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Psychiatry and Addictions Case Conference

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MEDICATION ALGORITHM FOR ANXIETY DISORDERS

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- None

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ANXIETY DISORDERS:
INITIAL MEDICATION CHOICE

- **SSRIs and Venlafaxine XR:**
  - Equally effective for PD, GAD, SAD, PTSD
  - SSRIs are better tolerated than SNRIs
  - Sexual side effects are the #1 reason for patients discontinuing these meds
  - Citalopram, escitalopram, and venlafaxine have are weak (clinically unimportant) 2D6 inhibitors. Paroxetine, sertraline, and fluoxetine are strong (clinically relevent) 2D6 inhibitors.
- Clomipramine may out-compete all other medications for OCD, though it has more side effects.

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TITRATION OF INITIAL MEDICATION TREATMENT

- Start at **low dose and**

  titrate gradually to a low-end therapeutic dose over 2-4 wks
- Initial response to antidepressant (>25% improvement in rating scale) 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 FDA maximum dose over another 4-6 weeks**
- **Try to get to maximum doses AND durations!**

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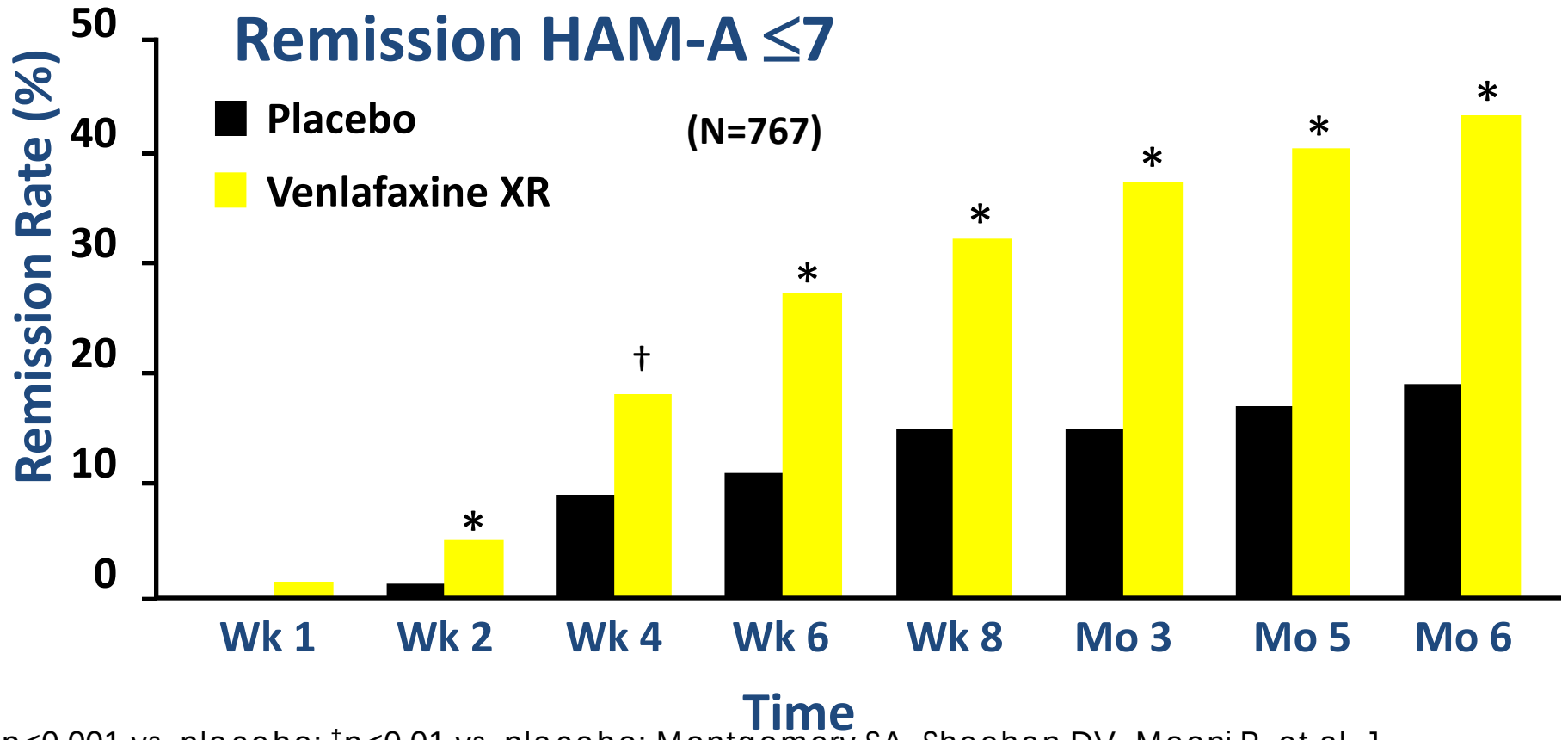
GAD Response Increases Over Time - Wait Before Changing



