**UW PACC**

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

# ANXIETY-MEDICATION TREATMENT


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project ECHO

# OBJECTIVES

1. Review what is first line pharmacologic treatment for anxiety disorders
2. Develop confidence in working through anxiety medication options
3. Look at other medications that may or may not be useful that are commonly used in anxiety disorders

# WHAT ANXIETY?

- Generalized Anxiety Disorder
- Social Anxiety Disorder
- Panic
- Anxiety NOS

- To be addressed later
  - PTSD
  - OCD

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# TRUE OR FALSE:

SEROTONIN REUPTAKE INHIBITORS HAVE EVIDENCE FOR THE TREATMENT OF ANXIETY DISORDERS?

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**TRUE OR FALSE:**

SEROTONIN REUPTAKE INHIBITORS HAVE EVIDENCE FOR THE TREATMENT OF ANXIETY DISORDERS?

**TRUE!**

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# 1ST: CRANK UP THE SEROTONIN!


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# GAD: ANTIDEPRESSANTS, NNT=5

## SSRIs

- Fluoxetine (Prozac) 20-60mg
- Paroxetine (Paxil) 20-60mg (RCT)
- Sertraline (Zoloft) 50-200mg (RCT)
- Citalopram (Celexa) 20-40mg (RCT)
- Escitalopram (Lexapro) 10-20mg (RCT)

## SNRIs

- Venlafaxine (Effexor) 75-300mg
- Duloxetine (Cymbalta) 30-60mg

Kapcinzinski et al, 2003

# FDA INDICATIONS

- Paroxetine: Social anxiety, GAD
- Sertraline: Panic, Social anxiety
- Venlafaxine ER: Panic, Social, GAD

**Bottom-line**: consider all SRIs as 1st line for use for GAD, Panic, Social Anxiety Disorder

# PRINCIPLES OF USE

**Need adequate trial (6 to 8 weeks) at an adequate dose for maximal benefit**

For anxiety, start at half the typical starting dose (4 wks)

Warn patients that anxiety may worsen before it improves

May need additional anxiolytic while titrating

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# WHAT ABOUT MIRTAZAPINE?

- Use to augment when symptoms are treatment refractory with insomnia.

Schatzberg AF et al, 2000

# Use the GAD7 at every visit

For screening, determining severity, and tracking outcomes for anxious patients!

# TRUE OR FALSE:

BUSPIRONE HAS BEEN FOUND TO BE AS EFFECTIVE AS LORAZEPAM FOR GAD?

Delle C et al, 1995

**TRUE OR FALSE:**

BUSPIRONE HAS BEEN FOUND TO BE AS EFFECTIVE AS LORAZEPAM FOR GAD?

**TRUE! (WITH A CAVEAT)**

Delle C et al, 1995

# GAD: BUSPIRONE, NNT=4.4

MOA: 5HT1A partial agonist

Target dose: 30-60mg/day, divided bid to tid

Well tolerated, no withdrawal

Most helpful?

- Only in GAD  (NOT depression or other anxiety d/o's)
- If patient has NOT been on a benzodiazepine before
- Alcohol use disorders and GAD (60mg/day)
- SRIs vs Buspar?

Chessick et al, 2003; Tollefson GD et al, 1992; Ipser JC et al, 2015

# TRUE OR FALSE:

GABAPENTIN HAS EVIDENCE FOR THE TREATMENT OF GAD.

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For screening, determining severity, and tracking outcomes for anxious patients!

# TRUE OR FALSE:

GABAPENTIN HAS EVIDENCE FOR THE TREATMENT OF GAD.

**FALSE!** (BUT PREGABALIN DOES)

Gabapentin has modest evidence for social phobia, anxiety in breast cancer, and perioperative anxiety.

