Anxiety in Older Patients

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Disclosures

Presenters have no financial disclosures.

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Objectives

To recognize the prevalence of anxiety among older patients.

To review common anxiety disorders among elderly patients.

To determine how to evaluate anxiety.

To assess management options for older patients with anxiety.

To evaluate challenging prescribing methodology.

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Epidemiology of anxiety in older patients

- The most common psychiatric disorders
- About 15% of the US population is older than 65 years of age
- Between 10-15% have an anxiety disorder (4.5-7.5 million individuals)
- A higher percentage have some symptoms of anxiety
- Over 40% of older adults with disability/limiting chronic medical illness
- Specific phobia is the most common

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Risk Factors

- Heritability
- Personality-neurotic, introverted, vulnerability, low self-efficacy
- Disability, limited chronic medical illness, spousal events
- Physiological
  - Hyperactive HPA axis-increased cortisol
  - Increased limbic activity
  - Reduce volume of hippocampus and amygdala

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Consequences

- Decreased quality of life
- Decreased physical activity
- Comorbid psychiatric conditions
  - depression and substance abuse
- Comorbid medical conditions
  - pain, migraine, lung/cardiac disease
- Increased risk of cognitive impairment/dementia
- Increased mortality

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Anxiety Disorders

- Specific phobia
- Generalized Anxiety Disorder
- Agoraphobia
- Panic Disorder
- Social Anxiety Disorder

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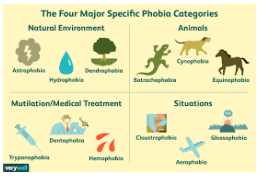
Specific Phobia



- Marked fear of specific object or situation
- Object or situation almost always causes fear/anxiety
- Avoiding situation
- Fear is out of proportion to actual danger
- Clinically significant distress
- Not explained by other factors
- Examples: Falling, stroke/MI, choking

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Generalized Anxiety Disorder

- Excessive worry more days than not
- Difficult controlling worry
- Three or more
  - Restlessness
  - Fatigue
  - Decreased concentration
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Clinically significant distress
- Not contributable to medical illness or substances
- 6 months duration

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Agoraphobia

- Two or more causing fear
  - Public transport
  - Open spaces
  - Enclosed spaces
  - Crowds/lines
  - Outside the home
- Fear/avoidance because cannot escape
- Situation(s) cause fear/anxiety and are avoided or require companion
- Out of proportion fear
- Not other medical cause
- Clinically significant distress
- 6 months
- Does not respond well to medications.

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Panic Disorder

- Four or more of following
  - palpitations, sweating, shaking, SOB, choking sensation, chest pain, nausea, dizziness, chills/heat, paresthesia, derealization, fear of losing control, fear of death
- Can have culturally specific symptoms
- 1 month or more
- Maladaptive behavior
- Non-medical cause

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Social Anxiety Disorder

- Fear/anxiety possible scrutiny such as social interactions, observation, performing in front of others
- Fears that anxiety will be negatively evaluated
- Avoidance
- Anxiety/fear out of proportion to situation
- Clinically significant distress
- Non-medical cause
- 6 months or more

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Approach to Evaluation

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Differential Diagnosis

Another anxiety disorder – easy to mix them up

Another psychiatric disorder

- neurocognitive disorder
- psychotic disorder
- personality disorder – paranoid, avoidant, dependent

A medical condition contributing to anxiety symptoms

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Medical Rule Out

Obtain history and estimate baseline function

Physical examination-medical and neurological origins

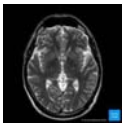
Review medications-polypharmacy

Lab work

- Common: Metabolic Panel, CBC, Vitamin B12, folate, thyroid studies, UA, UDS
- Less Common: metaneph/catechol, RPR, HIV, homocysteine, methylmalonic acid

EKG

Neuroimaging



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Assessment Tools

Self-reported measures
- GAD-7
- Worry Scale
- Beck Anxiety Inventory
- Penn State Worry Questionnaire

