THE ANXIOUS PATIENT

Stephanie Richards, MD
44th Refresher Course in Family Medicine
March 24, 2017
OBJECTIVES

- Recognize how anxiety disorders present in primary care and utilize the GAD-7 to screen
- Develop a differential diagnosis for anxiety symptoms including medical illness, medications, substance use, anxiety disorders and other psychiatric disorders
- Understand basic principles of non-pharmacologic and pharmacologic treatments for anxiety disorders
ANXIETY IN PRIMARY CARE
ANXIETY PRESENTATION IN PRIMARY CARE

- Somatic complaints
  - 83% of patients with anxiety present with somatic complaints; only 17% present with a psychiatric complaint
    
    *Kirmayer et al, Am J Psychiatry, 1993*

  - 1 in 3 patients who present with somatic complaints have a depressive or anxiety disorder
    
    *Kroenke et al, Am J Med, 1997*

  - Increasing number of physical symptoms increases likelihood of an Anxiety (or Depressive) disorder and increasing functional impairment
    
    *Kroenke et al, Arch Fam Med, 1994*
SOMATIC SYMPTOMS ASSOCIATED WITH ANXIETY

- CV
  - Palpitations
  - Chest pain
  - Dyspnea
  - Sweating
- GI
  - Nausea, vomiting, gas, indigestion
  - Constipation, diarrhea
  - Abdominal pain
- GU
  - Pelvic/genital pain
  - Urinary frequency/urgency
  - Menstrual problems
  - Sexual dysfunction
- Neurologic
  - Tremor
  - Paresthesias
  - Fatigue
  - Headache
  - Dizziness
  - Fainting
- Musculoskeletal
  - Joint and limb pain
  - Back pain
- Insomnia

Kroenke et al, Arch Fam Med, 1994
In 50% of cases, there was symptom overlap between anxiety symptoms, depressive symptoms and somatization.

Lowe et al, Gen Hosp Psych, 2008
Anxiety disorders are the most common psychiatric problem encountered in primary care.

- Prevalence 18% in general population
  
  Kessler et al, AGP, 2005

- Prevalence may be up to 30% in primary care

- 1/3 of patients had >1 anxiety disorder
  
  Kroenke, Ann Int Med, 2007

- The majority of patients with anxiety seek treatment in the primary care setting
  
  Wang et al, Arch Gen Psychiatry, 2005
An Anxiety Disorder diagnosis was strongly associated with impaired functioning and self-reported disability days.

Greater number of Anxiety Disorder diagnoses was associated with greater disability.

Anxiety Disorders increase disability also in patients with chronic medical conditions.

*Kroenke et al, Ann Int Med, 2007*

GAD-7 score correlates with disability.

*Ruiz et al, 2011*
15–36% of patients with an anxiety disorder are recognized in the primary care setting


Anxiety was recognized in 6% of patients at the FHC in 2009 before implementing annual screening

Ongkeko, LOPIR presentation, 2010
Almost 50% were untreated
20-40% treated with medications alone
25% received appropriate anti-anxiety meds at a minimally adequate dose and duration
<10% treated with counseling alone
13-25% treated with both medications and psychotherapy
Those with comorbid depression, medical illness and greater functional impairment were more likely to receive appropriate pharmacotherapy
Minority groups were less likely to receive treatment

Stein et al, AJP, 2004
SCREENING

GAD-2
GAD-7
USPSTF does not recommend screening for anxiety

Possible indications for screening

- Symptoms suggestive of an Anxiety Disorder
  - Multiple physical symptoms, especially from different organ systems
  - Unusual “non-physiological” symptoms
    - Atypical chest pain, palpitations
    - Dizziness
    - Syncope
- Patients with Depression, Bipolar, Substance Use Disorders
- New patients
- Annually for established patients

Generalized Anxiety Disorder Scale

- From the Patient Health Questionnaire
- GAD-2, GAD-7
### Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?  

<table>
<thead>
<tr>
<th></th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add the score for each column

| + | + | + | + |

Total Score (add your column scores) =

If you checked off any problems, how difficult have these 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 __________

