PRACTICAL PSYCHOPHARMACOLOGY

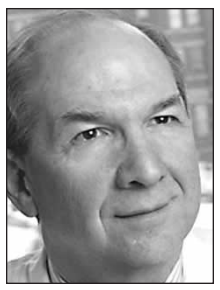
Late-Life Anxiety Requires Modified Approach

Lower profile for drug interactions makes citalopram, escitalopram, and sertraline attractive.

BY CARL SHERMAN
Contributing Writer

Anxiety seems to be as prevalent in older as in younger adults—data are inconsistent on this point—but may look different in each group. "The DSM criteria were developed for anxiety disorders in younger patients and don't always identify them in this age group," said Javaid I. Sheikh, M.D., professor of psychiatry at Stanford (Calif.) University.

Older patients tend to focus less on nervousness and worry than on somatic manifestations of anxiety, he said. Memory deficits and other cognitive difficulties are frequently part of the picture, possibly reflecting the neurotoxic effects of chronic anxiety on the hippocampus and other brain centers.



Switching to a tricyclic antidepressant such as nortriptyline is an option.

DR. RABINS

Anxiety also exacerbates the age-linked decline in restful sleep. Complaints of severe insomnia are "very common," Dr. Sheikh said.

More prominent than the distinct anxiety syndromes of early adulthood is a mix of anxiety and depression symptoms. "These appear together frequently enough to constitute a separate diagnostic category," said Carl Salzman, M.D., professor of psychiatry at Harvard Medical School, Boston.

Anxiety associated with medical disorders, medication, and mild to moderate dementia is frequently encountered as well, Dr. Sheikh said.

The possible contribution of medical factors should be considered, particularly if anxiety is of recent onset. Thyroid function, for example, may influence both mood and anxiety disorders. "I've found that thyroid status is askew in about 10% of the patients I see, and needs to be addressed for effective management," said Eric Lenze, M.D., of the Western Psychiatric Institute and Clinic in Pittsburgh.

"In my experience, people with chronic obstructive pulmonary disease have particularly high rates of comorbid anxiety," said Peter V. Rabins, M.D., professor of psychiatry at Johns Hopkins University, Baltimore. "Air hunger and anxiety are so intertwined that you can't simply treat one or the other. I empathize with the distress caused by air hunger as part of psychoeducation, and help people make lifestyle changes to minimize shortness of breath," he said.

Although there is little literature to guide treatment of late-life anxiety, serotonergic antidepressants are commonly the first choice, particularly when the patient exhibits depressive symptoms.

Dr. Lenze's group recently published what he believes to be the first prospective controlled trial validating the use of a selective serotonin reuptake inhibitor (SSRI)—citalopram (Celexa)—for late-life anxiety (Am. J. Psychiatry 2005;162:146-50). Another study, which retrospectively examined industry data, found venlafaxine (Effexor) equally effective for older and younger patients (J. Am. Geriatr. Soc. 2002;50:18-25).

In the choice among SSRIs, a lower potential for drug interactions makes citalopram, escitalopram (Lexapro), and sertraline (Zoloft) attractive, Dr. Lenze and Dr. Sheikh said.

Enhanced sensitivity to side effects—including exacerbations of anxiety—suggests initiation at low dosage and cautious titration. Dr. Sheikh may start at one-fourth the full therapeutic dosage and go to one-half after 2 weeks, go to three-fourths 2 weeks later, and then wait 4 more weeks to evaluate the need for further increases.

Although some may require a larger dosage, many elderly patients respond to SSRIs at even one-half the usual dosage for young adults, he said.

To Dr. Lenze, "management is more important than the choice of drug," in view of the high dropout risk. "The first 2 weeks are most critical. … If they stay with treatment this long, they're likely to get better." Because "the anticipation of something very bad happening is a core feature of all anxiety disorders," he addresses concerns preemptively by counseling patients about the side effects they might expect and stressing their essential benignity and probable transience. Frequent visits (and reassurance) early in treatment and availability by phone also help allay concerns, Dr. Lenze said.

The role of benzodiazepines, once the mainstay of anxiety treatment, is uncertain. They can impair balance and increase the risk of falls and consequent fractures. Cognitive function, particularly memory, may be affected, and one study linked long-term use to cognitive decline (J. Clin. Psychopharmacol. 2002;22:285-93).

To Dr. Salzman, benzodiazepine monotherapy may be safely used long term for reliable, well-selected patients who are not taking other sedatives or respiratory depressants, and are not substance abusers. "I'd be reluctant to give a benzodiazepine to someone who is already unsteady, or has serious memory problems, or is spending most of his time in bed, but for people in their 70s who are vigorous and functioning—and anxious—it can make all the difference in the world," he said.

