

# Post-MI Anxiety More Common Among Women

*Be sure to start patients on anxiolytics quickly after anxiety is diagnosed post myocardial infarction.*

BY MITCHEL L. ZOLER  
Philadelphia Bureau

CHICAGO — The high anxiety that many women have after an acute myocardial infarction may explain their high complication rate, compared with men, and it may offer a new way to improve patient outcomes.

“Early recognition and effective treatment of anxiety immediately after a myocardial infarction may decrease morbidity and mortality,” Debra K. Moser, D.N.Sc., said while presenting a poster at the annual scientific sessions of the American Heart Association. “Anxiety is a target for intervention. “One of the things most lacking in clinical cardiology today is the assessment of anxiety and depression” in AMI patients, she said.

The Brief Symptom Inventory (BSI) is the way that Dr. Moser and her associates have measured anxiety in patients after an acute myocardial infarction (AMI), and

treatment can include an anxiolytic drug as well as psychosocial interventions such as cognitive-behavioral therapy, said Dr. Moser, professor of nursing at the University of Kentucky, Lexington.

She and her associates examined the role of anxiety after AMI in 635 men and 244 women who were enrolled at several centers in the United States and four other countries. The anxiety level of all patients was measured within 72 hours of their hospital admission for their AMI using the BSI.

The BSI is a reliable and validated measure that uses six questions to measure anxiety, said Dr. Moser. Each question is rated on a scale of 0-4 (0 is the lowest level), and the scores from all six questions are summed and then averaged. A score of 0.33 or less indicates no anxiety. A score of 0.4 or more indicates clinically significant anxiety, especially if the score persists at this level over time. A score of 1.7 is what is typically seen in psychiatric patients

who are hospitalized for anxiety disorders. Results from prior studies by Dr. Moser and her associates showed that about 44% of AMI patients have mild or moderate anxiety, and about 25% have a BSI score of 1.7 or higher (the remaining patients do not have anxiety).

The average post-MI BSI score among the women in this study was 0.77, compared with an average score of 0.57 among the men, a statistically significant difference. Complication rates also showed a gender split, with a rate of 33% in women and 24% in men, a significant difference. The complications included in this tally were repeat infarctions, ventricular tachycardia that was sustained or that required intervention, ventricular fibrillation, acute recurrent ischemia, heart failure, cardiogenic shock, or death.

In a multivariate analysis that controlled for clinical and demographic differences among the patients, patients who had a BSI score that indicated anxiety had a significant 66% higher rate of complications, compared with patients who were not anxious. Other significant determinants of an increased complication rate were smok-

ing and a Killip class of II-IV. The analysis also showed that two factors were linked with significant protection against complications: treatment with a thrombolytic drug, and treatment with an anxiolytic drug, which was associated with a 44% drop in the rate of complications. The results also showed that the complication rates of men and women were similar if they were treated with an anxiolytic drug.

Typical anxiolytic drugs used on AMI patients by Dr. Moser’s group include alprazolam (Xanax) and diazepam (Valium). It’s important to start such drugs quickly once anxiety is first diagnosed post MI, but they can be stopped once the anxiety is relieved, often within a day. Dr. Moser recommended assessing anxiety levels early during AMI treatment, and then again when a patient is discharged from the intensive care unit, at the time of hospital discharge, at the first physician visit after hospital discharge, and then at 3, 6, and 12 months after the MI.

It’s also important to use nonpharmacologic treatments too. Dr. Moser’s group is testing the efficacy of cognitive-behavioral therapy in post-AMI patients. ■

## Biopsychosocial Model Effective For Patients With Comorbid Pain

BY SHARON WORCESTER  
Southeast Bureau

ATLANTA — A biopsychosocial approach may offer the most effective way to manage chronic pain in patients with a comorbid mood or substance use disorder without compromising recovery processes, Martin D. Cheatle, Ph.D., said at the Southeastern conference on alcohol and drug addiction.

