MOH CLINICAL PRACTICE GUIDELINES 1/2015

ANXIETY DISORDERS

EXECUTIVE SUMMARY

MINISTRY OF HEALTH
SINGAPORE

College of Family Physicians, Singapore

Chapter of General Physicians, College of Physicians, Singapore

Chapter of Psychiatrists Academy of Medicine, Singapore

Singapore Medical Association

SINGAPORE PSYCHIATRIC ASSOCIATION

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Introduction

This is the executive summary of the MOH Clinical Practice Guidelines (CPG) on Anxiety Disorders. It is intended to be used with reference to the full version of the CPG, which is freely available on the MOH website at this link: https://www.moh.gov.sg/content/moh_web/healthprofessionalsportal/doctors/guidelines/cpg_medical.html

How to use this document

All recommendations made in the CPG are summarised in this document.

Please note the following:

a. The page numbers of the full CPG document where each recommendation is explained are provided.

b. Each recommendation has a corresponding Grade of Recommendation and Level of Evidence (refer to page 3 for details).

c. Key recommendations are highlighted in blue.

d. This document is divided into 9 sections. Readers are recommended to follow this reading order:

    1. Section 1: Clinical Evaluation and Overview
    2. Specific sections of interest (refer to table of contents)
    3. Section 9: Clinical Quality Improvement

Common abbreviations used

SSRI: Selective serotonin reuptake inhibitor
TCA: Tricyclic antidepressant
SNRI: Serotonin-norepinephrine reuptake inhibitor
CBT: Cognitive behaviour therapy

Levels of evidence

Level	Type of Evidence
1++	High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++	High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

Grades of recommendation

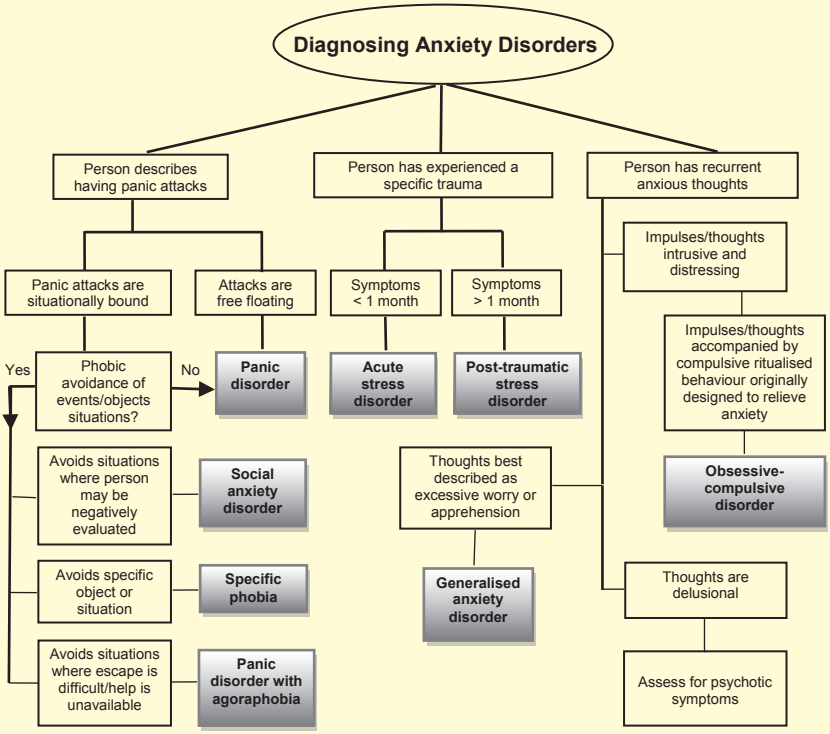
Grade	Recommendation
A	At least one meta-analysis, systematic review of RCTs, or RCT rated as 1++ and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+
GPP	Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group.

Clinical Evaluation and Overview

No.	Recommendation	Grade, Level of Evidence	CPG page no.
1	A diagnosis of anxiety disorder should be considered only after appropriate clinical evaluation and investigation to rule out general medical conditions have been done. Figure 1 summarises how the various anxiety disorders are diagnosed.	GPP	16
2	The initial management of anxiety disorders should ideally be instituted at the primary care level. The recommended framework for the management of anxiety disorders in primary care is described in Figure 2.	GPP	22
3	The following may be instituted in primary care immediately after diagnosis: • Educating patient on nature and origin of anxiety symptoms and providing appropriate reassurance, e.g. not having a 'heart attack' or 'going crazy' • Suggestion of lifestyle changes as appropriate, i.e., stress reduction strategies, reducing alcohol and caffeine intake, avoiding nicotine and drug use, regular exercise • Supportive counselling • Symptomatic relief with medication prescribed on a short-term basis • Evaluation and mobilisation of family and social resources • Monitoring and addressing early signs of relapse	Grade D, Level 4	22