### GAD-7 Score

<table>
<thead>
<tr>
<th></th>
<th>Any Anxiety Disorder</th>
<th>Generalized Anxiety Disorder</th>
<th>Panic Disorder</th>
<th>Social Anxiety Disorder</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensitivity (95% CI)</strong></td>
<td>0.77 (0.70-0.82)</td>
<td>0.92 (0.83-0.97)</td>
<td>0.82 (0.70-0.90)</td>
<td>0.78 (0.66-0.88)</td>
<td>0.76 (0.65-0.85)</td>
</tr>
<tr>
<td><strong>Specificity (95% CI)</strong></td>
<td>0.82 (0.80-0.85)</td>
<td>0.76 (0.73-0.79)</td>
<td>0.75 (0.72-0.78)</td>
<td>0.74 (0.71-0.77)</td>
<td>0.75 (0.72-0.78)</td>
</tr>
<tr>
<td><strong>Positive LR (95% CI)</strong></td>
<td>4.4 (3.7-5.2)</td>
<td>3.8 (3.4-4.4)</td>
<td>3.3 (2.8-3.8)</td>
<td>3.0 (2.6-3.6)</td>
<td>3.1 (2.6-3.6)</td>
</tr>
</tbody>
</table>

GAD-7 $> 8$ as cut-off

*Kroenke et al, Ann Int Med, 2007*
4 ADDITIONAL QUESTIONS

- Have you had a spell or attack where all of a sudden you felt frightened, anxious, and uneasy?  
  PANIC DISORDER

- Have you been bothered by nerves or feeling anxious or on the edge for 6 months?  
  GAD

- Have you had a problem being anxious or uncomfortable around people?  
  SOCIAL ANXIETY DISORDER

- Have you had recurrent dreams or nightmares of trauma or avoidance of trauma reminders?  
  PTSD

SCREENING

- At the UPMC Shadyside Family Health Center
  - Screen all New Patients and Annual Visits using GAD-2
  - If screen positive on GAD-2, receive a GAD-7 + 4ADQ

- Piloting PHQ-4
  - PHQ-4 = PHQ-2 + GAD-2 at every visit administered on i-Pad
    - If PHQ-2 positive, triggers PHQ-8
    - If GAD-2 positive, triggers GAD-7
EVALUATION
History
- Characterize anxiety symptoms including duration, time course, precipitants, relieving factors
- Medical conditions and medications (especially recent changes)
- Substance use / withdrawal
- Comorbid psychiatric illness: depression, bipolar disorder, substance use disorder
- Past treatment response
- Family History including treatment response

Physical Examination
- Targeted to history

Laboratory Studies
- TSH, (BMP, CBC, Ca, EKG)
- Targeted to history
DIFFERENTIAL DIAGNOSIS OF ANXIETY

- **Primary Medical Illness**
  - Consider especially if older age of onset, no life event/stressor, concern about anxiety itself and lack of avoidance behavior
- **Medication-Induced**
- **Substance-Induced**
- **Psychological Reaction to Medical Illness**
- **Primary Anxiety Disorder**
- **Other Psychiatric Disorder**
<table>
<thead>
<tr>
<th>Medical Illnesses</th>
<th>Medications</th>
<th>Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular diseases (IHD, arrythmia, valvular dz)</td>
<td>Class 1A antiarrhythmics, ACE inhibitors</td>
<td>Caffeine (intox and withdrawal)</td>
</tr>
<tr>
<td>Respiratory diseases (asthma, COPD)</td>
<td>Bronchodilators (albuterol, isoproterenol, epinephrine), Sympathomimetics (ephrine, phenylephrine)</td>
<td>Cocaine, amphetamines, psychostimulants</td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td>Estrogens, Progestins, Androgens</td>
<td>Alcohol/benzodiazepine/sedative-hypnotic withdrawal</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>Steroids, Interferon, Antivirals</td>
<td>Opiate withdrawal</td>
</tr>
<tr>
<td>Hyperparathyroidism</td>
<td>Antipsychotics (akathisia), Antidepressants</td>
<td>Nicotine abuse and withdrawal</td>
</tr>
<tr>
<td>Pheochromocytoma, Carcinoid</td>
<td>Antiemetics (prochlorperazine, promethazine), Prokinetics (metoclopramide)</td>
<td>Diet pills</td>
</tr>
<tr>
<td>Seizure disorder, Parkinson’s Dz, Post-stroke</td>
<td>Dopamine agonists, Anticholinergics</td>
<td></td>
</tr>
</tbody>
</table>
PSYCHOLOGICAL REACTION TO MEDICAL ILLNESS

- Prolonged uncertainty about diagnosis
- Future effects of illness on their body
- Fear of disability, dependence
- Fear of their illness’s effect on family, finances
- Fear of being alone in the hospital
- Fear of death
- Worry about their physician’s opinion of them

*Adjustment Disorder with anxiety*
Depression
- 50% of patients with GAD also have a Depressive D/O
Bipolar Disorder
Alcohol and Substance Use Disorders
Schizophrenia
- Prodrome or actively psychotic
Generalized Anxiety Disorder (GAD)
Panic Disorder (PD)
Social Anxiety Disorder (SAD)
Post Traumatic Stress Disorder (PTSD)
Agoraphobia
Obsessive Compulsive Disorder (OCD)
Specific Phobia
Characterize symptom as you would for any other presenting symptom
  \- i.e. chest pain, dyspepsia, shortness of breath

