

key points

SELECTED BY

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Anxiety disorders are a heterogeneous group of disorders

which affect around 4.2% of the UK population. Prevalence falls with age, but this may reflect underrecognition. Although anxiety disorders are more prevalent among women, this gender difference may decrease with increasing age. The prevalence is higher among older adults with other health problems, and those in hospital and care settings. Generalised anxiety disorder (GAD) is by far the most common anxiety disorder seen in older adults.

Between one in three and one in four patients with an

anxiety disorder also meet criteria for a mood or substance use disorder. A primary depressive disorder should be excluded whenever an older person presents with anxiety symptoms for the first time, and comorbid anxiety often indicates a more severe presentation of depression. Around four in five patients have a comorbid physical disorder. Medical conditions can mimic symptoms of, predispose to, or even directly precipitate an anxiety disorder, and may colour its symptomatology or limit treatment options.

Although it is desirable to have a specific anxiety

disorder diagnosis, in primary care it may be more important to elicit the nature and severity of anxiety symptoms, their impact on day to day functioning, and how they interact with other health conditions. The history should cover worries, preoccupations, ability to relax, physical symptoms, health concerns, activities which are avoided, and the level of distress, including suicide risk.

A medical workup is recommended if this is the first

presentation of anxiety or the patient is presenting after an extended symptom-free period. It should include cardiovascular and neurological examination, blood tests, urinalysis, an ECG and a review of known chronic health conditions. The use of medications which may contribute to anxiety should be reviewed. Patients should be asked about substance use, including alcohol, nicotine, cannabis, herbal supplements, benzodiazepines and caffeine.

NICE recommends a stepped care approach to management

guided by symptom severity and functional impairment. Step one comprises education and active monitoring. The link between anxiety and physical symptoms should be explained, exercise should be encouraged, and sleep hygiene advice given. Step two consists of low intensity psychological interventions, such as guided self-help. At step three patients should be offered a high-intensity, CBT-based psychological intervention and/or medication. An SSRI is recommended as first-line. GAD is treated with a combination of relaxation training, cognitive restructuring and problem solving, whereas phobic anxiety disorders are treated with exposure and desensitisation.

Referral is indicated where there is: a high risk to self

(suicide, self-neglect) and/or others; poor response to treatments; a need for specialist psychological therapy; diagnostic uncertainty; suspected OCD, PTSD or specific phobias requiring treatment; or suspected dementia.