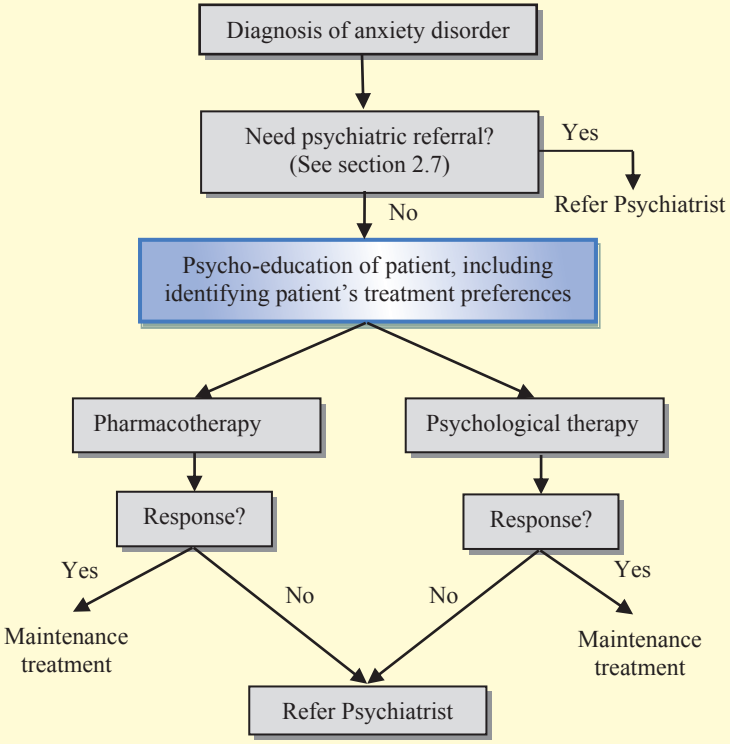
No.	Recommendation	Grade, Level of Evidence	CPG page no.
4	Psychiatric evaluation and treatment is appropriate when there is serious risk of suicide, there are psychotic symptoms, co-occurring drug/alcohol problems exist, symptoms are severe/complex or if symptoms fail to improve on initial treatment and follow-up.	GPP	27
5	Consider transferring patients with anxiety disorders from psychiatric to primary care for long-term management if they have the following characteristics: • Aged 18 or older • Stabilised for the past 3 months • No psychiatric hospitalisation in the past 6 months • No history of forensic or substance abuse • No disruptive personality disorders • Non suicidal • No history of aggressive behaviour • Not currently receiving clozapine, lithium, valproate, hypnotics (e.g. benzodiazepines, zopiclone, zolpidem) or formal psychotherapy treatment	GPP	27
6	All patients should receive education about their disorder, including aetiology, treatment choices, and prognosis.	GPP	28
7	As local patients may show higher propensity for initial side effects of antidepressants (e.g. paradoxical excitation), starting doses for local patients should be lower than those suggested by overseas guidelines.	GPP	30
8	The Clinical Global Impression scales (both severity and improvement sub-scales) may be used to measure illness severity and treatment progress during consultations for anxiety disorders.	Grade B, Level 2++	31

Figure 1 Differentiating Anxiety Disorders



Adapted from "Guidelines for assessing and treating anxiety disorder", National Health Committee, New Zealand, November 1998.

Figure 2 Anxiety Disorders management algorithm



Management of Panic Disorder

No.	Recommendation	Grade, Level of evidence	CPG Page No.
9	Either SSRIs or venlafaxine should be used as first-line agents for the pharmacological treatment of panic disorder.	Grade A, Level 1+	33
10	Imipramine and clomipramine are effective and may be used as second-line treatment of panic disorder.	Grade A, Level 1+	33
11	Benzodiazepines may be added to antidepressants in the short term to produce a more rapid therapeutic response in the treatment of panic disorder. In view of addictive potential, benzodiazepines should be tapered and withdrawn by 4 weeks.	Grade A, Level 1+	35
12	Depending on availability of treatment and patient preference, CBT or combination therapy (i.e. CBT and SSRIs or venlafaxine) may be used for the treatment of panic disorder.	Grade A, Level 1++	36

Management of Generalised Anxiety Disorder (GAD)