Implications for treatment

Implications for management of comorbid medical problems

Often patients have >1 anxiety disorder

However, a unified approach to treatment of the 4 most common anxiety disorders (GAD, PD, SAD, and PTSD) simplifies the treatment approach
PANIC DISORDER: DSM-5 CRITERIA

- Recurrent unexpected panic attacks
  - Abrupt onset of (at least 4) palpitations, sweating, shaking, SOB, choking, CP, nausea/abdominal distress, dizzy, heat/chills, paresthesias, derealization, fear of going crazy or dying
- Anticipatory anxiety or change in behavior (avoidance)
- May be associated with Agoraphobia
  - Fear or anxiety in 2 or more:
    - Public transportation, open spaces, enclosed spaces, crowds/in line, outside home alone
  - Fears or avoids these situations because thinks can’t escape or help not available or may be embarrassing
  - Situations are avoided, require a companion, or endured with intense fear or anxiety
GENERALIZED ANXIETY DISORDER:
DSM-5 CRITERIA

- Excessive anxiety and worry occurring more days than not for at least 6 months about a number of events or activities
- Difficult to control the worry
- Associated with (at least 3) physical symptoms
  - Restlessness / keyed up / on edge
  - Easily fatigued
  - Difficulty concentrating / mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance
Fear or anxiety about one or more social situations (conversations, unfamiliar people, being observed, performance) in which exposed to possible scrutiny

Fears that will act in a way that will be negatively evaluated (humiliating, embarrassing, be rejected, offend others)

The social situations provoke fear or anxiety

The social situations are avoided or endured with intense fear or anxiety

The fear or anxiety is out of proportion to actual threat

The fear, anxiety or avoidance is persistent (> 6 months) and causes significant distress
PTSD: DSM-5 CRITERIA

- Exposure to a traumatic event
  - actual or threatened death, serious injury, sexual violence
- Intrusion symptoms
  - memories, dreams, flashbacks, triggers cause distress, physiological reactions
- Persistent avoidance of stimuli associated with trauma
  - Avoidance of memories or reminders
- Negative alterations in cognition and mood (2 or more)
  - Dissociative amnesia, negative beliefs/expectations, distorted cognitions, negative emotional state, diminished interest/participation in activities, detachment, inability to experience positive emotions
- Alterations in arousal and reactivity (2 or more)
  - Irritable/angry outbursts, reckless/self-destructive behavior, hypervigilance, exaggerated startle response, poor concentration, sleep disturbance
- Duration greater than 1 month
TREATMENT
**TREATMENT STUDIES**

- **Brief intervention approach in primary care**
  - Unified approach for 4 most common anxiety disorders
  - Establish empathic working relationship, motivational interviewing, education, CBT, relaxation, lifestyle changes, medications
  
  *Roy-Byrne et al, JABFM, 2009*

- **CALM (Coordinated Anxiety Learning and Management)**
  - Patient choice of CBT and/or medication
  - Care management (IMPACT model)
  - Computer assisted CBT
  - Medication prescribed according to treatment algorithm
  
  *Roy-Byrne et al, JAMA, 2010*
**Non-pharmacologic**
- Motivational interviewing principles
- Education
- Relaxation techniques
- Lifestyle changes

**Psychotherapy - CBT**

**Pharmacotherapy/me dications**

**GAD-7 score** (symptom severity) guides treatment choice

<table>
<thead>
<tr>
<th>Score</th>
<th>Severity</th>
<th>Treatment Recommendation</th>
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<tbody>
<tr>
<td>5-10</td>
<td>Mild</td>
<td>Rx may be offered but not necessary</td>
</tr>
<tr>
<td>11-15</td>
<td>Moderate</td>
<td>Rx recommended – counseling and/or medications</td>
</tr>
<tr>
<td>&gt;15</td>
<td>Severe</td>
<td>Rx recommended – counseling and/or medications</td>
</tr>
</tbody>
</table>

**Patient choice of treatment predicts better outcome**
ESTABLISH AN EMPATHIC WORKING RELATIONSHIP

- Use motivational interviewing techniques
  - Get patient’s feedback about the problem; negatives about anxiety
  - Understand the patient’s motivation for treatment
  - Review possible barriers to treatment
- Promote self-activation
  - Making specific changes in behavior and thinking will speed improvement with or without medication
  - Resist avoidance
- Avoid an authoritarian or prescriptive approach
  - Can inadvertently encourage repeated reassurance seeking and interfere with self-activation
- Adopt role of “supportive companion” and “knowledgeable consultant”
EDUCATION: CYCLE OF ANXIETY

