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ANXIETY: FAST FACTS AND SKILLS FOR THE PRIMARY CARE PHYSICIAN

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SPEAKER DISCLOSURES

- None

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One Minute Anxiety Diagnosis: "Have you Had"

* Sudden unexpected anxiety or physical symptoms when no one around (**Panic**)
* Worry, tense, anxious more days than not for 6 months (**Generalized Anxiety-GAD**)
* Anxiety and/or avoidance in social situations (**Social Anxiety Disorder/Social Phobia**)
* Recurrent intrusive recollections of trauma or avoidance of trauma reminders (**PTSD**)

Means-Christenson et al: General Hospital Psychiatry 28 (2006) 108–118

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Education and Skills: A Context for Pharmacotherapy

* Medication will work better in a self-activated patient.
  - Just throwing meds at the problem will not work.

* Provide explanations that de-mystify and de-pathologize.
  - Anxiety is not one thing but three things (physical feeling, thought, and behavior)
  - Anxiety is a normal reaction that has just become triggered at times when it is not really needed.
  - It is a product of genetic make-up AND learning AND habit. It is not brain damage or a tumor.

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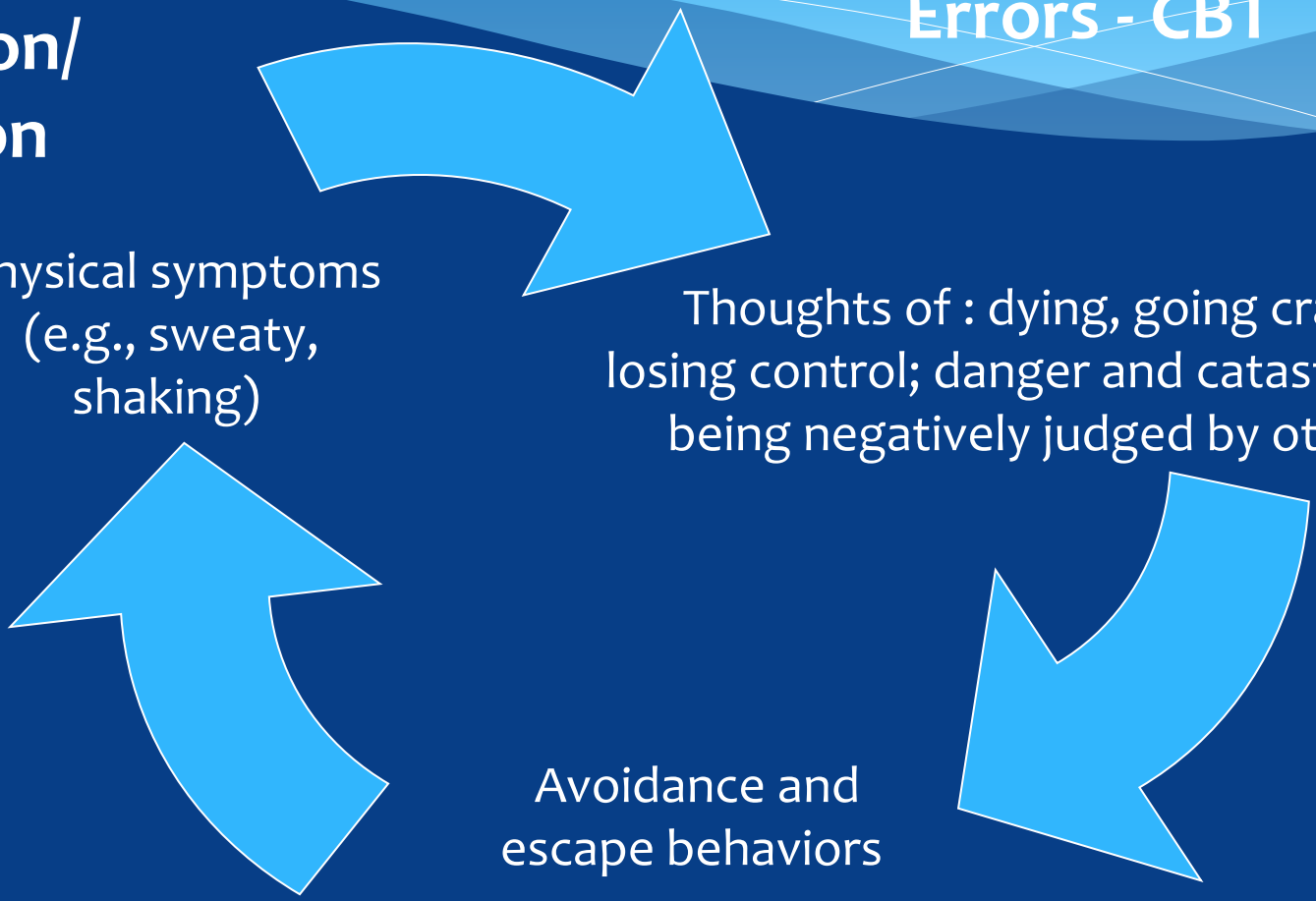
Education: Anxiety Cycle

