Generalized Anxiety Disorder

Take the stress out of managing anxiety in primary care!

Disclaimer

[music]

Matthew: Okay, Paul, looks like we are recording here, which I'll admit it. I forgot it in the past that I was supposed to press record. This, of course, is the Curbsiders. On our show tonight, we are going to be talking about anxiety with Dr. Deepa Sekhar. And Paul, all we also have a great cohost, but let's just leave that as a tease for right now and why don't you tell people, what is it that we do on Curbsiders?

Paul: Sure. We'll build the suspense. I like it. Matt, we are The Internal Medicine Podcast. We use expert interviews to bring your clinical pearls and practice changing knowledge. And now, I'm just going to reveal [laughs] we're joined by the fantastic Beth 'Garbs' Garbitelli. Beth, how are you?

Beth: Doing very well.

Paul: Great. I let you tell us a little bit about our guest.

Beth: Yes. We have the wonderful, Dr. Deepa Sekhar with us today. We're talking about generalized anxiety disorder, which is a very common diagnosis that we see in clinic. Dr. Sekhar is a proud general internist and clinician educator. She practices as a primary care physician and also supervises students and residents in both the primary care and inpatient settings. She loves thinking about how people learn so much, so that she has spent the last two years pursuing a master's in medical education. She's excited about promoting generalist careers in residency and enjoys mentoring learners to find their passions in medicine.

Matthew: Paul, before, I just wanted to tell you a little--

[laughter]

Matthew: A little personal anecdote. As you know, I have a great relationship with my tailor and I'm a little wary that she has anxiety. You know why?

Paul: She's all wound up.

Matthew: No, actually, she seems stressed. Paul. She's a seamstress and she seems stressed. So, I'm a little worried about her.

Beth: Wow. [laughs]

Matthew: Anyway, any thoughts, Paul, or should we move on?

Paul: Not so much. Let's just sit with it.

Matthew: I will sit with my shame. All right. Thank you *to 32hilariouspuns.com* for that joke. Anyway, I wanted to remind the audience that this and most episodes are available for free CME and mock credit through VCU Health at *curbsiders.vcuhealth.org.* I think now it's time we get to our guest. Deepa, thank you so much for sitting through that--

[laughter]

Matthew: -Which is most certainly a very painful intro. But welcome to the show and can you please give the audience a one liner about yourself and a hobby or interest that you have outside of medicine?

Deepa: Yeah. Thanks for having me. I'm excited to be here. I was holding in my giggles, because I didn't have the mic, yet, but that was a fun intro. I am a 34-year-old general internist. I have moved across the country for my training and excited to be here back in person at SGIM, meeting all these people that I've met over the last couple of years, again. Hobbies outside of medicine? I am going to be very honest. The pandemic gave me a lot of very common pandemic hobbies, and my cooking is better, and my gardening skills are better, but my dog is still my biggest hobbies. So, we have a lot of fun, lots of walks, and she gives me a wonderful company when I get home.

Paul: Yeah. Once again, we return to our most well-adjusted guests are gardeners.

Deepa: [laughs]

Paul: Why all my plants die? My usual, any book, movie, TV show that you've recently enjoy that you think our listeners would also enjoy as well?

Beth: Yeah. I'm actually reading this book called *American Dirt*, which is fantastic. I think it just gives a lot of the human perspective to a lot of what we hear in the news, highly recommend. I've actually spent this year reading more about political-war type stuff that [unintelligible [00:04:06] the country, but really just to understand the humanistic part behind it. So, it's been very informative.

Matthew: I thought this was going along with your gardening.

[laughter]

Deepa: Yeah.

Matthew: I totally was not what I was expecting.

Beth: Another question we'd like to ask and especially, as I'm rising almost intern, do you have any advice for folks, who are about to start intern year?

Deepa: Ooh, good question. Intern year, it's just a lot of learning and you're going to feel like you're blindsided at so many different turns. But I think approaching it with a growth mindset, I like to say as an educator and you're there to learn. So, soak it in, learn from your patients, learn from the people around you, learn from your peers.

Beth: Awesome. Love that advice.

Matthew: We did our 'Becoming a PGY1' episode, some of the advice from that that stuck with me was, I believe it was a program director survey and Alex Glaser, who's now a program director himself was saying that, "One of the things they want is just essentially people that are functioning well in the hospital, working well in teams, they've worked on their efficiency, we don't necessarily care if interns have the greatest differential diagnosis in the world." I think that unburdens people, just focusing on learning to do the job well and then as a second and third year, you really build your medical knowledge, and your differential, and all those things.

Paul: Which is when you actually have the time to do that, I think.

Matthew: Yes.

Paul: You're so overwhelming, you probably have too high expectations to yourself.

Matthew: Yeah. First week, find the bathroom.

Paul: Right. [laughs]

[laughter]

Matthew: All right and then probably, by the time this, this probably dropped at a good time for this to be in our first 10 minutes of the show, because I think this is going to come out just before intern year starts for people.

Beth: Yeah. I've been getting ready asking that question every episode I've been on for the past year or so.

Paul: [laughs]

Beth: You guys have to always have an episode ready.

Matthew: Right. Well, before we get into it, I think we probably have time, Beth, if you had a pressing pick of the week, we could take one from you, but no pressure.