ROY-BYRNE ET AL, JABFM, 2009
RELAXATION TECHNIQUES

- Goal is to reduce physiological reactivity
  - Deep Breathing
  - Progressive Muscle Relaxation
  - Guided Imagery
LIFESTYLE CHANGES

- Substances
  - Limit caffeine, nicotine, alcohol

- Sleep
  - Sleep hygiene

- Exercise
  - Daily exercise is a stress reliever
  - Yoga, meditation

- Diet
  - Eat a healthy and balanced diet

- Spirituality

- Self-care
  - Listen to music, talk with friends/family, take a bath
Cognitive Behavior Therapy (CBT)
- Equally effective as pharmacotherapy after 6-8 sessions in some cases
- Even more important than in depression

Changing how you think can change how you feel
- You learn to notice irrational thoughts about yourself.
- You learn to stop the thoughts.
- You learn to replace the negative thoughts with more positive thoughts.
- You can learn to relax your mind and body.
PSYCHOTHERAPY PLUS PHARMACOTHERAPY

- **Psychotherapy**
  - Learn new responses, ways of coping
  - Effective for long-term, relapse prevention

- **Pharmacotherapy**
  - Dampens the physiological and psychological response

- **Combined**
  - Better than either alone
PHARMACOLOGIC TREATMENT
Ask about past medication trials
  - Dose, duration, response, side effects
Ask about family history of medication response
Patients with anxiety often sensitive to medications and fearful of side effects
“Start low, go slow, but go”
Warn patients of possible worsening of symptoms early in treatment
# PHARMACOTHERAPY

<table>
<thead>
<tr>
<th>Medication</th>
<th>GAD</th>
<th>Panic</th>
<th>SAD</th>
<th>PTSD</th>
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</thead>
<tbody>
<tr>
<td><strong>SSRI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td></td>
<td>+ F</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>+</td>
<td>+ F</td>
<td>+ F</td>
<td>+ F</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>+ F</td>
<td>+ F</td>
<td>+ F</td>
<td>+ F</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td></td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>+ F</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>+</td>
<td></td>
<td>+ F</td>
<td>+</td>
</tr>
<tr>
<td><strong>SNRI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine (Effexor XR)</td>
<td>+ F</td>
<td>+ F</td>
<td>+ F</td>
<td>+</td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>+ F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-BZD anxiolytic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buspirone (BuSpar)</td>
<td>+ F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* + evidence from R, DB, PC controlled trials for efficacy
* F FDA approved
<table>
<thead>
<tr>
<th>Medication</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Line</strong></td>
<td></td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td></td>
</tr>
<tr>
<td>Venlafaxine (Effexor XR)</td>
<td>Few CYP450 interactions; inc BP</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>AVOID in pregnancy; short half-life</td>
</tr>
<tr>
<td><strong>Second Line</strong></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>Long half-life</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>No CYP450 interactions; Max 40 mg/d</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>No CYP450 interactions; Max 20 mg/d</td>
</tr>
<tr>
<td><strong>Bridging</strong></td>
<td></td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>Long half-life</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td></td>
</tr>
<tr>
<td><strong>Elderly</strong></td>
<td></td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>No CYP450 interactions; Max 20 mg/d</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td></td>
</tr>
</tbody>
</table>
Advantages
- Effective for all anxiety disorders
- Treats comorbid depressive symptoms
- Minimal side effects
- No dependency issues
- Safe in overdose

Disadvantages
- Delayed onset of action
- Initial worsening of anxiety common

Dosing
- Start with $\frac{1}{4} - \frac{1}{2}$ usual starting dose
- Titrate every 2-3 weeks
- 8-12 week trial at maximum suggested (or tolerated) dose
- Often need to titrate to maximum dose

FIRST CHOICE: SSRI OR SNRI
Acute treatment added to SSRI if very distressing or impairing symptoms or rapid control critical
- More rapid therapeutic response
- Taper after 4-12 weeks of SSRI
- Taper by 10-25% every 2 weeks to avoid withdrawal and rebound anxiety (slower if chronic use and slower towards the end)
- Prefer regular use instead of prn
  - Can cause rebound anxiety with fluctuating levels, worse CBT outcomes, get accustomed to reaching for pill rather than skills

Augmentation of SSRI if incomplete response and residual symptoms

Monotherapy may be indicated
- For Panic Disorder or Social Anxiety Disorder
- If nonresponse or intolerance to several antidepressants
- No substance abuse (current or past)
## Benzodiazepine Considerations