*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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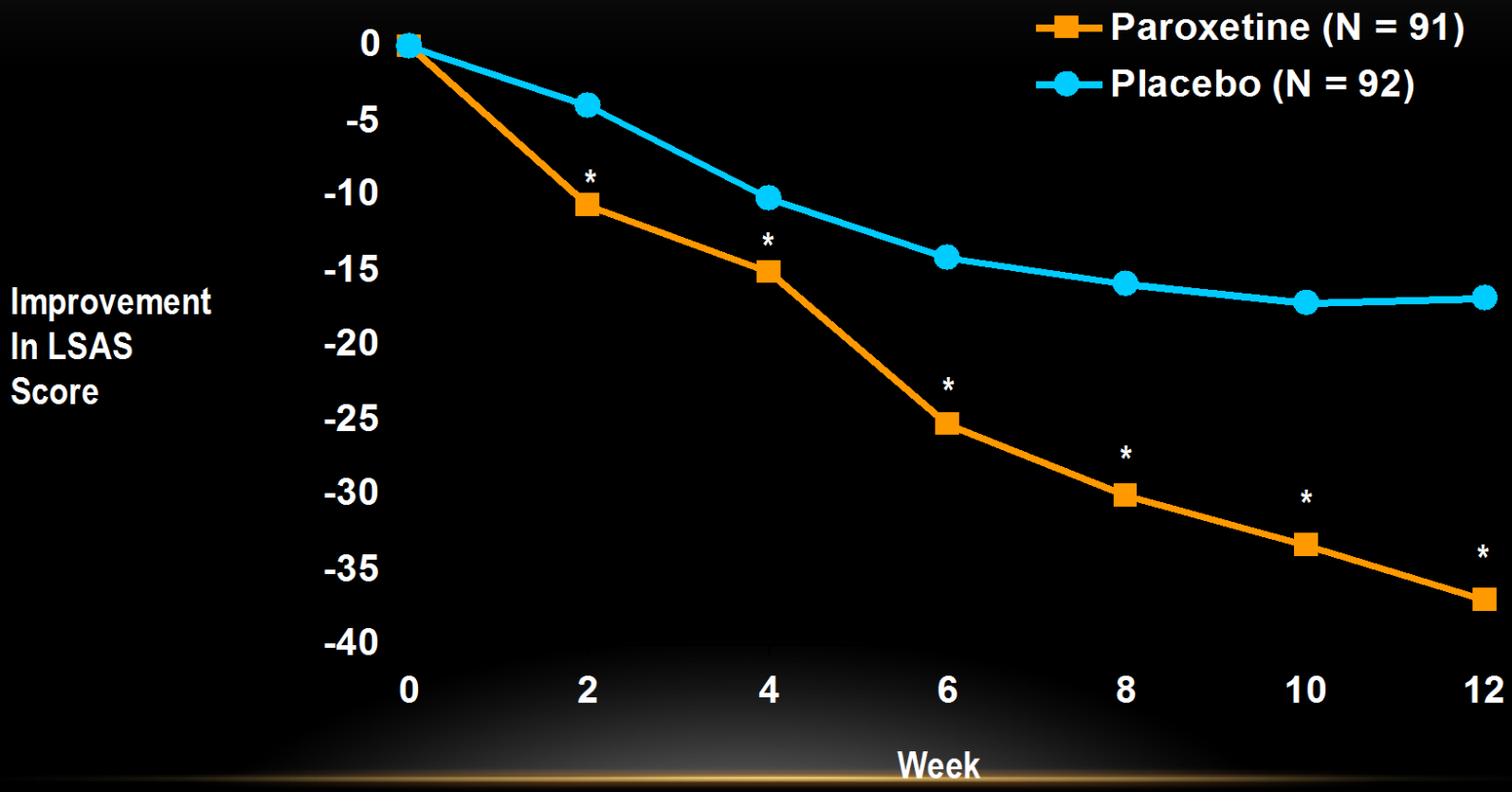
Figure 3

PAROXETINE IN SOCIAL ANXIETY DISORDER
LIEBOWITZ SOCIAL ANXIETY SCALE (ITT/LOCF) (LSAS)



* *P*<.05 vs PBO.
Mean dose = 36.6 mg/d at end point.
Stein et al. *JAMA.* 1998;280:708.