Only short-acting agents should be prescribed at low dosages (0.125-0.25 mg of lorazepam [Ativan] or 10-15 mg of oxazepam [Serax], one to three times daily) under close supervision, including frequent visits or phone calls, he said.

Long-term adjunctive benzodiazepines also may be useful, Dr. Lenze said, for "about 40% of patients [who] have an incomplete response to SSRIs, tolerate benzodiazepines well, and need them for breakthrough symptoms."

Other agents for anxiety that have shown an inadequate response as SSRI monotherapy have little research support. "I might add buspirone [BuSpar]," Dr. Sheikh said. "It's a great medication when it works, and has limited side effects, but it's inconsistent."

Dr. Rabins considers switching to a tricyclic antidepressant, preferably nortriptyline: "It is less anticholinergic than others, and you can monitor blood levels for a sense of adherence and the adequacy of the trial." He advises a low starting dose; slow titration; and ECG monitoring at baseline, then a week or two after initiation, and again once blood levels are stable.

Atypical antipsychotics can be helpful adjunctively, particularly when anxiety is associated with dementia or resists treatment in the context of depression. Dr. Rabins chooses an agent based on its side effect profile and begins at a very low dose (aripiprazole [Abilify] 2.5 mg/day, risperidone [Risperdal] 0.25 mg/day, or olanzapine [Zyprexa] 2.5 mg/day).

Psychotherapy is an option not to be overlooked. Contrary to conventional wisdom, older people are not particularly resistant to the idea, and in his experience "many would much prefer it to medication," Dr. Lenze said.

Dr. Sheikh recommends an appropriate form of cognitive-behavioral therapy whenever anxiety involves concrete problems that require retraining, such as phobias around driving. Often, cognitive-behavioral therapy is best begun after a 6-8 week regimen of pharmacotherapy has moderated symptom severity enough to make it more acceptable. ■

Low Fatty Acid Levels, Dementia Associated in Large Study

BY KERRI WACHTER
Senior Writer

WASHINGTON — Higher intake of n-3 fatty acids may have a protective effect against cognitive impairment, according to data presented at the annual meeting of the Gerontological Society of America.

In a study of almost 1,000 people aged 65 and older, those with dementia had significantly lower plasma levels of n-3 fatty acids, said Antonio Cherubini, M.D., of the Institute of Gerontology and Geriatrics in Perugia, Italy.

The n-3 fatty acids are an important component of the neuronal membrane, influencing membrane fluidity and all the related functions, such as signal transduction and enzyme function. Fish—particularly fatty fish, such as mackerel and albacore tuna—are the primary source of n-3 fatty acids.

Dr. Cherubini presented data from the Aging in Chianti (InCHIANTI) study, a population-based trial conducted between 1998 and 2000 in the Chianti region of Italy.

The 935 volunteers were categorized as having normal cognition (725 subjects), cognitive impairment without meeting criteria for dementia (153 subjects), or dementia (57 subjects). Cognitive function was screened using the Mini-Mental State Examination. The subjects with age- and education-unadjusted scores lower than 26 on the examination underwent more detailed tests.

The diagnosis of dementia was made according to DSM-IV criteria. Plasma fatty acid levels were determined using gas chromatography.

Subjects with dementia had the lowest n-3 fatty acid plasma concentrations—as a percentage of total fatty acid plasma concentrations in mg/L—with a mean of 2.7%, compared with 3.0% for the cognitively impaired group and 3.2% for the normal cognition group.

Subjects with dementia had the highest plasma concentrations of saturated fatty acids—as a percentage of total fatty acid plasma concentrations in mg/L—with a mean of 31.4%, compared with 30.1% for the cognitive impairment group and 30.3% for the normal cognition group.

"Subjects in the second group—those who have cognitive impairment but not dementia—tended to have intermediate values in many of the fatty acids," Dr. Cherubini said.

The finding of lower n-3 fatty acid plasma concentrations in subjects with dementia persisted even after adjusting for age, gender, education, smoking status, cholesterol and triacylglycerol levels, alcohol, fatty acid and total energy daily intakes, and total plasma levels of fatty acids.

The difference between normal subjects and those with mild cognitive impairment was no longer significant after adjustment, he said.

Previous studies have examined the relationship between n-3 fatty acid consumption and the development of dementia, but the results have been conflicting. This may be because the studies involved small sample sizes and relied on only one indicator of n-3 fatty acid status—intake or blood concentration—Dr. Cherubini said. ■