Beth: I'll give a quick pick of the week, because I read it on my way to SGIM. I'm almost done with it. Notes from a young black chef, fantastic read. It's about one man's journey through the culinary world and his story. It's going to be made into a movie. I could go on and on. It's excellent. Highly recommend reading it. Especially, when we're so used to seeing so many books about chefs or people in kitchens, who are white men. So, it's very refreshing.

Matthew: Well, let's get on to a case from Kashlak, because we have a great topic. We're going to talk about anxiety disorder here and Beth, can you start us off?

Beth: Yes. We're in clinic today and George is a 39-year-old man, who presents for his annual wellness exam. He reports that he's been in okay health the past year, although he's been concerned about worsening insomnia. He says multiple times a week, he's waking up before his alarm goes off and feels overwhelmed with worry about the day ahead. Often, he cannot get back to sleep. He reports he's worried about his finances, his job stability, current political affairs, pandemic, his physical exam is within normal limits and basic labs drawn prior to his visit show no abnormalities. So, we're giving away the spoiler alert of the what we think this might be going on with this patient with the episode title, but how would you approach a patient like this that you saw in clinic?

Deepa: Yeah, this is a great case. Patients present this all the time in their primary care setting. That report of been doing okay and having insomnia, I think is just so classic and they're not always going to come to you and say, "I have anxiety, I need help." Our job as the generalist is to tease out that information, and pick out these little features, and help get more information from the patient, and help them understand perhaps what they're feeling, and then help us understand all of the different parts of what they're feeling, and put it together that it might be anxiety disorder.

Beth: What are some red flag symptoms or things that you hear in a history that cue you up for anxiety disorder or physical manifestations that are very common for generalized anxiety disorder?

Deepa: There're so many things. The first thing is really the general exam of the patient right, so we write that general partner physical exam and maybe don't pay so much attention to it. But how they're sitting with you in the room, are they engaged, do they want to give you information or they hesitant to reveal that they've been struggling over the last year? And that sometimes, I think, is why the insomnia comes up first. They can tell you they're having trouble sleeping, but maybe you're having a little bit of trouble articulating why they're having trouble sleeping. And then using that insomnia and asking more questions, so, do you feel your muscles are tense, do you have headaches, anything else bothering you?

Then the other thing that cues me off is, in our general, in a well visit intake, new patient going through the social history and smoking or alcohol comes up just exploring that a little bit more, especially in the last two years, patients will say, "Yeah, I've been drinking a little bit more than usual or I've been trying to quit and I just haven't been able to quit smoking, and I haven't been able to." And if you explore what the barriers are often, if they're presenting this way, anxiety is one of the reasons they're reaching for another cigarette. So, listening for those little cues, so that you can jump in and find anxiety disorder.

Paul: Can I do the typical Paul thing and ask us to step back and just define our terms? Because we're getting to the symptoms of something without-- I don't think we've really fully defined it yet. I certainly, we don't need like the DSM-5 criteria. But can you just give us your overall conceptual framework for what general anxiety disorder is [crosstalk] that we get into how it might actually manifest?

Deepa: Yeah. I actually think that defining anxiety disorder is a little hard. It's a little vague. It's excessive worry. The DSM-5 says that it needs to be for six months. I struggle with that a little bit, because patients are struggling for one month, two months, three months and they're coming to you for something related to their anxiety disorders and we can get to that a little bit later. But excessive worry and that can be-- worries that keep you up at night. You're irritable with other people, you're having trouble focusing, because you're worried about other things happening or something catastrophic happening. As we get into symptoms, listening to those little cues are so important, but you're right. Knowing what you're listening for I think is important, since that's how I picture generalized anxiety disorder.

Matthew: When you go to code this in a note, there's panic disorder, anxiety, there's agoraphobia, there's all these, but I generally just, maybe this is the wrong thing to do, but I just consider this person has anxiety, and then maybe I'll treat it differently if there's panic present, and I'll explore some other-- how it's affecting their behaviors or their social interactions. But I think I haven't personally used the DSM criteria. It's not I'm checking boxes in the clinic. I'm not sure Paul if you have the same kind of approach.

Paul: I think I'm anxious to be corrected if I'm doing this wrong. But part of the issue, I think, is that the world is on fire and it's just been-- We've had catastrophic couple years. I think by most of the DSM

stuff is whether it actually has functional impairment or not. I think I'm expecting some anxiety from everyone, which is probably not the right thing. But I think the disorder part is when it actually has functional impact and I agree with you, Matt. I just think about it as a broad term as opposed to really narrowing things down, specifically. But I do sometimes have a hard time. I was going to actually ask you, if we're seeing more of that with recent pandemic, I think, probably the answer is yes. But I guess, since you're the expert, I'll just ask you find out are we seeing more anxiety with?

Deepa: Yeah, we are. Surveys and all of the data supports that we're seeing more anxiety, unfortunately.

Matthew: We're picking a lot of it up on the just the-- They start with the PHQ-2 and a lot of the times I'll get a positive on that. And then I generally, we have a form that has both the PHQ-9 and the GAD-7 together, and I'll pick up how they're functioning and I'll be like, "Oh, actually, depression is not the big thing. It's actually anxiety." I think part of what I'm trying to make the point with this is that, I was always thought that I could see the patient that's anxious, but sometimes, I have a patient very reserved in clinic, and they're just holding it all in, and they're very anxious, and I don't see it until I am going through a questionnaire with them. So, I think I'm not sure what it is, but where people say, "Oh, yeah, if you leave the room feeling anxious, the patient's anxious," but that doesn't always hold true in my experience.

