, a powerful narcotic often used by cancer patients that he had started using just five weeks before. The Food and Drug Administration issued warnings about the patches in 2007 after deaths were linked to it, but a private clinic in Albuquerque prescribed the medication because his other painkillers had

failed, records show.

With his increasingly bad memory, he often forgot what pills he was taking, his mother said. That night when he put on his new patch, he forgot to remove the old one. He died early the next day.

Was the Fentanyl the cause? Or was it the hydromorphone, another narcotic found in his system? Or the antidepressants? Or the sedative Xanax? Or all of the above?

The medical examiner could not say for sure, noting simply that the drugs together had caused "respiratory depression."

"The manner of death," the autopsy concluded, "is accident."