Anxiety Management Tips for Healthcare Professionals

Guiding Principles: Treat the anxiety if it is affecting the individual's quality of life.

Step 1. Top underlying treatable causes and diagnosis:

- Screen using: Putting Patients First (PPF) to assess extent of anxiety (Mild 1-3; Moderate 4-6; Severe ≥ 7)
- Social (having young children) and physical symptoms (pain, physical appearance changes) contribute to anxiety
- Major diagnoses to watch for (less common than depression):
  a) Generalized Anxiety Disorder (GAD): unrealistic worries, apprehension, autonomic hyperactivity, hypervigilance
  b) Panic Disorder
  c) Stress Disorders
- Important to assess to what extent anxiety is interfering with activities of daily living
- Assess for secondary causes:
  a) Poor symptom control (e.g. pain, dyspnea), infection, delirium, electrolyte imbalance
  b) Hypoxia, heart failure, coronary ischemia, pulmonary embolism, hypoglycemia
  c) Drugs: e.g. corticosteroids, antidopamine agents (e.g. haloperidol, metoclopramide), bronchodilators
  d) Substance abuse withdrawal: e.g. alcohol, opioids, sedative/hypnotics
- Adjustment disorder with temporary anxiety or depressed mood quite common
- Rule out delirium
- Mild distress (e.g. ESAS-r Anxiety 1-3) should also be addressed

Step 2a. Non-pharmacological management:

- Non-pharmacological management is useful for mild or moderate anxiety and distress
- Psychosocial referrals are often under-utilized
- Therapeutic relationships convey understanding and empathy
- Remember cancer affects the family. Patient and close others may benefit from supportive interventions that include problem-solving
- Supportive Counselling, Support groups (Caregiver support groups also available), Individual Psychotherapy – CBT particularly effective for anxiety disorders
- Mindfulness Meditation
- Complementary therapies: relaxation therapy, massage, aroma therapy, reiki, therapeutic touch, art, imagery, social work, animal therapy, physiotherapy
- Treat underlying possible contributing conditions

Step 2b. Pharmacological options:

- Major anxiety disorder likely needs both non-pharmacological and pharmacological treatment
- Acute, short duration: Lorazepam 0.5-2 mg daily-bid prn (Caution: ***frail*** or very ***elderly***)
- Long term control: Clonazepam 0.25-0.5 mg po bid (Caution: ***renal*** or ***liver*** dysfunction or ***frail*** or ***elderly***)
- Severe, chronic anxiety:
    - Duloxetine: (could be useful if coexisting pain)
    - Citalopram: start 10 mg po daily; increase q5-7d to maximum 60 mg daily [useful in Panic disorder] (***Elderly***: maximum 20 mg daily)
    - Escitalopram: start 5 mg po daily; increase q5-7d to maximum 20 mg daily (***Elderly***: maximum 10 mg daily); usual effective dose 10-15 mg
    - Venlafaxine: start 37.5 mg po daily; increase q7d to maximum 225 mg daily; usual dose 75-150 mg daily (dose adjust in ***reduced renal*** clearance)
    - Mirtazapine (good for insomnia too as sedating at doses < 15mg qhs): start 7.5-15 mg po qhs; increase q7-14d; usual dose 15-45mg
- 2nd line: Olanzapine 2.5-5 mg po qhs-bid (off-label use) or Quetiapine 6.25-12.5 mg po qhs (off-label use) (Caution: ***elderly***)
- Propranolol (10-20 mg po daily-bid) maybe used in select cases to control somatic symptoms of panic disorder and/or anxiety (Caution: ***elderly***)

Step 3. When to refer to specialists:

- Psychiatrist:
    - If anxiety symptoms worsening despite above treatments
    - Significant history of anxiety or other psychiatric illness that predates latest episode
    - Severe distress with risk of harm to self and/or others
- Palliative Care:
    - Concomitant physical symptoms (like pain) that are difficult to control
    - Existential distress requiring involvement of multidisciplinary team (social worker, rehabilitation, spiritual care)

For more detailed information on Anxiety and Distress visit:
https://www.cancercareontario.ca/en/symptom-management/3981

End of Life Considerations:

- Benzodiazepines maybe more useful as 1st-line
- Delirium is common in end of life and requires different management. See delirium tip.

NOTE: Guidelines do not replace individualized care and clinical expertise.

References:

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