

## HIV-RELATED ANXIETY DISORDERS

- ◆ **Anxiety Disorders:** include a broad range of syndromes that have as their central feature symptoms of anxiety (sense of impending doom.) Always evaluate for: substance abuse, current medications / OTC's, recent stressors, past psych. hx., family hx., medical status, medical labs. Severe anxiety may be associated with acute major depression and higher risk of *suicide* (see also "Mood Disorders"). Anxiety disorders require rapid evaluation and treatment with the goal of symptom relief as soon as possible.
- ◆ **Epidemiology:** difficult to ascertain prevalence due to the broad spectrum "anxiety disorders" entails, however, utilizing structured interviews, a range of 5-35% of sero-positive individuals suffer from clinically significant anxiety, depending upon illness stage and other variables noted above. There is an increased prevalence of anxiety with HIV disease progression. Disease "milestones" (e.g., first physical symptoms, onset of disabilities, chronic pain syndromes, declining CD4's, increasing viral loads, etc), and disease "stage" (immediately post sero-conversion, mid-stage and late-stage), all may *predict* exacerbations. Higher risk patients have: prior history of anxiety disorders, poor social supports, maladaptive coping skills, unresolved grief issues. Adjustment disorders are the most common anxiety disorders. Panic disorders may occur in HIV+ individuals more frequently than in the general population. A PTSD-like syndrome has been described in some persons who have experienced multiple AIDS-related losses for whatever reasons.
- ◆ **Symptomology:** Always r/o organic etiologies! Chest pain, hyperventilation, choking sensation, muscle tension, diarrhea, nausea, diaphoresis, palpitations, dyspnea, sense of "dying", paresthesias, fatigue, tachycardia, increased blood pressure, flushing, vertigo, headache, nausea, vomiting.
- ◆ **DSM Differential:** Adjustment d/o with anxious mood (most common; may progress if not treated); acute stress d/o; anxiety due to a general medical condition; \*panic d/o with or without agoraphobia; generalized anxiety d/o (GAD); obsessive-compulsive d/o (OCD); specific or social phobias; PTSD; substance-induced anxiety d/o; AIDS-related bereavement; mood disorders with comorbid anxiety; delirium with agitation/anxiety. \*(Panic disorder has a known association with both viral syndromes and cocaine/ drug abuse.)
- ◆ **Medical Differential:** *Toxic or withdrawal effects of drugs:* ETOH; cocaine amphetamines; ecstasy; crystal meth; opiates; benzo's; nicotine; caffeine. *Medications:* antiretrovirals, efavirenz, INH (and other anti-TB meds), psychotropics (e.g., SSRI's, venlafaxine, bupropion, psychostimulants, neuroleptics, anticholinergics), antihypertensives, steroids, bronchodilators, thyroid meds, acyclovir, interferon/interleukin, pentamidine, quinolones. *Herbals:* ginko biloba, ginseng, ma huang, ephedra. *Physical conditions:* HIV-related CNS diseases (HAD, toxoplasmosis, cryptococcal meningitis, herpes encephalitis, neurosyphilis); respiratory conditions (hypoxemia, PCP, pulmonary KS, lymphoma, pulmonary embolus/edema, etc.); endocrinopathies (hyperadrenalism, hypocalcemia, hypo/hyperthyroidism); metabolic conditions (anemia, hypoglycemia, hyponatremia, hyperkalemia, hyperthermia); seizure disorders; cardiovascular disease (angina, arrhythmias, MVP, hypovolemia, cardiomyopathies); hyperventilation syndrome; sustained fever, dehydration.
- ◆ **General Treatment Principles:** determine need for inpatient vs. outpatient care, type of psychotherapy, type of pharmacotherapy. HIV/AIDS patients are extremely sensitive to most psychotropic medications. Start *lower* and go *slower*. Titrate to lower serum levels where meds utilizing serum levels are indicated. Avoid very anticholinergic meds if possible. Seek *shorter* half-lives. Seek lower potentials for drug-drug interactions. Know patient's prescribed and OTC meds. Check PDR/pharmacy for most recent data, dosing, and drug interactions with newer antiretrovirals.
- ◆ **Non-Pharmacologic Interventions:** psychotherapy (individual, group, couples) is very important and should be considered *before* medications if possible. Acupuncture; cognitive-behavioral techniques; biofeedback (EMG); muscle relaxation; meditation techniques; hypnosis/self-hypnosis

FAST FACTS

CLINICAL  
REFERENCE  
SERIES

OFFICE OF HIV  
PSYCHIATRY

AMERICAN  
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useful. Educate pt., integrate care with continuity of providers, establish social net. Such interventions decrease pill burden, polypharmacy, drug interactions.