Deepa: Yeah, I completely agree with that. I can think of so many times, I'm actually surprised that anxiety comes into the picture. They either look like they're shy or perhaps, they have depression. But then they will say something. Either the sleeping or stress at work, something will come up. And then, as I'm typing notes and trying to be efficient, I will turn around and be like, "Oh, tell me more." And that's where it comes out and I think that's the primary care piece there that tell me more, I want to hear more, that helps us figure it out.

Matthew: Yesterday, at SGIM, we were talking at lunch with Dr. Saul Weiner and he was telling us about that just listening for those things when the patient's giving you the history that are clues and if you don't pull that thread, you might miss something important. I think with mood disorders, anxiety, depression, that is definitely part of the case. I mentioned some of the scoring systems. Do you have a favorite one that you would recommend to the audience?

Deepa: I use the GAD-7 often. I think it's helpful for me and the patient actually. As I'm talking to them, I'm getting some hints that there might be some anxiety or perhaps, they've even brought it up themselves. We'll go into I think a little bit later the differential diagnosis of an anxiety disorder. I think the GAD-7 asks questions that help you parse that out, and will clarify to you and the patient, perhaps, how severe the symptoms are, and then get into functional impact. And then as we talk about next steps for treatment, if it's somebody that's a little bit more hesitant, I can show them on the GAD-7 or as they're answering the questions and they tell me more than half the day, every day for everything, it starts to hit home for them, too.

Matthew: And for tracking over time, I think it works to track it over time as well.

Deepa: Yeah. It's helpful as a baseline. And if you do either therapy or medication treatment and follow up with them, you can redo the GAD-7 and see if it's improving.

Matthew: Yes. I think it's really helpful for partial remissions too, because Paul, you get these patients that they're still not feeling great, but sometimes you can say, "Well, you were a 14 and now, you're a seven. So, we have made some improvement. You're not in remission yet, but what we're doing is working at least a little bit and you can explore from there."

Deepa: Mm-hmm.

Beth: And how do you think through the differential for this in terms of other comorbid disorders they have or physical complaints? Are there any labs you like to order in this initial workup too?

Deepa: Yeah, I think maybe let's take a step back and just talk about the differentials though. When patients come in, I think their complaint is what will tip me off to the other parts of the differential. Commonly, we think of ADHD, panic disorder, OCD, I think I normally am trying to parse your anxiety disorder, ADHD, and panic disorder, those three things more commonly in my setting. The things they tell me, "So, I can't sleep, because I'm worrying or is more likely to me an anxiety disorder" and then we'll flush out the rest of it. If they're feeling anxious that's episodic in different settings, and they can tell me what the setting is, and they start to have all of these very intense physical symptoms all at once, definitely thinking about panic disorder.

And then ADHD, I think is very difficult to diagnose in their primary care setting, but there are things that will tip me off. The trouble concentrating, perhaps not because they're worrying, but they're just having trouble concentrating and it's affecting them in multiple settings. Oh, and the last thing I want to throw in is, is this hyperactive part that some people have with anxiety and the insomnia, is there may be some hypomania and I need to be thinking about bipolar disorder, because that will affect treatment down the road?

Paul: Is there any other disease states you're looking like you're routinely for say a thyroid dysfunction-

Deepa: Yeah.

Paul: -or a person who is with insomnia, who has the right phenotype, are you doing polysomnography before you --?

Matthew: Come on, Paul, you got to get that TSH.

Deepa: [laughs]

Paul: No threshold. But even though we talked about it in prior episodes palpitation patients often mislabeled as anxiety, who actually have SVTs and stuff. So, I guess, is there any other objective testing you're doing other than I think some of the questionnaire stuff just to make sure that we're actually treating the right thing?

Deepa: Yeah, no, I think that's a good question. I think I agree that just getting the TSH is a low threshold and especially in a young woman or in a young patient doing that is helpful. But yes, palpitations, what do they look like when they're sitting in front of you? The exam is still a very important part of all of this. Did it happen all of a sudden when associated with other stressors or have they been told for a while that they are look anxious, they're hyperactive, but maybe they don't really think they're anxious? So, that might tip me off for a TSH.

The other organic medical, those are the wrong words for this. But things that might get me concerned are chest pain and shortness of breath that patients have with anxiety, especially panic disorder, and I will do my due diligence as a primary care doctor. We don't want to miss those things. Asking a pertinent review of systems is still important.

Matthew: I think in general, my practice is to not immediately jump to anxiety as the diagnosis for any physical complaint just because I think the downside is too high. Paul, do you have a similar approach?

Paul: Well, we have the diagnostic instruments, too. I think that's the other thing is, I think I sometimes see people rely on gestalt to make the diagnosis, which is, there's a role for, but I think just because someone seems anxious to me is not a reason to diagnose them with anxiety. I think we have better diagnostic criteria for them.

Paul: And do you assess suicidal ideation in these patients as soon as you start to think about this?

Deepa: Yeah. Once we get through the questions and I think I leave it a little bit to the end. If a patient isn't thinking that they're having an anxiety disorder already and this is new information to them, I let it sink in and then I pause and I say, "I have a serious question and this is a safe space, but have there been any thoughts of harming yourself or suicide in the past?" Just you have to make sure. Again, that you're not missing it. So, important to still do that.