Berlin R et al, 2015, Generoso MB et al, 2016

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# PREGABALIN

MOA: GABA analog→inh Calcium currents
Dose: 50-300mg/day divided bid
SE: dizziness, sedation, peripheral edema

- Notes
  - Onset: within days (4 in one study)
  - Can develop tolerance and dependence
  - Will likely need PA
  - Also found to be helpful for somatic anxiety symptoms
  - Can use to augment antidepressant partial responders

- Consider: if fails SRI, or if transitioning from benzodiazepines

# TRUE OR FALSE:

BENZODIAZEPINES ARE EFFECTIVE IN TREATING GAD

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# TRUE OR FALSE:

BENZODIAZEPINES ARE EFFECTIVE IN TREATING GAD

**TRUE!**

Also: Meta-analysis comparing benzodiazepines to SSRIs and Pregabalin found them comparable.

Generoso MB et al, 2016; Offidani E et al, 2013

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# TRUE OR FALSE:

SECOND GEN ANTIPSYCHOTICS ARE GOOD FOR EVERYTHING!

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# TRUE OR FALSE:

SECOND GEN ANTIPSYCHOTICS ARE GOOD FOR EVERYTHING!

## FALSE! (BUT THEY ARE HELPFUL FOR ANXIETY)

Also: Meta-analysis comparing benzodiazepines to SSRIs and Pregabalin found them comparable.

Gao K et al, 2006; Maher AR et al, 2011

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# Use the GAD7 at every visit

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# SECOND GENERATION ANTIPSYCHOTICS

MOA (Quetiapine): antagonist-5HT1a, 5HT2, D1, D2, H1, a1, a2, M1 (metabolite)

Dose (Quetiapine): 50-300mg/day

Side Effects: sedating, EPS (rare), wt gain, metabolic side effects, TD (rare)

- Notes
  - Augmentation or monotherapy
  - Efficacy found in GAD, OCD, PTSD, and Bipolar, and Psychosis!!! Maybe SAD.
  - Side effects often intolerable

# TRUE OR FALSE:

BETA BLOCKERS ARE HELPFUL FOR PHYSICAL SYMPTOMS OF ANXIETY.

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# TRUE OR FALSE:

BETA BLOCKERS ARE HELPFUL FOR PHYSICAL SYMPTOMS OF ANXIETY.

**TRUE! (BUT THEY AREN'T GREAT FOR MENTAL SYMPTOMS)**

Evidence is limited for panic. Not effective for PTSD, SAD, or Panic (monotherapy).

