

key points

SELECTED BY

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Anxiety disorder in the elderly is twice as common

as dementia and four to six times more common than major depression. Anxiety is associated with poorer quality of life, significant distress and contributes to the onset of disability. Mortality risks are also increased, through physical causes, especially cardiovascular disease, and suicide.

Diagnosing anxiety disorders in older adults remains a

challenge because of the significant overlap in symptoms between physical disorders (shortness of breath; abdominal and chest pain; palpitations) and depression (disturbed sleep; poor attention, concentration and memory; restlessness).

Good history taking is crucial in elucidating whether

the complaint is of new onset or whether it is a recurrence of a previous disorder. The presence of comorbid depression should be clarified. If present, its temporal relationship with the anxiety symptoms will indicate whether there is an independent anxiety disorder.

A medication review is warranted, as a number of

drugs may be causative (calcium channel blockers, alpha- and beta-blockers, digoxin, L-thyroxine, bronchodilators, steroids, theophylline, antihistamines) or may cause anxiety in withdrawal (e.g. benzodiazepines). Substance and alcohol abuse should be excluded, as withdrawal from either may cause anxiety. A new or exacerbated physical illness may be related to anxiety. Medical investigations will help clarify the extent to which a particular somatic symptom is the result of anxiety.

The evidence-based treatments for generalised anxiety

disorder (GAD) based on studies in older adults are SSRIs. While pregabalin has gained a place as first-line treatment in GAD the evidence in older patients is promising, but limited. Cognitive behaviour therapy (CBT) is an important treatment option, but there is no evidence that combining pharmacotherapy with CBT leads to an augmented response. CBT and also relaxation training and supportive therapy have been shown to have independent positive effects on anxiety in older adults, as well as on limiting the use of benzodiazepines.

Referral to secondary services, community mental

health teams, may be appropriate if the first or second line of treatment fails, there is comorbid major depression, which worsens the treatment prospects, or if there are significant concurrent medications with the risk of interactions.