Matthew: I think maybe to summarize what we've talked about so far. We were talking about George, our 39-year-old guy, we're thinking might have anxiety. We said that we like to take a pretty comprehensive history, part of the differential that you're thinking about as you're taking your history is you said, ADHD and panic disorder, I think we may be hinted at substance use could be a part of it as well. In his case, you were trying to tie maybe anxiety and insomnia together. And then the other thing was OCD, was one of the other ones that you would ask about and asking them part of what helped you, if it was panic or another situational anxiety is just asking like, what situations is it occurring?

Deepa: Yeah, exactly.

Matthew: Am I missing any of the big pieces so far? Maybe we can give George-- Beth, do we have a score for him on the GAD-7? I think 10 to 14 is the moderate range, and above that is severe, and scores low or mild.

Beth: Let's say he's around 14. We've done a nice review of systems with him, we've talked to the GAD-7, he doesn't have any comorbid substance use disorders thankfully, and no SI. But when you bring up this diagnosis based on the survey, he's really taken aback by the suggestion of this as a diagnosis. How do you counsel a patient, who's surprised by being diagnosed with something like anxiety?

Deepa: Yeah. Usually, as I go through the GAD-7, I can see them, their wheels start turning, and they're reflecting. But I think it is commonly a surprise to patients, either because there's stigma about mental health disorders or they're just not thinking about and they haven't been around other people that have had similar challenges. If I noticed that they are surprised, I'll explain that I'll normalize it. It's a normal thing. Mental health disorders are very common. I'll start by normalizing it and I will say I see this very often. The good thing is that we can offer help. There's therapy, there're medications, but it's really what you want to get out of it. I think giving them a little bit of ownership over this new diagnosis that carries some baggage with it in the world that we live in, it helps a little bit. You're struggling with this, what are you hoping that we can get to as we start to talk about maybe some treatment or therapy, what parts of this are really impacting your life functionally that we could maybe address and ease that burden?

Matthew: As we're going to get, I know into talking about treatment, I find it's helpful. If someone's coming to you and their plan was to talk about an anxiety or a mood disorder, oftentimes, they will maybe have researched medications or talked to people who've been on medications and they want to try the same thing that the friend or family member has gotten. Or, they know, they definitely don't want meds and they want talk. I find that I usually try to explore that conversation as well. I think this situation here is one where, if you're taking it by surprise, then the patient is, it's a totally different conversation.

Deepa: Yeah.

Matthew: I think there's non-pharmacologic and there's pharmacologic therapies. Are there any just big general principles that you like to counsel patients about at that first visit just things they can do right off the bat to help?

Deepa: Yeah. A little bit of background I think for that is, one, I think commonly patients are nervous about medications, unless they're already coming to you asking. But for those that are surprised by it, medications are not usually an easy thing that they're receptive to. Sometimes, the therapy also has some stigma with it, too. The association for anxiety and depression, actually suggest there's several societies out there that suggest a lot of basic things upfront. In this parry pandemic world that we live in, where it's really hard to find mental health providers, because everyone is full, what can we offer to our patients that they can do on their own. It sounds basic and simple. Ensuring a safe home environment, good sleep, access to food, and I know I said that, that sounds simple and I know it's not simple for a lot of people.

Making sure that you're addressing those social needs first. Exploring sleep. Sleep is a big part of anxiety and if we can do something to help them get better sleep then that might improve the symptoms that are impacting their daily life. Really starting at the basics is important to remember as a primary

care doctor. I think that's where we all are focused and we know that that's important, but I think that's what we can offer to that perhaps other places.

Matthew: If you forget, I know there are simple things to ask about not simple things to fix, but if you're trying to just load on medications to a patient that just doesn't have some basic needs, or sleep, or food security, whatever, safety in the home, then it's an uphill battle. So, I think it's a great place to start with this.

Deepa: I'd also add, I think patients have more coping skills than they think. Helping them reflect on that, too, so, what do you do in these situations that's helpful to you. Is there anyone in your family or your network that you can rely on? And I've had patients that say, they don't want to see a therapist. They feel really well supported and they think they can get through this for now. Or, maybe helping them identify who those people are. So, those are things that are within their reach and in a more timely fashion than just a referral.

Matthew: I think we're going to talk about medications and that's probably what the audience is going to want to hear about. I think some people are more comfortable than others prescribing. Is that where you wanted to go with this next, Beth? Are we missing anything else in the plan here?

Beth: Yeah, the only thing I was going to check in is, if you had any plugs for some of the apps.

Deepa: Yeah.

Beth: Websites, folks can use workbooks, any suggestions on those kinds of things, who wants--? [crosstalk]

Deepa: Yeah, so, a couple of things and I guess, I should say, no disclosures at this point, I'm going to mention some apps. But before we get to the apps, there are some mindfulness techniques that you can just offer in the exam room that's very quick to go over. Focused breathing, it's hard for someone that's anxious to take slow, deep breaths. I actually have them take their hand out show me a high five, and I have them trace their finger up and down. Deep breath in, deep breath out as kind of a calming mindfulness modality. There is the rapid muscle, I think I'm saying the term incorrectly, but essentially, clenching your muscles in sequence and drawing on the difference between a stressed clench state and then a relaxed state is one that's been shown to be effective.

