



NICE Bites

Generalised anxiety disorder in adults

NICE CG113; 2011

This guideline refers to the management of both GAD and panic disorder (with or without agoraphobia) in adults and replaces NICE CG22 (2004). The recommendations for panic disorder (see over page) have not changed.

Definition of terms

GAD	generalised anxiety disorder
CBT	cognitive behavioural therapy
SSRI	selective serotonin reuptake inhibitor
SNRI	serotonin-noradrenaline reuptake inhibitor
PPI	proton pump inhibitor
OTC	over the counter

Principles of care for people with GAD – see full guideline

Management follows a stepped-care model:

Step 1: Identification and assessment

- ◆ Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:
 - > have a chronic physical health problem, **OR**
 - > do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups), **OR**
 - > are repeatedly worrying about many different issues.

Intervention: education and active monitoring

- ◆ Discuss use of OTC medicines including the potential for interactions and lack of evidence on safety and efficacy.

In people diagnosed with GAD who:

- ◆ have a comorbid depressive or other anxiety disorder; treat the primary disorder first.
- ◆ misuse substances:
 - > harmful and dependent substance misuse should be treated first,
 - > non-harmful substance misuse is not a contraindication to treatment.

Step 2: GAD that has not improved after Step 1 interventions

Intervention: low-intensity psychological therapy

- ◆ Offer one or more of the following, guided by the person's preference:
 - > non-facilitated self-help,
 - > guided self-help,
 - > psychoeducational groups.

Step 3: GAD with marked functional impairment or that has not improved after Step 2 interventions

Intervention: high-intensity psychological therapy; either CBT or applied relaxation, **OR** pharmacological treatment – **see Box 1**

- ◆ Choice of treatment should be guided by the person's preference.

If there is **inadequate response** to:

- ◆ high-intensity psychological therapy then offer a pharmacological treatment,
- ◆ pharmacological treatment then offer a high-intensity psychological intervention **OR** an alternative drug.

If there is **partial response** to pharmacological treatment then offer a high-intensity psychological intervention in addition.

If any of the following factors are present see step 4:

- ◆ a risk of self-harm/suicide,
- ◆ significant comorbidity,
- ◆ self-neglect,
- ◆ inadequate response to step 3 interventions.

Box 1

Pharmacological treatment

First-line – SSRI* e.g. sertraline **N §**

Second-line – an alternative SSRI* or SNRI* e.g. venlafaxine

If unable to tolerate an SSRI/SNRI:

Third-line – pregabalin

Do NOT give a benzodiazepine in primary or secondary care except as a short-term measure during crises.

Do NOT give an antipsychotic in primary care.

* Not all SSRIs/SNRIs are licensed for GAD. Check SPC for individual agents.

N new recommendation

§ Editorial note: NICE recommend sertraline first-line as it is the most cost-effective drug. However, it is not licensed for use in GAD. Obtain and document informed consent.

Monitoring

- ◆ Review effectiveness and adverse effects of drug treatment every 2 to 4 weeks during the first three months and then every three months.
- ◆ Continue drug treatment for at least a year as the likelihood of relapse is high.

Prescribing and Counselling – see Box 3 over page

Step 4: Complex treatment-refractory GAD and very marked functional impairment or high risk of self-harm

Offer a specialist assessment – usually by a community mental health team but may include specialist services or specialist practitioners in primary care.

Intervention: after all other interventions have been offered consider using:

- ◆ combinations of psychological and drug treatments**,
- ◆ combinations of antidepressants**,
- ◆ augmentation of antidepressants with other drugs**.

However, take into account the:

- ◆ lack of evidence,
- ◆ potential for increased adverse effects and drug interactions.

** Specialist use only

Panic disorder in adults

NICE CG113; 2011

Principles of care for people with panic disorder

Management follows a stepped-care model: see algorithm in full guideline.

Step 1: Recognition and diagnosis

Presentation in A&E department or other setting

- ◆ If a person presents with a panic attack, he/she should:
 - be asked if they are receiving treatment for panic disorder,
 - undergo the minimum investigations necessary to exclude acute physical problems,
 - not usually be admitted to a medical or psychiatric bed,
 - be referred to primary care for subsequent care, even if assessment has been undertaken in the A&E department,
 - be given appropriate written information about panic attacks and why they are being referred to primary care, sources of support, including local and national voluntary and self-help groups.

