ANXIETY

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Overview

Anxiety disorders represent approximately 1 in 5 to 1 in 12 patients presenting to primary care.[3] Anxiety disorders cause a substantial burden on patients, and consume a significant amount of psychiatric and non-psychiatric medical services.[3] Patients with anxiety disorders are associated with an increased risk of suicidal behaviour.[3,4]

Differential Diagnosis[9,10]

Many symptoms of anxiety overlap with organic medical disorders, as patients may present with such symptoms as shortness of breath, palpitations, and hyperventilation. As such, differential diagnosis may include the following:

- Cardiac: CAD, CHF, arrhythmia
- Pulmonary: PE, asthma, COPD, upper airway obstruction, pneumonia
- Endocrine: Hyper/hypothyroidism, hyperparathyroidism, hypoglycaemia, pheochromocytoma, menopause
- Neurologic: neoplasm, encephalitis, vestibular dysfunction
- Drugs: caffeine, amphetamines, cocaine, alcohol, nicotine, BZD withdrawal, decongestants, salbutamol, antipsychotics, levodopa, SSRIs
- Psychiatric: Phobias, other co-morbid psychiatric conditions (e.g. depression)

Investigations

The Generalized Anxiety Disorder (GAD-7) scale is a validated tool designed for screening of GAD in primary care:

http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

Patients should also be screened for comorbid psychiatric disorders and medical conditions that may manifest with similar symptoms of anxiety. A careful history taking (including drugs and medications used), complete physical examination and appropriate laboratory studies is essential to rule out organic disorder.[4]

General approach to management

Lifestyle management includes limiting caffeine and stimulants, avoiding alcohol consumption to treat anxiety. Overall, SSRI and SNRIs are first line for PD, SAD, PTSD, GAD and OCD[5]. Benzodiazepines can be used to abort initial panic attacks but avoid "as needed" short acting benzodiazepines[3]. Adequate trial (8-12 weeks) at optimal dosage is needed to see response from therapy[3]. If inadequate response, switch to another agent; if partial response achieved, consider adding an augmenting agent[3]. Refer to specialist or consider second or third line agent if still inadequate response[3].

Disorder	Diagnostic Criteria[6]	Treatment
Generalized Anxiety Disorder	1. Excessive anxiety and worry occurring for at least 6 months about several events or activities (such as work or school performance) 2. Person finds it difficult to control the worry 3. The anxiety and worry are associated with 3 or more of the following: a. Restlessness or feeling on edge b. Fatigue c. Difficulty concentrating d. Irritability e. Muscle tension f. Sleep disturbance 4. Anxiety and worry are not due to substance abuse or another medical or mental disorder The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	• CBT (all therapy types seem effective but CBT likely most effective)[3] • Exercise, yoga[3] • SSRIs/SNRIs all similarly effective[3] • Buspirone, TCAs and low dose benzodiazepines[3]

Panic Disorder, PD (with or without agoraphobia)	1. Recurrent unexpected panic attacks 2. 1 or more of the attacks has been followed by 1 month or more of 1 or more of the following: a. Persistent concern about having additional attacks b. Worry about the implications of the attack or its consequences c. A significant change in behaviour related to the attacks 3. The presence (or absence of agoraphobia) 4. The panic attacks are not due to a substance abuse, a medication, or a general medical condition The panic attacks are not better accounted for by another mental disorder	• CBT[3] • SSRIs/SNRIs[3] • Benzodiazepines can be used to augment or monotherapy[3] • TCAs and less commonly MAOIs can also be used[3]
Social Anxiety Disorder (SAD)	1. Marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others 2. Exposure to feared social or performance situation that provokes anxiety (e.g. situational panic attack) 3. Recognition that fear is excessive or unreasonable 4. Avoidance of feared situation or endurance with distress 5. Avoidance or fear cause significant distress or impaired functioning 6. Fear or avoidance are not due to another medical or mental disorder	• CBT[3] • SSRIs/SNRIs[3] • Beta-blockers or benzodiazepines for acute situations and performance anxiety[3] • TCAs and moclobemide can also be used as third line therapy[3]
Obsessive Compulsive Disorder (OCD)	**Obsessions:** 1. Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and cause marked anxiety/distress 2. The thoughts, images or impulses are not simply excessive worries about real-life problems 3. The person attempts to ignore or suppress the obsessions, or to neutralize them with other thoughts or actions 4. The obsessions are recognized as a product of his or her own mind **Compulsions:** 1. Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession or according to rigid rules 2. Compulsions are aimed at reducing distress or preventing some dreaded event; however these compulsions are not connected in a realistic way with what they are designed to neutralize, or are clearly excessive The person recognizes the obsessions or compulsions are excessive or unreasonable ('ego-dystonic') Causes marked distress, are time consuming (>1hr daily) or significantly interfering with the person's normal routine, occupation, academic, social functioning Not due to substance abuse, or another medical or mental disorder	• Exposure therapy with response prevention (ERP)[3] • Benzodiazepines generally not useful in OCD on their own[3] • High dose often required of: SSRIs/SNRIs or TCAs (i.e. 1st line: sertraline, paroxetine, fluoxetine, fluvoxamine; 2nd line: venlafaxine, or clomipramine, mirtazapine, citalopram)[3]
Post-traumatic stress disorder (PTSD)	The person has been exposed to a traumatic event leading to 3 main types of symptoms: 1. Re-living: experiencing recurrent and intrusive memories, dreams or nightmares, physical or psychological distress when reminded of the trauma 2. Avoidance: of stimuli or events associated with the trauma and numbing of general responsiveness, including 3 or more of the following: Avoid thoughts, feelings, conversations, activities, places, or people; Inability to recall aspect of the trauma; Diminished interest or participation in activities; Feeling of detachment or estrangement from others; Restricted range of affect; Sense of foreshortened future 3. Arousal: persistent symptoms including 2 or more of the following: Difficulty falling or staying asleep; Irritability; Difficulty concentrating; Hypervigilance; Exaggerated startle response Duration of symptoms >1 month Severity of symptoms sufficient to cause "clinical significant distress" or impaired functioning	• CBT or ERP[3] • Monotherapy with benzodiazepines not recommended[3] • SSRIs/SNRIs (most evidence of effectiveness for sertraline, some trial evidence for paroxetine and for venlafaxine and fluoxetine)[3] • There is some evidence that antipsychotics may have a role in augmentation therapy[8]