And then the apps, so the hard part about apps is the data isn't perfect, because they haven't been perfectly studied. But actually, the apps that most people will recognize do have some randomized controlled trial data that shows that they help, so Calm, Headspace, and then Worry Knot and I think Worry Knot is free, are some apps that I'll suggest to patients.

Matthew: Paul, do you feel comfortable starting medications for anxiety? I imagine you probably do. Do you have any favorites or where do you want to start with this discussion about medications?

Paul: I feel relatively comfortable. I'd be happy to hear if I was wrong. I feel my usual choice is probably SSRIs for most patients, but I would obviously like to hear from our expert if there're any other broad classes that you'd like first. Actually, I think a better way to ask the question is, what is your overall treatment approach? How do you think about medications or anything about prescribing anxiety?

Deepa: Yeah, I agree. SSRIs is where I reach for. I think a little bit about which SSRI depending on what their symptoms are, so the activating ones versus the sedating ones. That's really all we have to go off of based on data. There's data that, if a medication has worked for a family member, perhaps starting there, and then I'll even ask if a patient comes to me with questions like, if there is one they want to start, because as a class, there's not a lot of differences. I will probably just go with that. Then the other thing is that, some of them have a shorter half-life. So, in counseling them, when we start the medication, that's another thing that I'll think about.

Paul: Are you using-- or well, yeah, I'll just ask. Well, actually, no. I actually use the Mayo Clinic shared decision tool for the depression, because it's still the same medications, the classes of medications to go through with patients, what potential side effects there are and what features that most interests them? Because even though, we're dealing with anxiety here, I still think that tool itself was really helpful and having the patient choose their medication with you gives them ownership of their treatment and improves adherence to some extent to. So, I'm not sure is that a tool that you use as well?

Deepa: It's not, but I'm going to steal it. That's a great idea. I love educating the patient as you go through that. Yeah.

Matthew: I wanted to go back to the activating and sedating SSRIs. Can you tell us a little bit about that? I think it'd be really helpful for me personally to get a little bit more in depth on some of these [crosstalk] that I think we're probably using, but some of the nuance about it.

Deepa: Yeah, I think as I was transitioning from residency to primary care, it was just a class and I was like, "I don't know we pick one." [laughs] And then part of that is counseling the patient like, "This is going to be a little bit of trial and error. You should be prepared for that, because it can be disheartening if you start them on a medication and it's not working." But the activating ones, I think are helpful to know, because most patients with anxiety are struggling a little bit with that hyperactive difficulty sleeping. So, sertraline and fluoxetine are more activating. And then the sedating ones are paroxetine and somewhat citalopram.

If they're having trouble sleeping, I will start with paroxetine or citalopram and avoid sertraline or fluoxetine. But those tend to work really well too just from practice anecdotally. So, it's hard to just stay away from them. But if we're starting from scratch and they've never been on something, that's what I'll do.

Matthew: And I saw in your slides and this has been something that I think I've just come to by default is prescribing at the lowest dose and sometimes, even all, let's say sertraline, for example.

Deepa: Mm-hmm.

Matthew: I might start at half a tablet once a day, because I just find that some patients just seem to be too amped up or they're just so sensitive to the side effects. If you start them at too high a dose and they get side effects, then they will not touch that med again and you might have lost even the whole class.

Deepa: Yes, yeah and I think I agree with that and that's where the counseling comes in. But starting especially with sertraline, starting with a lower dose and then you can also think about bridging them a little bit. I do use hydroxyzine and sometimes buspirone, which we'll get in a second.

Matthew: Oh, okay.

Deepa: If they're very anxious that sertraline, it's going to take a couple of weeks to really feel the effect and as we walk them up. I will bridge, I will offer hydroxyzine as a PRN, and then I will think about buspirone, because they tend to feel those effects a little bit sooner. The other nice thing about buspirone, it's not a PRN medication, but sometimes patients like the fact that they can take something twice a day. It gives them a little bit more control. And then generally speaking, if you started them on an SSRI and you're partial, you've gotten halfway there, buspirone is your next step for augmenting. So, if you need to start it earlier on, that is something that I reach for, for more of an immediate effect.

Matthew: I think the patients' that-- With a guy like George, the patient that we've been talking about, he's coming here. He's surprised by his anxiety. But I've certainly and maybe Paul's experienced this too, where you get the patient that's just like, they're anxious, they're crying, they want to feel better immediately, and then you're like, "Okay, I'm going to give you this medicine. Two, three weeks, you're going to feel great." [laughs]

Deepa: Yeah. But maybe you won't, because then we have to try something else, right? [laughs]

Matthew: Yeah. In very specific cases, I think about benzodiazepines, but I like the idea of-- I hadn't really thought to use hydroxyzine or buspirone as a bridge. I think that's a great idea. What would a typical dose look like for either of those agents, if you're doing this?

Deepa: I think it depends a little bit on the patient. Buspirone side effect is that they can feel a little orthostatic after you start it. If it's a young, lower weight female, I tend to start a little bit lower, because they are a little bit more susceptible to those side effects. I start five milligrams b.i.d. being a very, very low dose, but I'm worried about the side effect. And then 10 to 15 milligrams b.i.d. is a starting. If it's a patient whose distribution is going to be a little bit more stable, then I'll feel more comfortable starting and their anxiety is very prominent I also feel comfortable starting at 15 and amping them up pretty quickly, 15 b.i.d. and going up quickly.