Breathing/ Meditation/ Relaxation

Correct Cognitive Errors - CBT



Exposure and Activation

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Prior to Initiating Treatment

* Assess severity of anxiety so you can monitor the effects of treatment!
* Use GAD-7 at each visit
* In motivated patients, use daily diaries with 0-10 scales for individual anxiety symptoms
* Use the PHQ-9 for depression
* Work on motivation for CBT and not just medication.

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ____ = Add Columns ____ + ____ + ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Spitzer, R. L. et al. Arch Intern Med 2006;166:1092-1097.

ARCHIVES OF INTERNAL MEDICINE

Medication Rating Scale

Name ____

Start Date ____

Write in number using scale below as guide

Symptom/Behavior	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun

SCALE FOR SEVERITY JUDGMENT

0 1 2 3 4 5 6 7 8 9 10

|_____ | ______ |_______| ______ |______| ______ | ______|______ | _____ |_______|

not at all ⇐ mild ⇒ ⇐ moderately ⇒ ⇐ markedly ⇒ very severely

Anxiety Disorders:
Initial Medication Choice

* **SSRIs and Venlafaxine XR:**
  - Equally effective for PD, GAD, SAD, PTSD
  - SSRI better tolerated!

* Don't assume prior medication trials were ineffective unless **optimal dose (top doses) and durations (10-13 weeks)** were reached

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Titration of Initial Medication Treatment

* Start at **low dose and**

  titrate gradually to therapeutic dose over 2-4 wks
* Initial response to antidepressant (>25% change) usually occurs within 4-6 weeks
* Partial responders after 4-6 weeks **should be titrated to higher doses if tolerated**
* If no response after 4-6 weeks at therapeutic dose, but med is well tolerated AND patient is willing, **titrate to maximum dose over another 4-6 weeks**
* **Try to get to maximum doses AND durations!**

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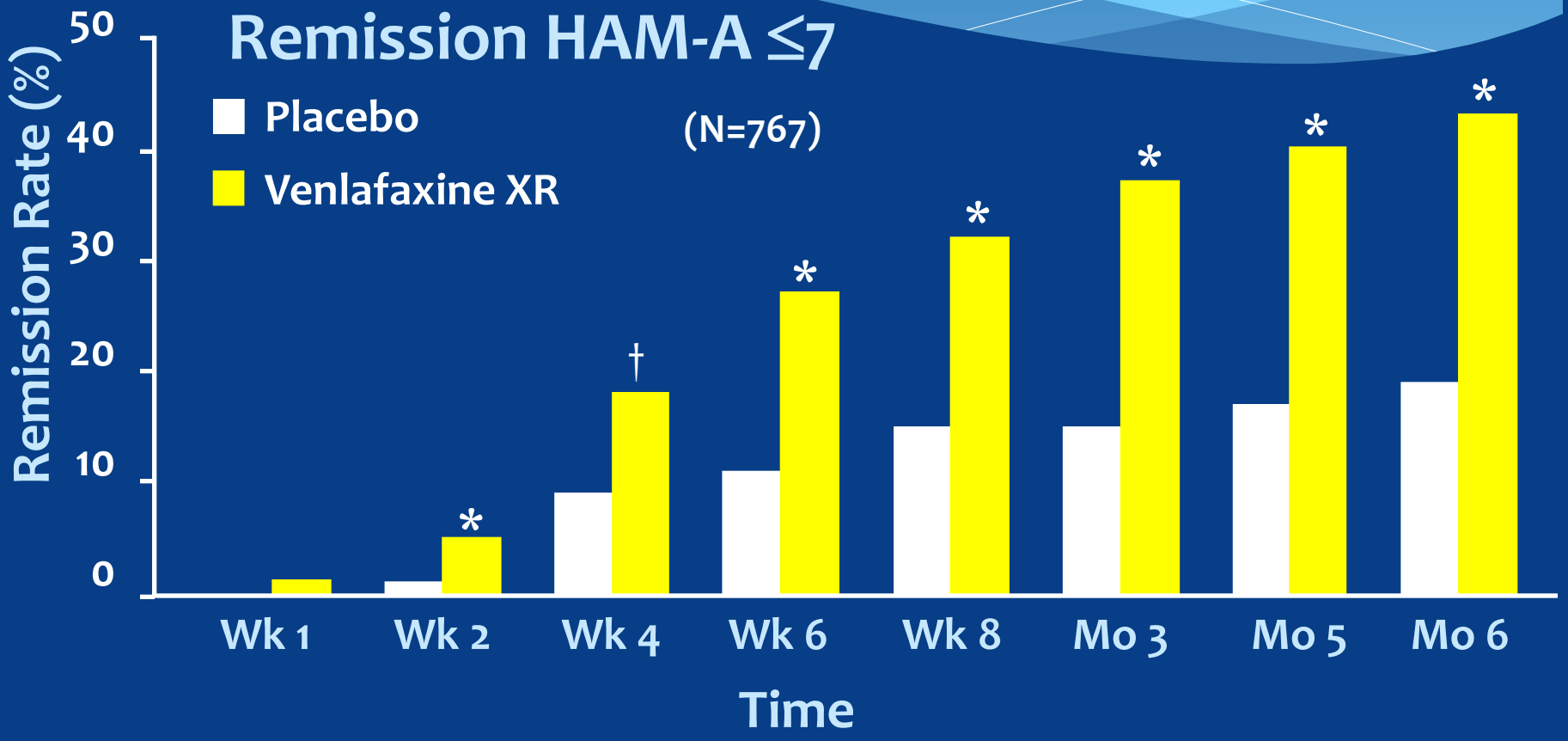
Case #1

