Primary care management of anxiety throughout the patient journey

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Our series of commentaries from the Primary Care Neurology Society (P-CNS) provide a primary care perspective on neurology articles featured in Progress in Neurology and Psychiatry. Here, Dr Jane Stephens discusses ‘The pharmacological management of anxiety disorders’ (see page 27)

In their paper, Stephen Bleakley and Simon Davies give us a broad overview of the classification of anxiety disorders. The authors note that psychological therapies should be considered as the first line of treatment before medication, depending on patient preference, previous response and local availability. The majority of their paper goes on to describe the main drug groups that can be used to treat anxiety disorders, and which disorders those drugs can be used with, along with side effects and review schedules.

In this review, I will highlight the areas I found most helpful in the context of primary care practice and make recommendations for managing anxiety more effectively throughout the patient journey.

Helpful nuggets

- In order to meet the diagnostic criteria for generalised anxiety disorder (GAD), the patient must have the symptoms for at least six months.
- There are a range of anxiety disorders, and different drugs have been shown to work with different efficacies depending on the diagnosis. For example, mirtazapine may be harmful if a patient with post-traumatic stress disorder (PTSD) wants to do trauma-focused therapy, and benzodiazepines may be harmful immediately following trauma.
- The best evidence for drug treatment for GAD is with fluoxetine and sertraline.
- The number needed to treat to see one benefit with antidepressants is five in adults with GAD or PTSD and 14 in children with anxiety disorders.
- It is recommended that the patient be started on half the dose one would use for treating depression. It may take up to 12 weeks to see the full effect, which is longer than we allow for depression. During this time, the patient needs regular (two- to four-weekly) reviews.
- It is recommended that treatment is necessary until that patient is back to their normal self plus 12–18 months, depending on the disorder and the patient’s history, before tailing off drug treatment.

Reflections

The diagnostic criteria do not really allow for the multifaceted picture the patient may bring to us – often of several anxiety disorders with depression, along with other comorbidities. The NICE guidelines and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) assume we are starting with a clear diagnosis. We may need a number of meetings to get the diagnosis correct, since this will influence our treatment recommendations.

In reality, a patient is often desperate to start drug treatment for acute anxiety. If the patient is wanting acute treatment, I would be choosing a sedating antihistamine and possibly a beta-blocker over a benzodiazepine. If we are considering longer-term treatment in a recurrent anxiety disorder situation, eg with a selective serotonin reuptake inhibitor (SSRI), and the patient is acutely anxious, we may want to consider sticking with fluoxetine and sertraline. We need to bear in mind the low dose starting point, and discuss the long length of treatment, danger of sudden withdrawal and a possible increase in anxiety initially, and review them regularly until 12 weeks.

We know that anxiety is more common in people with chronic conditions so I would suggest to primary care practitioners that you add a couple of screening questions for anxiety in all your chronic disease templates. I would like to recommend that practices are paid to screen high risk groups for anxiety and would like to see development of a CPD tool for primary care practitioners in anxiety management.

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