Matthew: That's a great tip. Yeah, I will have to think about that next time in that situation. Paul?

Paul: Hydroxyzine and I'd love to hear your experience. This seems to be effective for patients, where insomnia is a big somatic manifestation of their anxiety, so just a little bit of hydroxyzine at night is

sometimes very, very helpful. The SSRIs kick in for younger patients, because the anticholinergic effects and it's an anti-histamine, it's not something I would do with my older patients. But for someone, who's young and does not have a lot of comorbidities just a kiss of anti-histamine at nighttime [crosstalk] is sometimes helpful.

Deepa: I'll add to that bridging idea of perhaps, gabapentin and pregabalin. If there's some other neuropathic pain, I'm thinking about it and I want some bridging effect, and then also, the nighttime sleeping. Maybe a small dose of gabapentin at nighttime as we're waiting for the sertraline, for example.

Matthew: Right. From what I remember from our sleep medicine shows, which we've done several-- The gabapentin dose for sleep is 100 to 300 milligrams before bedtime. It's not 900 [crosstalk]

Paul: The 300 that everyone gets.

Matthew: The 300 that everyone gets. Yes. What we've talked about so far, medication wise, the SSRIs, some of the ones that may be more sedating were paroxetine and citalopram. The sertraline is one of the ones that was more, you said maybe more activating. We were talking about starting at a lower dose, because you don't want to make someone more anxious in the near term. And then bridging with either maybe hydroxyzine as needed or buspirone twice a day at a lower to intermediate dose depending on the patient's size, and then gabapentin is another one we could think of, especially if we're cross purposing it for maybe something else going on with the person. Anything else on SSRIs before we move on to some of the other classes?

Deepa: In terms of starting, I think those are the big things to think about. And then we talked a little bit at the very beginning about other comorbid symptoms. IBS, GI symptoms thinking more about the SNRIs in those situations, but I do still usually go to the SSRIs.

Matthew: What does the follow up look like when you start somebody on a medicine and how are you counseling them to uptitrate?

Deepa: Yeah, I think about it in a couple of ways like when are we going to make some contact and how that contact is going to happen? Again, thinking about like their lives and somewhat virtual world we're in still. Four weeks, because I especially with severe anxiety, I want to check in with them. Even though I offer to patients, let me know if you feel you're having side effects or this is really not doing the trick, we can switch you over before I see you again, they usually don't reach out. So, I make sure to have an appointment on the books pretty soon to make sure we're making progress and things haven't gotten worse than we don't know about it.

Matthew: And if you're lucky enough to have a behavioral health person, we have a social worker in some of the places, where I've worked multiple places at this point, where I was able to tell them, "Hey, I started this person and they're both starting some non-pharmacologic therapy with that person. That person will let me know if the medicine isn't going well." So, if people have that resource, it really helps,

because they can do that two-week check in and you don't lose that month, person took one dose and stopped it, because they feel well.

Deepa: Yeah. It's great if they're already seeing a therapist or they're able to see a therapist. Unfortunately, in the last couple of years, I've just had a really hard time getting a therapist available unfortunately. So, I make that happen--

Matthew: Yes. Okay. Well, what about the SNRIs? Any nuance there that you wanted to point out to the audience? Are you also starting those at lower doses than you would in somebody that's having a depression? Can those be activating as well? My impression was maybe they could be.

Deepa: Venlafaxine, I worry about because it's short acting mostly. If the patient is very sensitive, I think, to taking the medication and perhaps, not taking it at the exact same time the next day or something like that or missing a dose, I'll be careful about venlafaxine. But if that's not an issue, I do prefer venlafaxine over duloxetine. There is some data that it's more effective than duloxetine at anxiety symptoms specifically.

Beth: Are there any side effects in particular for this entire class SSRI and SNRI that you let folks be aware of or be thoughtful about? Because if people google these, of course [crosstalk] laundry list?

Deepa: Yeah, I'm glad you brought that up. In patients that already have anxiety and they're worrying about things, if you're going to introduce another side effect that they haven't expected, you could amplify. Counseling your patients on side effects is very important. GI side effects, being the most common and I find that usually, if we walk through it ahead of time, they're much more calm about it and when I follow up. Sometimes, patients are starting to have those symptoms. They actually want to just see if they go away over time, instead of switching immediately or just giving up. So, GI side effects decrease, sexual interest is another one and I counsel patients, "It's hard to know if that is from increased anxiety or the medication. So, let's try and we can always switch later."

Paul: Let's say we start a patient on paroxetine. We like stating effects. It's the one you've chosen together through shared decision making and then the patient returns to you and he's experiencing some of the sexual side effects, so he might be concerned about. Say, he has decreased libido, or anorgasmia, or what have you. Is this a case where you would do augmentation with bupropion or how would you address this specific concern?

Deepa: Yeah, that's a good question. I think I do two approaches and I discuss it with a patient. He's feeling better. It's hard to taper him off and switch him. But one option is just doing BuSpar on by itself or he's feeling better, but still having some symptoms and adding bupropion on. The benefit of that is that, it actually can decrease the sexual side effects of SSRIs. It's not one that I would start by itself in anxiety disorder upfront. So, that's something that's important to remember, because it can increase anxiety symptoms, but adding it on after the fact if you're worried about side effects down the road can be helpful.

