Anxiety is a common mental health problem affecting nearly 15% of the population. Anxiety often coexists with depression, reported in over 3 million Australians. Anxiety affects women more than men. Whilst the highest rate of anxiety disorders occurs in the 35-44 years age group, it is common in older people in residential care. Anxiety is often underdiagnosed and undertreated.

Types of anxiety
Anxiety disorders can be divided into 7 categories:

- Separation anxiety disorder
- Selective mutism
- Phobias
- Social anxiety disorders (SAD)
- Panic disorder
- Agoraphobia
- Generalised anxiety disorder (GAD)

The DSM-5 classifies post-traumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD) as separate conditions, although they are still considered anxiety disorders.

Generalised anxiety disorder is one of the most common anxiety disorders in older people. Residents can experience more than one type of anxiety disorder.

Symptoms
Anxiety symptoms include:

- Restlessness or feeling ‘keyed up’ or ‘on edge’
- Fatigue
- Difficulty concentrating or mind ‘going blank’
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

Residents may demonstrate emotional symptoms such as fear, worry, and anticipation. Some of the physical signs include palpitations, hyperventilation and dry mouth.

Anxiety disorders are associated with an increased disability, mortality and decreased cognitive functioning.

Assessment
Initial assessment can identify people who need further investigation. Residents can be asked to rate how often they have felt two types of emotions over the past week – feeling nervous or anxious, and uncontrollable worrying. A score of three is suggestive of an anxiety disorder and warrants further evaluation.

The 20-item Geriatric Anxiety Inventory (GAI) is used in the diagnosis of generalised anxiety. An Australian geriatrician has developed a 5-item version of the GAI. A score of three or greater can detect GAD using positive responses from these items:

- I worry a lot of the time
- Little things bother me a lot
- I think of myself as a worrier
- I often feel nervous
- My own thoughts often make me nervous

Comorbidities
Anxiety can be a symptom or coexist with other mental health disorders such as depression, bipolar disorder or a psychotic disorder. GAD increases the likelihood of having depression nearly 30-fold.

Many medical conditions can be associated with anxiety, including:

- Hypoglycaemia
- Hypo- or hyper-thyroidism
- Cardiac conditions
- Chronic respiratory conditions
- Irritable bowel syndrome
- Chronic pain
- Withdrawal of benzodiazepines and alcohol

Anxiety frequently complicates mild cognitive impairment (MCI) and dementia. Frailty is independently associated with anxiety.

Management
Psychoeducation and pharmacotherapy are both effective in managing anxiety, with dual treatment more effective than either therapy used alone and more effective than placebo.

Psychoeducation includes relaxation, cognitive behaviour therapy (CBT), exercise and yoga. CBT has the greatest evidence for benefit and has been found to be significantly effective.
more effective than worry reduction. CBT focuses on how people’s feelings and thoughts drive their actions and behaviours. Relaxation techniques include progressive muscular relaxation, guided imagery and mindfulness based meditation. People usually prefer CBT to medication as CBT is more likely to be effective in the long term.

Pharmacotherapy includes antidepressants, benzodiazepines, and pregabalin. Regular review is vital to monitor for clinical improvement and to identify adverse effects.

Antidepressants
Worsening of anxiety symptoms can occur at the beginning of treatment with antidepressant therapy. Treatment should be started at half the usual dose used for depression, titrating up slowly. All antidepressants are approved for major depressive disorders, so if concomitant anxiety exists, treatments may assist both conditions.

Selective serotonin reuptake inhibitors (SSRIs) are considered first-line therapy for the treatment of anxiety, in particular for GAD and SAD. Response to therapy usually occurs within 6 weeks. However, up to three-quarters of patients fail to achieve remission after initial therapy. Augmentation with clonazepam is an option for people with SAD who fail to respond to an initial antidepressant, although it is not available on the PBS for this purpose.

Not all SSRIs are available on the PBS for treatment of anxiety. Sertraline and paroxetine are approved for OCD and panic disorder only. Fluvoxamine and fluoxetine are restricted to OCD. Escitalopram is available for treatment of moderate to severe generalised anxiety disorder (GAD), and moderate to severe social anxiety disorder (social phobia, SAD) with some additional restrictions.

Common adverse effects of SSRIs include nausea, vomiting and diarrhoea (usually subside within a few weeks), insomnia and sexual dysfunction.

Serotonin and noradrenaline reuptake inhibitors (SNRIs) venlafaxine (Effexor-XR) and duloxetine (Cymbalta) have demonstrated efficacy for GAD, although again they are only approved in Australia and on the PBS for major depressive disorders.

SSRIs and SNRIs increase the risk of bleeding.

Tricyclic antidepressants (TCAs) are effective but are not considered first-line treatment due to adverse effects, especially in older people. TCAs can be used for panic disorder if a SSRI has not been effective. Nortriptyline (Allegron) is preferred in older people as it has the least anticholinergic effects.

Benzodiazepines
Benzodiazepines are commonly used for panic disorder and GAD. They have clear short term efficacy, a quick onset of action and generally good tolerance. However long-term use is associated with significant potential problems including tolerance, dependence, withdrawal, relapse, interactions with other medications and side effects. Use should be restricted to short term use (i.e. up to 4 weeks) at the lowest possible dose.

Withdrawal symptoms of benzodiazepines can mimic symptoms of anxiety with increased anxiety, restlessness, tremor, sweating, weakness, insomnia, headaches, dizziness, depression, and muscle cramping or spasm.

The short-acting benzodiazepine alprazolam (Xanax) was rescheduled in January 2014 to a controlled drug to reduce overuse and misuse.

Pregabalin
Prebagalin (Lyrica) is effective in the treatment of GAD, acting quickly often within a few days. It can also enhance the effects of SSRIs or SNRIs. According to the Therapeutic Guidelines the initial dose is 150 mg daily and increases gradually after 1 to 2 weeks to 450 to 600 mg daily. Effects are seen within a week. Adverse effects include somnolence, dizziness and dry mouth, and are more prominent when higher doses (600 mg daily) are used. Doses need to be adjusted for renal impairment. It should be noted that pregabalin is not approved for use in GAD in Australia nor approved on the PBS for this purpose.

Summary
Anxiety disorders are common in residential care, significantly affecting quality of life. Both medications and behavioural interventions are effective in older people. Antidepressants are recommended treatment options in generalised anxiety disorder, panic disorder and social anxiety disorder, with pregabalin and benzodiazepines as second-line options.

References
Am J Psychiatry 2014 Jan 1;171:44.

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