<table>
<thead>
<tr>
<th>Benzodiazepine</th>
<th>Considerations</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam (Ativan)</td>
<td>Short onset; intermediate half-life; less complex hepatic metabolism</td>
<td>0.5-1 mg bid-tid (max 10 mg/d)</td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>Long half-life, slower onset of action reduces abuse liability; impaired cognition</td>
<td>0.25-2 mg qd-bid (max 4 mg/d)</td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>Immediate onset of action (greater abuse potential); shortest half-life (withdrawal); difficult to d/c; AVOID</td>
<td></td>
</tr>
</tbody>
</table>
**Advantages**
- Effective for Generalized Anxiety Disorder
- No withdrawal symptoms
- No abuse potential
- No sedation
- Safe in overdose

**Disadvantages**
- Not effective for Panic, Social phobia
- Delay in benefit (up to 6 weeks)
- Patients often prefer immediate relief of benzos

**Dosage**
- 5-20 mg tid

**Side effects**
- Dizziness
TCAs
- Clomipramine (serotonergic TCA)
- Nortriptyline, desipramine

Other GABAergic agents
- Gabapentin
  - Effective for PD and SAD in small controlled trials
- Pregabalin
  - Effective in controlled trials for GAD and SAD

Other antidepressants
- Mirtazapine
- Bupropion
SGAs
- Risperidone, quetiapine

Prazosin
- For PTSD nightmares and hypervigilance
- 1-15 mg qhs or bid

Hydroxyzine
- Benzodiazepine alternative for prn use
<table>
<thead>
<tr>
<th>GAD-7 score</th>
<th>Phase</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD-7 ≥ 8</td>
<td>Acute</td>
<td>1. Start or adjust counseling and/or medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Follow up within 1 month</td>
</tr>
<tr>
<td>GAD-7 score &lt;8</td>
<td>Continuation</td>
<td>1. Continue current treatment for at least 6-12 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Follow up within 3 months</td>
</tr>
</tbody>
</table>
TREATMENT: DURATION

- Continue medication for at least 6-12 months to reduce risk of relapse
- Discuss risks and benefits of tapering meds
- Continue maintenance treatment if high risk of relapse
  - Residual symptoms
  - Multiple anxiety disorders/psychiatric co-morbidities
  - Multiple medical problems
  - Ongoing psychosocial stressors
- Taper slowly over several months and assess for recurrence of symptoms with each dose decrease
Anxiety Disorders typically present with somatic symptoms in primary care.

Screen using the GAD-2 and GAD-7.

If GAD-7 positive, evaluate for primary causes of anxiety including medical illness, medication or drugs.

Identify type of anxiety disorder (if possible) and comorbid psychiatric disorders.

Management includes employing motivational interviewing techniques, self-activation, education, lifestyle changes, and relaxation techniques.

Offer psychotherapy (CBT) and or medications.

SSRIs/SNRIs are first line treatments +/- benzodiazepines.

Use GAD-7 to monitor treatment response to remission.

Consider taper meds after 12 months or long-term treatment.
REFERENCES

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A 55 yo man with diabetes, CAD, HTN, dyslipidemia and an anxiety disorder frequently misses appointments and has been non-adherent with his bloodwork and health maintenance and is behind on requesting refills of his medication. There is a family history of colon cancer, CAD and CVA. His last HbA1C was 11.1 and lipid profile was markedly elevated from 1 year ago. The best approach is:

A. Educate him about the potential risks of not taking care of himself and doing the tests you have ordered.
B. Explore the reasons for his non-adherence and address with Motivational Interviewing.
C. Prescribe alprazolam 0.5 mg prn so he can get to appointments
D. Sertraline 50 mg daily
E. Refer for Cognitive Behavioral Therapy

Answer: B
Which of the following is not an appropriate treatment for Post Traumatic Stress Disorder?

A. Clonazepam
B. Sertraline
C. Prazosin
D. Venlafaxine
E. Cognitive Behavioral Therapy

Answer: A
A 32 yo woman presents with vague complaints of chest pain, palpitations, dizziness, nausea, neck and shoulder pain, urinary frequency and diarrhea. PMH is remarkable for IBS, TMJ and GERD and she takes an OCP and an H2-blocker. VS are stable and PE is unremarkable and she is visibly anxious. GAD-7 is 18. EKG is NSR. The most appropriate next step is:

A. Check a CMP, TSH, stress test, 24-hour Holter monitor
B. Lorazepam 1 mg prn
C. Citalopram 10 mg daily
D. Paroxetine 40 mg daily
E. Clonazepam 1 mg daily

Answer: C