Matthew: I did not know that. You're saying that if someone's on an SSRI having sexual side effects, and you add bupropion it somehow mitigates [crosstalk]. Total knowledge gap there for me. Oh, that's good, good to know. With the sexual side effects, I do find that that's one in general just that patients especially, male patients are worried about with going on this. I guess, we gain would be the other big one that folks worry about as well with this. For the agents, I believe on our Obesity Medicine episode we recently did, fluoxetine was one of the ones that was less associated with weight gain is what she told us. But do you have any other tips there for?

Deepa: Yeah, I do have patients concerned about that as we start them, because I think they hear that from either other people or in the lay media. I don't have anything specific. I just say, "Let's weigh the benefits here. This anxiety, it sounds like it's impacting your life. I think it's worth trying." I think for all of the SSRIs, the data is uncertain. I say that maybe it's a possibility, but it's not really clear that the effect is there. [crosstalk]

Matthew: Yeah. We're aware of it ahead of time, at least say, let me know if you start to notice the weight gain, because then we can switch you to something else. That's part of my strategy. I think the SNRIs maybe have less weight gain. So, if that's a concern, then [crosstalk] think about those agents, but--

Deepa: And then bupropion, again, would be another one. Yeah.

Matthew: Okay. Before we talk about some of the other types of agents, what would be a typical treatment duration? How do you talk to patients about that? I like to use the term like exit strategy, when I'm talking about this. So, what is it? What would that look like?

Deepa: Yeah, that's a good question. I think sometimes patients will bring up the idea of being dependent on a medication, because again, there's the association with the history of benzos. One counseling that the medications are not dependent and we can taper you off in the future once we get you stable. There's some data that it's actually helpful to treat patients' anxiety disorder to a year. If you stopped them at six months, those patients had a higher relapse in the following six months and the ones that were treated out to a year.

And then the other addition to that is, if they're also getting, had CBT or undergoing some therapy, they're less likely to relapse, so that plays in. But thinking about I think at that one-year mark and earlier if they seem very stable, and they have other tools from therapy that are helping them, and then tapering at that point.

Matthew: And is it a taper over weeks, I would imagine? You come down by a certain percentage and every week or two?

Deepa: Yeah. I knew [unintelligible [00:39:50] to little bit different depending on which one and mostly, because especially, with the short-acting ones, in a patient with underlying anxiety, the first thing I do is I say, "Let's back off slowly if you notice your symptoms, return and let me know." Because the last

thing is we wanted to stop it and have the same issue again. But with citalopram and venlafaxine and I believe paroxetine, the shorter-acting ones, I back off very slowly.

The way I decide how slowly to do it is actually to ask the patient like, "If you miss a dose or if you take a dose later in the day, do you notice?" And if that's the case, I have decreased venlafaxine increments at two weeks very, very slowly. And then for the longer-acting ones, you can do it a lot quicker. So, a half a dose every week probably and get them off probably in two weeks.

Matthew: Excellent.

Paul: And I should have asked this earlier and I'm sorry to kind of throw this in out of order. But I would love to hear your script for how you counsel patients, how they'll feel after they start the medications? Because often I don't want to be a zombie when I start this first. Maybe [crosstalk] I don't think there's a great grasp of how psychotropics work in general and I always struggle with how to address their concerns without being dismissive. Could you just talk me through how you talk to patients about how they'll feel differently once they start the medication?

Deepa: Yeah. I think the big thing to tell patients, it's quite honestly, for every person, hard to know how every person will respond. I will say that upfront. If and this idea of having some fogginess, I think is heard a lot from other people. The data is, again, a little bit equivocal. I will say, "If you feel that way, let me know. We can change the dose to a nighttime dose, so, you're not feeling that as much. But if you're feeling it, it might be part of the medication. So, we should talk about it."

And then thinking about how your anxiety is starting to change or your panic episodes are starting to change, for some patients that can be helpful to keep a diary, so that they see that progress. I will say that with a caveat in some patients with a history of trauma or a natural disaster type of setting, journaling and keeping track of these things without guidance can be triggering. That's a little bit of a caveat. But guiding them on what to look for that side effects, if you feel them, they could be real, please tell me, so that they know that you're going to listen and hear them.

Matthew: I wanted to bring it to, in your talk, you had a slide. This was from [unintelligible [00:42:21] and the International-- some journal of psychopharmacology. And it had all these different agents we've been talking about, SSRIs, SNRIs, benzos, hydroxyzine, buspirone, quetiapine, and pregabalin. Paul, what do you think was the most efficacious in that based on these studies that they were looking at? Which one of those agents would you guess? There's probably the one we use all the time in primary care, right?

Paul: Oh, yeah. No, that's the one I have the most familiarity with.

Matthew: [laughs]

Paul: Certainly, not something like an atypical antipsychotic.

Matthew: Right. Yeah. Was that surprising to you, Paul? It's not something. I can't say. Have you prescribed quetiapine for anxiety?

Paul: For me it's more akin. I kicked down the road and something I will start and although so it's not something I have a whole lot of comfort with.

Matthew: Good thing. We have an expert here with as well.

