Practice Guidelines and Principles: Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines and principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Purpose: Patients that have Generalized Anxiety Disorder (GAD) are more often treated by their primary care physician than by a psychiatrist. These patients are difficult to diagnose as they tend to have multiple, unexplained somatic symptoms coupled with frequent office visits or telephone calls. Early diagnosis of GAD can improve the patients overall sense of wellbeing and can eliminate the multiple symptom complaints. Other anxiety disorders such as; panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and phobias are not the focus of this guideline.

Key Messages:

• More than 19 million American adults are affected by an anxiety disorder. Of this population, 4 million have GAD during the course of a given year. (Grade A)
• Among PCP patients, GAD has a 8% prevalence. This is the most prevalent anxiety disorder in the primary care environment. (Grade B)
• Research shows that GAD often coexists with depression, substance abuse, or other anxiety disorders. Other conditions associated with stress, such as irritable bowel syndrome, often accompany GAD. (Grade A)
• Anxiety disorders are highly treatable, yet only about one-third of those suffering from an anxiety disorder receive treatment. (Grade A)
• Treatments for GAD include medications and cognitive-behavioral therapy. (Grade A)

High Risk Populations/Disparities

• GAD is more prevalent in women then men with a median onset in the early 20s.
• Some research suggests that GAD may run in families, and it may also grow worse during stress. GAD usually begins at an earlier age and symptoms may manifest themselves more slowly than in most other anxiety disorders.
• Geriatric patients tend to have an altered drug metabolism and multiple medical diagnoses. When medication is needed, smaller doses are usually required and side effects can be greater than in the non-geriatric patients.
• Benzodiazepines should be used with caution in geriatric patients.

Distributed to: Primary Care Physicians, including Internists, General Practice and Family Practice Physicians,

Developed by: Eugene Schneider, MD, Excellus BlueCross Blue Shield (chair); Mona Chitre, PharmD, Ann Griep, MD, Excellus BCBS; Susan McDaniel, PhD, Psychology; John McIntyre, MD, Psychiatry; Michael Privitera, MD, Psychiatry; Timothy Sheehan, CSW, Thomas Campbell, MD, Family Medicine.

ROCHESTER COMMUNITY-WIDE GUIDELINES GRADING SYSTEM

STRENGTH OF RECOMMENDATIONS: The Rochester Community-wide Clinical Guidelines Steering Committee (CWGSC) grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A—CWGSC strongly recommends that clinicians provide [the service] to eligible patients. There is good evidence that [the service] improves important health outcomes to conclude that benefits substantially outweigh harms.

B—CWGSC recommends that clinicians provide [this service] to eligible patients. There is at least fair evidence that [the service] improves important health outcomes to conclude that benefits outweigh harms.

C—CWGSC makes no recommendation for or against routine provision of [the service]. There is at least fair evidence that [the service] can improve health outcomes to conclude that the balance of benefits and harms is too close to justify a general recommendation.

D—CWGSC recommends against routinely providing [the service] to asymptomatic patients. There is at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I—CWGSC concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that the [service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

QUALITY OF EVIDENCE: The quality of the overall evidence for a service is on a 3-point scale (good, fair, poor).

Good—Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair—Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor—Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Adapted from the USPSTF grading system. Approved 05.16.05
Symptoms of Generalized Anxiety Disorder (GAD)  
DSM-IV Criteria

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) is a guide to the diagnosis of mental disorders in the United States. The following are a list of the criteria for Generalized Anxiety Disorder. Please note: although these criteria are designed to provide a guideline to diagnosis they cannot substitute a visit to a doctor or mental health practitioner. These guidelines are provided for information purposes only.

**Diagnostic Criteria for Generalized Anxiety Disorder (GAD)**

**A.** Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

**B.** The person finds it difficult to control the worry.

**C.** The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

- restlessness or feeling keyed up or on edge
- being easily fatigued
- difficulty concentrating or mind going blank
- irritability
- muscle tension,
- sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

**D.** The focus of the anxiety and worry is not confined to features of another anxiety disorder. For example:

- the anxiety or worry is not about having a Panic Attack (as in a Panic Disorder),
- being embarrassed in public (as in Social Phobia),
- being contaminated (as in Obsessive-Compulsive Disorder),
- being away from home or close relatives (as in Separation Anxiety Disorder),
- gaining weight (as in Anorexia Nervosa),
- having multiple physical complaints (as in Somatization Disorder), or
- having a serious illness (as in Hypochondriasis), and
- the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

**E.** The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**F.** The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental

Other factors that can be associated with GAD:

- Family history of an anxiety disorder or alcoholism
- High utilization and urgent care needs
- Repeated office visits or ER visits with negative work-ups
- Diagnosis of an anxiety disorder that include: atypical chest pain, hyperventilation, and irritable bowel syndrome
TREATMENT OF GENERALIZED ANXIETY DISORDER IN THE PRIMARY CARE SETTING