* Sydney is a 21 year-old UW student. She notes she has always been a "worrier." She feels exhausted all the time because she lies in bed worrying for hours. She notes irritability and poor concentration. She notes that her sister was diagnosed with GAD a couple years ago and, after a number of medication trials, had had good success with venlafaxine. Syndey's PCP diagnoses her with GAD and titrates venlafaxine up to 300mg over the next 4 weeks. After six weeks, Sydney feels her schoolwork is going a little better, but is worried that her worrying will never be able to relax like other people. How long should Sydney's provider wait before switching antidepressants?

GAD Response Increases Over Time - Wait Before Changing!



*p<0.001 vs. placebo; †p<0.01 vs. placebo; Montgomery SA, Sheehan DV, Meoni P, et al. J Psychiatr Res. 2002(July-Aug);36(4):209-217

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Anxiolytic Pharmacotherapy: Medications with minimal utility

* **Bupropion** Ineffective for ALL disorders!
* **Buspirone** only works for GAD
* **Beta-blockers** only work for Performance Anxiety (GAD data very equivocal)
* **Antihistamines** only work for GAD, and usually have problematic side effects
* TCAs have more side effects than SSRIs, are lethal on overdose, and don't work for Social Anxiety

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Case #2

* A 48yo woman notes panic attacks for several decades, though they previously occurred only a couple times a year. For the last two months, however, she notes symptoms consistent with a major depressive episode and notes her panic attacks now occur daily. Though excruciating, the attacks last only 20 minutes. She has no history of psychiatric medication trials, but has recently started working with a therapist. She asks her primary care provider for a medication to take when she is experiencing a panic attack.

When Would I Want to Choose a Benzodiazepine?

* If history of non-response to two different antidepressant classes **and** a combination of SRI and mirtazapine (or gabapentin?) **and** therapy
* If severe medical illness or other contraindications to using other antidepressants
* If patient is Bipolar (for some, SRIs are destabilizing)
* If patient does not have a prior history of substance abuse problems
* If concomitant depression already being treated
* If diagnosis is NOT PTSD (may worsen response rate)
* **Best to use in combination with an AD**

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Info Needed to Assess and Manage Current Benzo Use

* Regular schedule (daily prn is "regular," but bad)
* Duration of use
* History of substance use/abuse
* Diagnosis (most justified for panic and Social Anxiety; less for GAD; **no utility for PTSD or MDD**)
* **"GAD" is the least definitive Anxiety Diagnosis**--could be: occult substance abuse, personality disorder, anxious depression, unrecognized bipolar illness, or even ADHD

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Managing The Patient Who Is Already On A Benzo When You Meet Them

* **Patient needs to commit to work with exclusively with you** (check Rx monitoring program) and must have no substance abuse history (UTOX?)
* Note your aim is for a **gradual reduction in dose**
* Say reduction will be done AFTER other medication or behavioral treatment is initiated
* Give plan for initiation of reduction as within 2 months, and hopefully don't need med at all after 6 mo.
* **NO PRN USE!!** Regular schedules

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Atypical Neuroleptics: High Risk—Limited Gain

* **Limited RCT evidence** (but still better than anticonvulsant data)
* **Strongest data** support adjunctive use, added to SSRI, **in OCD** (Olanzapine, Risperidone, Quetiapine)
* **Adverse effects on lipids, glucose and weight much better established than clinical benefits!**
* **Adjunctive use** is third line option in disabling, resistant anxiety **—In patients without a history of substance use disorders, benzos may be safer overall than antipsychotics, and with better evidence for efficacy!**

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