The key is treating the whole patient, and treating the disorders concurrently rather than sequentially. A patient who goes through detox but goes home in pain is at high risk for returning to narcotics abuse, and the effects of depression and anxiety on pain and treatment outcomes, and vice versa, also have to be considered, said Dr. Cheatle of the Behavioral Medicine Center, Reading (Pa.) Hospital and Medical Center.

The biopsychosocial model involves the use of evidence-based medication management along with cognitive-behavioral therapy and an exercise/physical therapy program with a goal of empowering the patient to take charge of the pain. Relaxation and thought focus techniques, and development of adaptive resources such as coping skills, strength, and stamina can help in providing that empowerment.

Also key to success is community support via a network of specially trained primary care doctors and specialists working together in the patient’s interest.

Programs incorporating this approach have been shown to improve treatment outcomes, promote return to gainful employment, reduce pain, and increase functionality. For example, a

study of 123 patients at the Behavioral Medicine Center showed that from admission to 1.5 years following completion of a 3-week residential behaviorally based pain program including rehabilitation and group cognitive-behavioral therapy, the use of opioids, benzodiazepines, nonsteroidal anti-inflammatories, and antidepressants dropped dramatically, and the use of over-the-counter treatments for pain increased.

The frequency of walking and cycling significantly increased, and depression scores dramatically decreased. Pain scores were reduced by half, Dr. Cheatle said.

Further, employment increased from 5% to 74%, and health care utilization dropped by 78%.

It is important to note that the population which completed the treatment program was a motivated population—nonmotivated patients dropped out early—thus the findings are somewhat skewed, but the approach does appear

to be of benefit, he said.

As for the use of opioids for the treatment of pain in patients with a substance use disorder or substance abuse history, these drugs aren’t necessarily contraindicated. Data are lacking, but noncompliance with prescription nonopioid drugs, insistence on rapid release formulations of pain medication, complaints of pain at varying body sites (initial treatment for back pain and a later call with tooth pain), and numerous phone calls or clinic/emergency department visits requesting pain medication are among the signs of an increased risk for substance abuse.

History of substance abuse, smoking, or psychiatric disorders also should be considered when deciding the best approach for treating pain. ■

## Meditation Helps Breast Cancer Patients After Tx

BY BRUCE JANCIN  
Denver Bureau

SAN ANTONIO — The mindfulness-based stress reduction program developed by Jonathan Kabat-Zinn, Ph.D., appears to be beneficial to patients with early-stage breast cancer in the immediate posttreatment period as they transition to survivorship, Cecile Lengacher, Ph.D., reported at a breast cancer symposium sponsored by the Cancer Therapy and Research Center.

This transition is an underappreciated period of high risk for emotional distress. Many patients experience fear of recurrence while also coming to grips with changes in body image, concern for their children and other family members, and difficulties reintegrating into work and family roles, explained Dr. Lengacher of the Lee Moffitt Cancer Center and Research Institute, University of South Florida, Tampa.

Because few clinical interventions addressing this challenging period are available to offer patients, Dr. Lengacher and her coworkers decided to do a non-randomized pilot feasibility study of mindfulness-based stress reduction, the structured program developed by Dr. Kabat-Zinn of the University of Massachusetts, Worcester.

The program is designed to teach patients to self-regulate

their arousal to stress through awareness of their thoughts and feelings during stressful circumstances. It emphasizes regular practice of four meditation techniques: sitting meditation, body scan, gentle Hatha yoga, and walking meditation.

The formal program entails eight 2-hour weekly group sessions, along with a minimum of 45 minutes per day 6 days per week practicing the various forms of meditation individually outside of class.

Investigators offered the program to women who had undergone lumpectomy plus radiotherapy and/or chemotherapy. Nineteen participated, and 17 completed the classes.

Thirteen of the 17 patients kept a practice diary. Entries showed they averaged 372 minutes per week in sitting meditation, 212 doing the body scan, 139 in walking meditation, and 123 minutes doing yoga.

Fifteen of the 17 patients found the program beneficial, and 13 said they could better handle stress and had improved coping skills. Serial measures of anxiety, depression, and pain were obtained, but the results are pending.

Since patients found the 8-week course too lengthy, investigators have since condensed the program to 6 weeks. A randomized trial is planned. ■



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