Patient presenting with excessive worry and anxiety occurring on more days than not for at least six months

Evaluate:
- any medical reason for symptoms
- medication usage
- history of substance/alcohol abuse
- rule out any other anxiety and mood disorder
- family history
- other psychosocial factors
- previous history of counseling, medication therapy (note if successful or failed treatment)

Assess Suicide/Homicidal Risk Factors
Does patient have:
- suicidal thoughts
- plan
- means
- intent

→ High Risk

Low Risk

Non Pharmacological Treatment:
- relaxation techniques
- lifestyle changes: regular exercise, adequate sleep, avoid caffeine / alcohol
- consider referral to behavioral health specialist

Pharmacological Treatment:
- indicated for those patients that anxiety results in significant distress or the inability to perform daily functions (See GAD Medication Algorithm)
- consider a referral to mental health services anywhere along that medication guideline.

Monitoring the Treatment Progress
- Consider utilizing attached GAD Self Test
- Monitor monthly to bimonthly via office visits for symptom improvement
- Patient documentation of symptom frequency and duration, situational triggers, and coping mechanisms utilized

Refer to and Collaborate with a Psychiatrist or Mental Health Provider
- Patient is not able to obtain/maintain recovery
- Patient does not respond to behavioral therapy and pharmacological treatment
- Co-morbidity suspected, such as depression
Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs. Approved October 17, 2005. Next scheduled update by October, 2007.
# Generalized Anxiety Disorder Dosing

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Initial Dose</th>
<th>Dose Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10</td>
<td>20-60</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>5-10</td>
<td>10-80</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>25</td>
<td>25-300</td>
</tr>
<tr>
<td>Paroxetine* (Paxil)</td>
<td>10</td>
<td>10-50</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>25</td>
<td>25-200</td>
</tr>
<tr>
<td><strong>Serotonin Norepinephrine Reuptake Inhibitor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine* (Effexor)</td>
<td>25-37.5</td>
<td>50-75 TID</td>
</tr>
<tr>
<td>Venlafaxine XR* (Effexor XR)</td>
<td>37.5</td>
<td>75-225</td>
</tr>
<tr>
<td><strong>Azapirone</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buspirone* (BuSpar)</td>
<td>10-15</td>
<td>10-60</td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>25-75 (qhs)</td>
<td>100-250</td>
</tr>
<tr>
<td>Desipramine(Norpramin)</td>
<td>10-75 (qhs)</td>
<td>150-300</td>
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<tr>
<td>Imipramine(Tofranil)</td>
<td>10-75 (qhs)</td>
<td>50-300</td>
</tr>
<tr>
<td>Nortriptyline(Pamelor)</td>
<td>10-50 (qhs)</td>
<td>50-150</td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
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</tr>
<tr>
<td>Alprazolam* (Xanax)</td>
<td>0.25-0.5</td>
<td>2-10</td>
</tr>
<tr>
<td></td>
<td>TID</td>
<td></td>
</tr>
<tr>
<td>Chlordiazepoxide(Librium)</td>
<td>5-25</td>
<td>15-100</td>
</tr>
<tr>
<td></td>
<td>TID/QID</td>
<td></td>
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<tr>
<td>Clonazepam(Klonopin)</td>
<td>0.25 BID</td>
<td>0.5-2</td>
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<td>Diazepam* (Valium)</td>
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<tr>
<td>Lorazepam* (Ativan)</td>
<td>0.5 BID</td>
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<tr>
<td>Oxazepam (Serax)</td>
<td>10-30</td>
<td>30-120</td>
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<tr>
<td></td>
<td>TID/QID</td>
<td></td>
</tr>
<tr>
<td><strong>Atypical Antidepressants</strong></td>
<td></td>
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</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>15</td>
<td>15-45</td>
</tr>
<tr>
<td><strong>Antihistamine</strong></td>
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<tr>
<td>Hydroxyzine (Atarax, Vistaril)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
<tr>
<td><strong>Beta-Blocker</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propranolol(Inderal)</td>
<td>Varies</td>
<td>Varies</td>
</tr>
</tbody>
</table>
| * FDA indication for GAD
Generalized Anxiety Disorder: Consideration Points

** Choice of SSRI depends on many factors:
- Patient past response
- Patient opinion
- Pharmacokinetics
- Drug interactions
- Adverse effects
- Cost

Benzodiazepines:
- High addiction, abuse and overdose potential
- Primary symptom (Worry) not relieved
- Patients (>33->50%) do not reach remission
- Higher recurrence rate with this class verses other anxiolytic classes
- No antidepressant properties
- Problematic side effects

Buspirone:
- No antidepressant properties
- Compliance with TID dosing
- Long term efficacy not well studied

SNRI: Venlafaxine
- Significant risk of hypertension with doses >300 mg/d
- Careful monitoring of blood pressure is indicated in these patients
References