ANXIOLYTIC PHARMACOTHERAPY: OTHER MEDS

- **Bupropion** is ineffective for all anxiety disorders!
- **Buspirone** and **Pregabalin** work for GAD.
- **Beta-blockers** only work for Performance Anxiety.
- Scheduled **antihistamines** only work for GAD.
- **TCAs** have more side effects than SSRIs, are lethal on overdose, and don't work for Social Anxiety

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ATYPICAL NEUROLEPTICS: HIGH RISK—LIMITED GAIN

- **Strongest data** support adjunctive use, added to SSRI, **in OCD** (Olanzapine, Risperidone, Quetiapine)
- **The 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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WHEN WOULD I WANT TO CHOOSE A BENZODIAZEPINE?

- Consider using in patients with a history of non-response to two antidepressant classes **and** a combination of SRI and mirtazapine (or gabapentin?) **and** therapy
- If patient has Bipolar and SSRIs are destabilizing
- If patient doesn't have a history of substance abuse
- If concomitant depression is already being treated
- Diagnosis (most justified for panic and Social Anxiety; less for GAD; **no utility for PTSD or MDD**)
- **Best to use in combination with an antidepressant**

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BENZOS FOR PANIC

- Benzos do separate from placebo, though the effect size is no better than SSRIs. Benzos are sometimes used to augment SSRIs in refractory cases.
- Most psychiatrists do not use Xanax because of the short half-life. If you are going to use a benzo in Panic Disorder, consider scheduled (start 0.5mg QHS) clonazepam and move to BID if there is breakthrough anxiety.
- Do not use PRN benzos. Patients give the benzo credit for relief of the panic attack, even if it is before the med could possibly be working.

BENZO DOSES AND HALF-LIVES

	Dose Equivalent	half-life (hours)
• **Alprazolam (Xanax)**	**0.5**	**12**
• **Lorazepam (Ativan)**	**1**	**15**
• **Temazepam (Restoril)**	**10**	**11**
• **Chlordiazepoxide (Librium)**	**25**	**100**
• **Clonazepam (Klonopin)**	**0.25**	**34**
• **Diazepam (Valium)**	**5**	**100**

- Don’t give Valium or Librium to the elderly or patients with impaired liver function.
- **OTL = oxazepam temazepam lorazepam = Outside The Liver**

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BENZOS IN SOCIAL ANXIETY DISORDER

- SSRIs and venlafaxine are 1st line treatments for social anxiety disorder (SAD)
  - Sertraline, paroxetine and venlafaxine are FDA approved for SAD
  - Fluvoxamine and escitalopram shown to be effective in double blind trials
- Benzos for SAD are complicated by high rates of alcohol use disorder and place patients at risk for BNZ use disorder (Schneier, et al., 1992)

BENZOS IN GAD

- Benzos are more effective than other meds in the first two weeks of treating GAD. However, after the first two weeks, buspirone becomes comparable and SSRIs surpass benzos.
- Benzo doses needed are lower by approximately half than those used in treating panic disorder.
- Caution should be used in prescribing benzos to patients with even minor depressive symptoms, as they do not respond as well to most benzos, and may have an increase in negative emotions as well as a decrease in positive emotions.

BENZOS IN PTSD

- Benzodiazepines do not reduce core symptoms of PTSD (and may even worsen them).

- Benzodiazepines may actually impair extinction learning in exposure-based treatments of PTSD.

BENZOS FOR SPECIFIC PHOBIA

- The treatment of choice for specific phobias is behavior therapy (systematic desensitization). Pharmacotherapy data are extremely limited.

MANAGING THE PATIENT WHO IS ALREADY ON A BENZO WHEN YOU MEET THEM

- **Patient needs to commit to work exclusively with you** (check Rx monitoring program) and must have no substance abuse history (UTOX?)
- Tell them your aim is for a **gradual reduction in dose**
- Say reduction will be done AFTER other medication or behavioral treatments are 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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