**Pharmacologic Interventions:** In anxiety disorders, the SSRI's are safer, efficacious and useful for long-term administration (see Mood Disorders). However, they may take 3-6 weeks to work, thus, benzodiazepines (BZP's) may be prescribed in the interim (as short-term treatment). Other antidepressants (e.g., imipramine, trazodone) have been shown to have anxiolytic effects also, but beware their anticholinergic properties. Antidepressants may be preferred for patients with chronic co-morbid substance abuse problems. Benzodiazepines are best used for *time-limited conditions*, and are considered a first-choice. Benzodiazepines are agonists at the central BZ receptor (part of the GABA receptor complex). It is the major inhibitory system in the CNS. There are 2 receptor subtypes – BZ 1 & BZ 2. Habituation, tolerance, physical dependence, & withdrawal may occur. Pt.'s spelling "*trouble*" may be at higher risk of addiction (*transient, regressive, overanxious, unstable, bulimic, labile, episodes*). BZP side effects: drowsiness, ataxia, incoordination, disinhibition, amnesia, syncope, liver dysfunction, granulocytopenia, CO2 retention, rebound insomnia, accident proneness, respiratory suppression at higher doses. Inform patient regarding excessive, prolonged use leading to habituation, tolerance, physical dependence, and serious withdrawal. All BZP's are equally efficacious in treating acute anxiety, but have different properties (e.g., short-medium-, and long-acting). Non-Benzodiazepines, such as buspirone, requires 4-7 weeks to begin to work, but is safer in pulmonary disease than BZP's, and have no abuse potential. However, it is not useful "prn".

BZP	dose range/day	~elim. t <sub>1/2</sub>	met. pathway	Comments*
lorazepam	0.5-8mg/d	~13hrs	glucuronide conjugation	less likely to accumulate
oxazepam	30-120mg/d	~7hrs	glucuronide conjugation	less likely to accumulate
clonazepam	0.5-8mg/d	~25hrs	oxidation	
diazepam	2-60mg/d	~50+hrs	oxidation	
chlordiazepoxide	15-100 mgd/	~50+hrs	oxidation	
alprazolam	0.25-4.0 mg/d	~12hrs	oxidation	very difficult withdrawal
temazepam	7.5-30 mg/d (hs)	~12hrs	glucuronide conjugation	less likely to accumulate

Benzodiazepines	"Safer" with 3A4 inhibitors	Avoid with 3A4 inhibitors
lorazepam	Safer	-----
temazepam	Safer	-----
oxazepam	Safer	-----
alprazolam	-----	Avoid
triazolam	-----	Avoid
estazolam	-----	Avoid
midazolam	-----	Avoid

\* *Drug-interactions:* coumadin and disulfiram slow the metabolism of BZP's causing enhanced, prolonged effects; INH and estrogens exacerbate effects of BZP's through enzyme inhibition; rifampin and tobacco interfere with enzyme induction and may reduce BZP effects.

#### Other Classes Used in Treating Anxiety Disorders

Non-BZP (buspirone)	5mg tid-20mg tid	see PDR
SSRI's	see "Mood Disorders" & cautions	only certain ones
TCA's	see "Mood Disorders" & cautions	only certain ones
atypical AD's	see "Mood Disorders" & cautions	(venlafaxine, nefazodone)
antihistamines	avoid if possible (anticholinergic); may worsen delirium, cognition	
neuroleptics	are generally not prescribed for the treatment of an anxiety disorder, unless a comorbid psychiatric condition exists which would require use of a neuroleptic, such as schizophrenia, schizoaffective d/o, bipolar d/o, etc.	
beta-blockers	are contraindicated in patients with bradycardia, A-V block, CHF, COPD, DM.	