Steps 2 to 4: Management in primary care

Offer one of the following, based on the person's preference:

- ◆ CBT – see full guideline,
- ◆ Pharmacological treatment – **see Box 2**,
- ◆ Self-help:
 - bibliotherapy based on CBT principles,
 - information about support groups,
 - advice on the benefits of exercise.

CBT has the greatest evidence for the longest duration of effect, followed by pharmacological treatment then self-help.

Box 2

Pharmacological treatment

First-line – SSRI* e.g. citalopram, paroxetine

If an SSRI is not suitable, **OR** there is no improvement after 12 weeks, **AND** further drug treatment is appropriate:

Second-line – imipramine** or clomipramine**

Do NOT give benzodiazepines, sedating antihistamines or antipsychotics.

* Not all SSRIs are licensed for panic disorder. Check SPC for individual agents.

**Unlicensed indication. Obtain and document informed consent.

Prescribing and Counselling – see Box 3

Monitoring

- ◆ Review efficacy and adverse effects within 2 weeks of starting treatment and again at 4, 6 and 12 weeks.
- ◆ If drug treatment continues for more than 12 weeks, review at 8 to 12 week intervals.
- ◆ Follow the SPC for individual drugs for all other monitoring requirements.
- ◆ Use short, self-complete questionnaires to monitor outcomes wherever possible.

If one treatment has been tried:

Step 3: Review and consider alternative treatments

If two treatments have been tried:

Step 4: Review and refer to specialist mental health services

Step 5: Care in specialist mental health services

Ongoing management

- ◆ Long-term treatment and doses at the upper end of the dose range may be necessary.
- ◆ If symptoms improve; continue treatment for 6 months at optimal dose then consider tapering the dose.

Box 3

Prescribing: GAD and Panic disorder

- ◆ Before prescribing, consider:
 - age,
 - previous treatment response,
 - risk of suicide and likelihood of toxicity in overdose,
 - possible adverse effects and withdrawal symptoms,
 - possible interactions with concomitant medications,
 - the person's preference,
 - cost, where equal effectiveness.

Adverse effects of antidepressants

- ◆ To minimise adverse effects start at a low dose and gradually increase the dose until a satisfactory response is achieved.
- ◆ Initial adverse effects can be managed by:
 - close monitoring if mild symptoms, or
 - reducing the dose, or
 - stopping the drug and offering either an alternative drug, or a psychological intervention.

Tricyclic antidepressants (TCAs)

- ◆ TCAs are more dangerous in overdose than SSRIs.

SSRIs/SNRIs

- ◆ Are associated with an increased risk of bleeding:
 - give a gastroprotective drug (e.g. PPI) in high risk patients e.g. elderly or those on concomitant drugs which increase gastrointestinal bleeding.
- ◆ Are associated with an increased risk of suicidal thinking and self-harm in people aged <30 years:
 - inform patient of risk,
 - see patient within one week of first prescribing,
 - monitor weekly for the first month.
- ◆ Consider risk of toxicity in overdose – high with venlafaxine.

Discontinuation/withdrawal symptoms

These may occur on stopping or missing doses or occasionally on reducing the dose (especially with paroxetine and venlafaxine).

- ◆ **Do NOT** stop abruptly - reduce dose gradually over an extended period of time.
- ◆ If mild symptoms – reassure person and monitor.
- ◆ If severe symptoms after stopping the drug consider:
 - reintroducing the antidepressant and gradually reducing the dose whilst monitoring symptoms, **OR**
 - prescribe another antidepressant from the same class with a longer half-life.

Counselling

Explain fully:

- ◆ the likely benefits of different treatments,
- ◆ the adverse effects, and any drug interactions,
- ◆ that symptoms of increased anxiety may occur initially,
- ◆ that it takes over one week or more for the full anxiolytic effect to develop,
- ◆ the importance of taking medication as prescribed,
- ◆ the risk of discontinuation symptoms on stopping or missing doses,
- ◆ the need to contact GP if experiencing discontinuation symptoms. The most common symptoms include dizziness, numbness and tingling, nausea and vomiting, headache, sweating, anxiety and sleep disturbances.
- ◆ the need to continue drug treatment after remission to avoid relapse.