Clinical-rated
- Structure clinical interview
- Anxiety Disorders Interview Schedule
- Hamilton Anxiety Rating Scale
- Physician Withdrawal Assessment

Complicated picture
- Neuropsychological assessment

GAD-7 Anxiety

Over the last two 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

Column totals ___ + ___ + ___ + ___ = ___

Total score ___

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at rls58@columbia.edu. PRIME-MD is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–5: mild anxiety

6–10: moderate anxiety

11–15: moderate anxiety

17–21: severe anxiety

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Treatment

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Recent Literature

Recent research has limited usefulness in clinical practice

CBT with behavioral activation and problem solving may be helpful

Most recent studies have had sample sizes that are quite small

Little research on anxiety and coexisting depressive disorders

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Psychotherapy

Combination with pharmacology is often superior

Specific phobia
- exposure and response therapy
- SSRIs sometimes are helpful
- Benzodiazepines for certain situations (fear of flying, lorazepam)

GAD
- CBT relaxation, cognitive restructuring, behavioral activation

Agoraphobia
- CBT or psychodynamic therapy

SAD
- psychotherapy first line-CBT or social rehabilitation focus

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Pharmacology-FDA Approved Agents

Specific Phobia
- (paroxetine), sertraline

Generalized Anxiety Disorder
- (paroxetine), escitalopram, venlafaxine, duloxetine, alprazolam, clonazepam, buspirone

Panic Disorder
- sertraline, (paroxetine), fluoxetine.
- *can augment with non-serotonergic antidepressant*

Social Anxiety Disorder
- (paroxetine), sertraline, venlafaxine.
- beta-blocker (propranolol for anxiety with public speaking)

Can take up to 8 weeks to see effects of SSRIs/SNRIs

Start low, go slow

Are all these medications good options?

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Treating anxiety in patients with cognitive decline

Consider severity of both conditions

CHEIs can contribute to mood symptoms

Polypharmacy at low doses of each med can work better in some patients than larger doses of single medications

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Psychopharmacology - Clinical Pearls

- Avoid paroxetine use due to anticholinergic side effects.
- Sertraline and escitalopram are good options to start with:
  - Sertraline has the least risk of QTC prolongation, starting dose 25-50mg daily.
  - Escitalopram, recommend starting lower dose in elderly, 5-10mg daily.
- Citalopram has highest risk of QTC prolongation at higher doses.
- Venlafaxine caution if hypertension, starting dose 37.5-75mg daily.
- *Benzodiazepines . . .*

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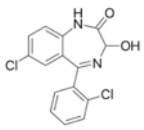
Benzodiazepine benefits and risks

Benefits
- Work quickly
- Can be used to "break" a cycle of high levels of acute anxiety or severe insomnia

Risks
- Physiologic dependence / withdrawal phenomena
- Often misused with other drugs of abuse
- Falling – leading to broken bones including hips and skulls which can be catastrophic and possibly deadly
- Connection with dementia – recent meta-analysis showed a significant increased risk, especially in those taking long half-life BZD and for longer than 3 years



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Avoiding Benzodiazepine Trouble From The Start

- Engage in a risk-benefit discussion with the patient.
- Explain the concept of physiologic dependence.
- Avoid prescribing in patients with substance misuse history and in patients taking opiates, barbiturates and who are misusing alcohol.
- Set a date for reassessment of the usefulness of the medication, especially when patients are using daily.
- Avoid long-term prescriptions for daily benzodiazepine use in order to avoid physiologic dependence which can give patients the illusion that they can "never" d/c BZD.
- Alternatives to benzodiazepines for patients at risk
  - Hydroxyzine, diphenhydramine, ?gabapentin, propranolol
- "Holding out" for long term solutions to work including psychotherapy and SSRI's/SNRI's

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Getting out of benzodiazepine trouble

Explain to the patient that you have now learned more about benzodiazepine safety and you want to share what you now know

Express confidence that with time and determination, you can assist the patient in d/c of benzodiazepines even if they have been taking them for decades

If there is not an acute safety risk, slow downward tapers work best

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Questions?

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