Steenan SA et al, 2016

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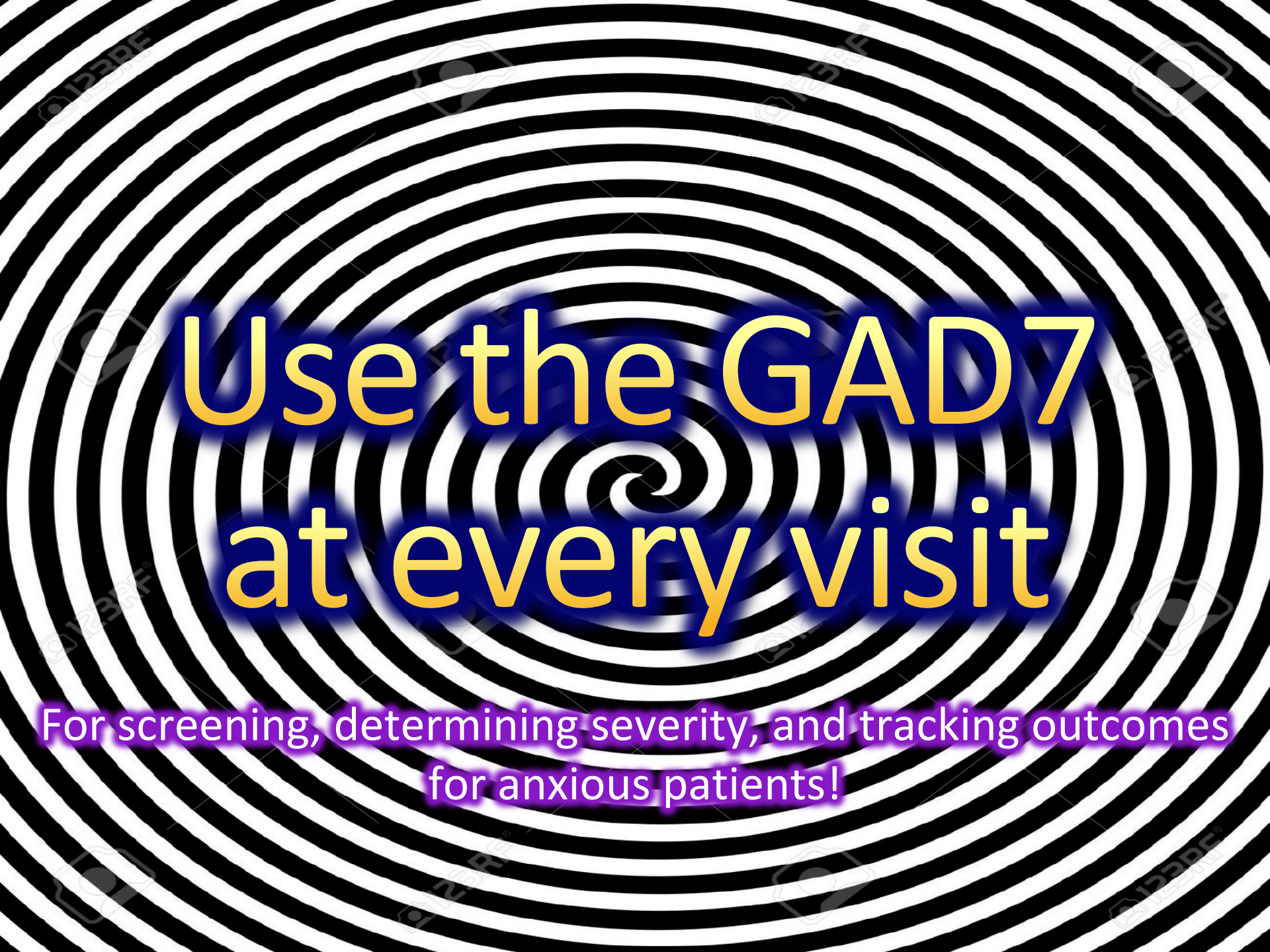
# BETA BLOCKERS (PROPRANOLOL)

MOA: b1, b1 blocker

Dosing for anxiety: 10mg bid, up to 30-120mg/day

Side effects: conduction disturbance, syncope, hypotension, dizziness, etc

- Notes
  - Evidence for somatic symptoms of anxiety
  - Use as augmenting agent when starting SSRI in panic disorder
  - No evidence for monotherapy


Use the GAD7
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# ANTIHISTAMINES: HYDROXYZINE

MOA: antihistamine

Dose: 50mg qhs, or 25-50mg tid

Side effects: sedation, anticholinergic

- Notes
  - Sedating
  - Augmentation (insomnia)
  - Worsening anticholinergic at higher doses (not great for geriatric populations)

Guaiana G et al, 2010

# ALPHA 2 AGONISTS: CLONIDINE

- Limited evidence-last study from 1981!
  - Decreased anxiety attacks
  - Decreased psychic symptoms
  - Somatic symptoms least affected
  - Dose: 0.2-0.6mg/day

- Consider
  - If no other options have been helpful

Hoehn-Saric R et al, 1981

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# TREATMENT APPROACH

1st: SSRI or SNRI

No response after adequate trial→different SSRI or SNRI, or Buspar or Pregabalin

Partial response→augment with Buspar or Pregabalin

Still no improvement→augment with Benzos (if no SUDs); or Quetiapine; if insomnia consider Mirtazepine