No.	Recommendation	Grade, Level of evidence	CPG Page No.
13	Either SSRIs or venlafaxine should be used as first-line pharmacological treatment for patients with GAD.	Grade A, Level 1++	38
14	Imipramine may be considered as a second-line treatment for GAD, in view of the possibility of poor tolerability and the danger of fatal overdosage.	Grade A, Level 1+	38
15	Mirtazapine may be considered as a second-line treatment for GAD due to its anxiolytic effects.	Grade A, Level 1+	38
16	Benzodiazepines should not be used for the long-term treatment of GAD.	Grade B, Level 1+	39
17	Pregabalin may be prescribed for patients with GAD as it has anxiolytic effects which may be more rapid acting. Due caution must be exercised when prescribing to patients who are at risk of abusing substances.	Grade B, Level 2++	39
18	Hydroxyzine may be used as adjunctive treatment together with other anxiolytic agents for treatment of GAD.	Grade C, Level 2+	39
19	Propanolol is not recommended for the long-term treatment of generalised anxiety disorder.	Grade B, Level 1+	39
20	Drug treatment for GAD needs to be continued for at least 32 weeks as high relapse rates were reported after discontinuing medications.	Grade A, Level 1+	40
21	CBT may be used as first-line psychotherapy treatment for GAD.	Grade A, Level 1++	40
22	A specialist's opinion should be sought for patients with complex GAD and/or with marked functional impairment, or at high risk of self-harm.	GPP	40

Management of Specific Phobia

No.	Recommendation	Grade, Level of evidence	CPG Page No.
23	CBT should be used as first-line treatment of specific phobia.	Grade A, Level 1++	41
24	Benzodiazepines may be used on a short-term basis for temporary anxiety relief in specific phobia, pending resolution of symptoms with other forms of treatment.	Grade B, Level 1+	42

Management of Social Anxiety Disorder (SAD)

No.	Recommendation	Grade, Level of evidence	CPG Page No.
25	Either pharmacotherapy or psychotherapy alone may be used as first-line treatment for SAD, depending on patient preferences, values and economic considerations.	Grade A, Level 1++	43
26	Either SSRIs or venlafaxine should be used as first-line pharmacotherapy for SAD.	Grade A, Level 1+	44
27	Moclobemide may be used for the treatment of SAD if treatment with SSRIs or venlafaxine has not been effective.	Grade A, Level 1+	44
28	Benzodiazepines may be used on a short-term basis for temporary anxiety relief pending resolution of phobic symptoms with other forms of treatment.	Grade A, Level 1+	44
29	Beta-blockers (e.g. atenolol, propranolol) are not recommended for the treatment of SAD as they have been found ineffective. However, they may be used for the treatment of performance anxiety (e.g. playing an instrument, giving a speech).	Grade B, Level 2++	45
30	CBT should be used as first-line psychotherapy treatment of SAD.	Grade A, Level 1+	45
31	Pharmacotherapy with SSRIs, venlafaxine, or moclobemide in SAD should be continued for at least 12 months to prevent relapse.	Grade B, Level 2++	45

Management of Obsessive-Compulsive Disorder (OCD)

No.	Recommendation	Grade, Level of evidence	CPG Page No.
32	Either pharmacotherapy or psychotherapy alone may be chosen as first-line treatment for OCD, depending on patient preferences, values and economic considerations.	Grade A, Level 1++	46
33	The first-line pharmacological treatment for OCD should be a 10-12 week trial with an SSRI at adequate doses.	Grade A, Level 1++	47
34	Clomipramine may be used as a treatment for OCD after an adequate trial of SSRI treatment has failed.	Grade A, Level 1++	47
35	An adequate treatment trial in OCD should last for at least 12 weeks. If the patient does not respond to treatment in adequate dosages, the medication may be changed or specialist opinion sought.	Grade D, Level 4	48
36	Venlafaxine may be considered in patients who have not responded to SSRIs and clomipramine. Monitor blood pressure during treatment as venlafaxine at high doses can raise blood pressure.	Grade A, Level 1+	48
37	CBT may be used as first-line treatment for OCD if patients prefer psychological treatment over pharmacotherapy.	Grade A, Level 1+	49
38	CBT augmentation of serotonergic antidepressants (e.g. SSRIs, clomipramine) in the treatment of OCD may be considered for those who are treatment-resistant or partially responsive to medications.	Grade B, Level 1+	49
39	Patients with OCD who respond to antidepressants in the acute phase should be continued on their medication for at least 12 months.	Grade A, Level 1+	49

Management of Post-Traumatic Stress Disorder (PTSD)

