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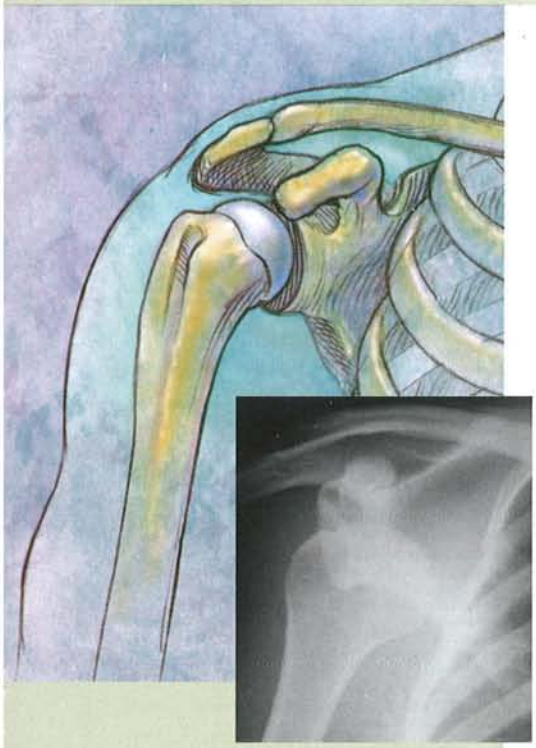

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CONSULTANT'S CORNER

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Department Editor

How should I help this man who worries all the time?

Shirah Vollmer, MD

You see a 56-year-old executive who complains of being nervous all the time and unable to relax. He tells you that as long as he can remember he's been a worrywart, afraid that something is going to go wrong. He was a "basket case" when his children were growing up because he was worried that they would have a terrible accident or develop some awful disease. Now he says he has a hard time dropping his granddaughter off at school because of what might happen to her while she's away from him.

What is the most likely diagnosis?

This patient in all probability has generalized anxiety disorder (GAD). This disorder is characterized by chronic anxiety, exaggerated worry, and tension, even when there is little or nothing to worry about. These patients anticipate disaster and are overly concerned about health issues, money, family problems, or difficulties at work. Sometimes just the thought of getting through the day produces anxiety.

What are the clinical features of GAD?

The diagnosis is made when someone has had excessive worry about everyday problems for at least 6 months. Such a person realizes that the worry is more intense than the situation warrants, but he or she cannot relax, startles easily, and has difficulty concentrating—and often falling asleep or staying asleep, as well. Associated physical symptoms include fatigue, headaches, muscle aches and tension, and irritability.

What diagnostic tests would you order?

GAD is a clinical diagnosis, and no laboratory tests can help make the diagnosis. Questionnaires can be used, however. One such is the GAD-7, a 7-item scale that has been found valid and efficient in screening for and assessing the severity of GAD.*

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What are the management options?

Medications will not cure GAD, but they may keep some of the symptoms under control. Cognitive behavioral therapy (CBT) can be very useful. The cognitive component helps people change the thinking patterns that support their fears, and the behavioral part helps them change the way they react. The best treatment approach for most people is to combine CBT with medication.

What would be your first-line drug therapy?

Selective serotonin reuptake inhibitors (SSRIs) and dual-uptake inhibitors such as venlafaxine HCl (Effexor) are useful for GAD. These medications are started at low doses and gradually increased until they have beneficial effects. The extended release formulation of venlafaxine is preferred and started at 37.5 mg, and the patient is monitored every 2 weeks until symptoms remit. If symptoms do not improve, the dose can be titrated upward in increments of 37.5 mg to 225 mg daily.

Venlafaxine can cause hypertension, so monthly monitoring of blood pressure is important. In addition, all of the SSRIs and selective norepinephrine reuptake inhibitors can cause an increase in eye pressure and symptoms of mania or hypomania. Persistently elevated or irritable mood, racing thoughts, decreased need for sleep, or rapid speech merit clinical evaluation. Frequent eye examinations are necessary for monitoring eye pressure.

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*Spitzer RL, Kroenke K, Williams JBW, et al. A brief measure for assessing generalized anxiety disorder. The GAD-7. Arch Intern Med 2006;166: 1092-1097.

How would you manage the sexual side effects of these drugs?

Sildenafil citrate (Viagra), vardenafil HCl (Levitra), or tadalafil (Cialis) is appropriate for managing sexual dysfunction associated with SSRIs or dual-uptake inhibitors. Sildenafil, which cannot be given to men who are taking nitrates, is started at 25 mg, 1 hour before intercourse. The most common side effects are headache, facial flushing, and upset stomach; less common are bluish or blurred vision or sensitivity to light.

What if the sexual dysfunction continues to be a problem?

Buspirone HCl (BuSpar) would be my next option. This psychotropic drug belongs to the class of compounds known as azaspirones and has anxiolytic properties but is not related to benzodiazepines or barbiturates. It acts as a 5-HT_{1A} receptor agonist, but its mechanism of action has not been fully elucidated. Still, it is clear that buspirone is efficacious for anxiety symptoms and does not cause sexual side effects. The initial dose is 5 mg bid or tid, depending on the level of anxiety, and it can be adjusted to the patient's needs up to a maximum of 60 mg daily in divided doses, according to tolerance and response.

What role, if any, do you see for benzodiazepine therapy?

A solid body of evidence supports short-term efficacy of benzodiazepines for GAD. They are appealing to many clinicians because of their efficacy, reasonable side-effect profile, and good tolerability. There is an abuse potential, however, as well as an association with dependence. For middle-aged patients who have no history of addiction, benzodiazepines with a long half-life are useful in the treatment of GAD because of their low risk for interdose rebound anxiety and withdrawal symptoms. I use benzodiazepines in the early phases of treatment with SSRIs or dual-uptake inhibitors to achieve some symptomatic relief until the antidepressant has had time to work (roughly 2-3 weeks). This approach also protects against the occasional early worsening of anxiety seen at the beginning of antidepressant therapy. ■

Disclosure *The author has no relationship with any commercial entity that might represent a conflict of interest with the content of this article.*