Deepa: [laughs]

Matthew: I just love it.

Paul: I'm not the expert.

Deepa: Well, I will say, my primary care kindred spirit, it's not one that I use a lot. If there's really bad insomnia and we're not getting anywhere, whether an SSRI, quetiapine can be helpful. Again, the important thing to know, there is the side effects are very different than the SSRIs we've been talking about. It's important to know that. A lot of metabolic side effects that you as a primary care doctor are going to be comfortable treating, but knowing that you have to watch out for them. But if that's where we are, it's really a trigger for me that psychiatry needs to get involved and we've done our due diligence as a primary care doctor to try the other medications first.

Matthew: Yes, I think that-- Most of my patients have metabolic syndrome already, so I hesitate to give them a medicine that is most surely to give it to them. Quetiapine, is it being used as monotherapy in some patients or is it being used in addition to SSRIs, SNRIs?

Deepa: I think it's usually in addition to especially, in the primary care setting, I've never seen it uses monotherapy.

Matthew: Right. I think we always like to ask about when to refer. Certainly, if I'm starting to think that, I need to delve into atypical antipsychotics. I typically don't touch those or certainly, not without a prompt referral. What else might make you think someone needs a referral for an anxiety disorder?

Deepa: I think if we've tried a couple of classes of medications and honestly, we're having trouble finding a therapist for the patient. That's when I'm going to reach out to you. There are psychiatrists that's tied in with the clinic or hopefully, a psychiatrist. Again, everyone's busy. So, whether they can get in is a question. But trying multiple classes of medications, still seeing the patient really struggling in terms of impacting their life, then I will reach out for help. And then if we've exhausted our options and we haven't seen the improvement that the patient is looking for, that is definitely a place to refer.

Matthew: We talked a little bit earlier in this, but I want to bring it back to benzos. When are you reaching for those? I always really hesitate to [crosstalk]. We mentioned exit strategy. I will have a very clear-cut exit strategy and maybe some sort of a patient contract if I'm starting those.

Deepa: Yeah, that's a hard one. I can probably think of one instance, where I have de novo started benzo on someone that has not been on it in the past. And I only done it when starting a better medication. That's in a patient that is very anxious. It's very much impacting their daily life. I'm not sure that waiting two to four weeks for the medication to help out is going to be enough for the patient. I will only do it if they have absolutely no history of any type of substance use. And then actually exploring the home setting and knowing the other things that have gone on, have they reached out to other people for help really taking good social history with a lot of caution.

Matthew: And what about for panic as well?

Deepa: Yeah.

Matthew: Our patient, we gave you as generalized anxiety, but if someone's having very clearcut panic attacks, is that the same kind of conversation still or do you give people--?

Deepa: I think I entertain it more frequently with a panic disorder, but I actually still try hydroxyzine first and see if they have help. If it's not working, then we can go there. But hydroxyzine with a beta-blocker, we have to try that before we get to benzos because those are usually effective.

Matthew: Okay.

Deepa: Yeah.

Paul: Do you have a favorite benzodiazepine that you prefer, that you use commonly in clinical practice?

Matthew: Yeah, Paul, there's still way too much alprazolam out there. It just crushes me every time.

Paul: The routine like the t.i.d. dosing that it gets from some outside. Yes. But yeah, so, I guess, I was hoping for the answer to not be it.

Deepa: [laughs] The absence of--

Paul: Yeah.

Matthew: Okay, so, no favorite. I think for me like lorazepam, very low dose, half milligram, something like that is what I will. If I am ever prescribing, that's something that I might prescribe for a very clearcut. "Okay, here's what. We're going to start you on something. I'm going to give you, we're going to check in every month, I don't want you to take these every day take it as needed. Try to ramp up whatever is going to be there chronic--" [crosstalk]

Deepa: Exactly. Giving a limited supply, I think the other thing I'll add to that is, if this patient is presenting to the ER, especially, with a lot of panic episodes, that is one place I will think about it, but I will still try hydroxyzine first. But, that's great, because every time they show up to the ER, they're not

getting the other holistic care approach that they need and they really just need to come back to clinics. So, that's one other place I think about it.

Matthew: Deepa, can you give us a couple take-home points, like favorite take home points that you think maybe the audience that you definitely want them to-- ? Not maybe. Let you strongly-- [crosstalk]

Deepa: Yeah. [laughs]

Matthew: What are two or three take-home points that you definitely want people to remember?

Deepa: Yeah. I think the biggest thing is remembering what a primary care doctor can offer that a lot of times gets missed in other settings. And somebody said it beautifully during a plenary yesterday here at SGIM is be a listener. Listen to what your patient is saying, what are they hoping to get out of treating their anxiety disorder, listening, so that you can pick up on the cues that there might be underlying anxiety disorder. I think that we're not going to be able to diagnose and treat unless we do that first.

[music]

Paul: This has been another episode of the Curbsiders bringing you a little knowledge food for your brain hole.

Beth: Yummy.

Paul: Get your show notes at the *curbsiders.com* and while you're there, sign up for our mailing list to get our weekly show notes in your inbox, plus twice each month you'll get our new Curbsiders Digest recapping the latest practice changing articles, guidelines, and news in internal medicine.

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Beth: I've been Beth 'Garbs' Garbitelli.

Paul: And I remain Dr. Paul Nelson Williams. Thank you and goodbye.