No.	Recommendation	Grade, Level of evidence	CPG Page No.
40	Either the SSRIs or venlafaxine may be used as first-line pharmacological treatment for PTSD.	Grade A, Level 1++	51
41	Mirtazapine may be considered as a second-line treatment for PTSD.	Grade B, Level 1+	51
42	Either amitriptyline or imipramine may be considered for PTSD if the first-line and second-line treatments are ineffective or poorly tolerated.	Grade A, Level 1+	52
43	Benzodiazepines should not be used for the treatment of PTSD.	Grade A, Level 1+	52
44	Risperidone, olanzapine, quetiapine, and lamotrigine may be prescribed as adjunctive treatments for PTSD in conjunction with the SSRIs.	Grade B, Level 1+	52
45	Pharmacological treatment for PTSD should be continued for at least 12 months.	Grade D, Level 4	53
46	CBT should be used as the first-line psychological treatment for PTSD.	Grade A, Level 1+	53
47	Eye Movement Desensitisation and Reprocessing therapy may be used as second-line treatment for PTSD.	Grade B, Level 2++	54
48	If CBT or eye movement desensitisation and reprocessing therapy for PTSD are contraindicated or have failed, combination therapy (i.e. CBT plus pharmacotherapy) may be used as an alternative treatment.	Grade B, Level 1+	54

Management of Anxiety Disorders in Pregnancy

No.	Recommendation	Grade, Level of evidence	CPG Page No.
49	If a woman is planning a pregnancy or becomes pregnant while on medication for an anxiety disorder, consider: • stopping medication and starting CBT, if necessary and if not already tried. • switching to a safer drug, if the decision is to maintain her on medication.	Grade D, Level 4	55
50	When prescribing a drug for a woman with an anxiety disorder who is planning a pregnancy, already pregnant, or breastfeeding: • choose drugs with the lowest risk potential for the mother and foetus/infant • start at the lowest effective dose, and slowly titrate upwards • continue for the shortest possible duration • use monotherapy instead of combination treatment	Grade D, Level 4	56
51	Sertraline, paroxetine and citalopram should be avoided during pregnancy.	Grade C, Level 2+	57
52	Benzodiazepines should not be routinely prescribed for pregnant and breastfeeding women, except for the short-term treatment of extreme anxiety and agitation.	Grade D, Level 4	59
53	The risk-benefit ratio of prescribing benzodiazepines should be assessed on a case-by-case basis; use the lowest dose for the shortest time, or avoid prescribing at all during the first trimester.	GPP	59
54	Atypical antipsychotics should be prescribed with caution in patients suffering from or at risk of gestational diabetes.	Grade D, Level 3	59

No.	Recommendation	Grade, Level of evidence	CPG Page No.
55	Medication for nursing mothers should be maintained at the lowest effective dose to minimise infant exposure.	Grade D, Level 3	60
56	When antidepressant treatment is indicated in the postpartum period, women should generally not be advised to discontinue breastfeeding.	Grade D, Level 3	60
57	Treatment with paroxetine or sertraline should be preferred over other SSRIs in treatment-naive breastfeeding women due to the low infant exposure to these drugs.	Grade D, Level 3	61
58	Drugs for which little data exist, such as fluvoxamine, venlafaxine, bupropion and mirtazapine, should not be considered as first-line therapies in breastfeeding women, but they may be used in special cases.	Grade D, Level 4	61
59	If mothers have been successfully treated with a particular SSRI, TCA, or SNRI, this drug should be the first-line treatment if there are no contraindications. An individual risk-benefit assessment should always be done before starting antidepressants.	Grade D, Level 4	61
60	Women on long term treatment with high dose benzodiazepines should continue to breastfeed, as stopping of benzodiazepine may precipitate withdrawal symptoms in the infant. Gradual tapering and stopping of benzodiazepines may be attempted at a later stage when the infant has grown bigger.	GPP	62
61	During maternal treatment with benzodiazepines, infants should be monitored for signs of sedation, lethargy, poor feeding and weight loss.	Grade D, Level 4	62

Clinical Quality Improvement

The following clinical and audit parameters, based on recommendations in these guidelines, are proposed:

1. Percentage of patients with an anxiety disorder who are assessed using the clinical global impression scales (both severity and improvement component scales) during consultations (see pg 31).
2. Percentage of patients with panic disorder who receive treatment with an SSRI or venlafaxine, if pharmacological treatment is given (see pg 33).
3. Percentage of patients with generalised anxiety disorder who receive treatment with an SSRI or venlafaxine, if pharmacological treatment is given (see pg 38).
4. Percentage of patients with social anxiety disorder (social phobia) who receive treatment with an SSRI or venlafaxine, if pharmacological treatment is given (see pg 44).