When it’s all too much

Careful elimination of differentials leads to a diagnosis of general anxiety disorder in a young student

Case report

A 24-year-old student presents a month before his final examinations with decreased energy, tension in the neck and back, and sleep impairment. On further questioning, persistent worry, irritability and concentration problems have been present for months. Past medical history is notable for irritable bowel syndrome and tension headaches. There is no substance use or alcohol abuse history.

Physical examination is normal, and a battery of recent tests including: urine toxicology screening, full blood count, liver function tests, thyroid function, fasting glucose, ESR and U&L are normal. Mental state examination shows a young man who presents as euthymic, and is noted to be alert and ‘eager’. Excessive worry is also noted. There are no self-harm features and the rest of the examination is unremarkable.

Discussion

The features of poor sleep, low energy and concentration suggest are suggestive of depression, but the absence of low mood in the history or examination makes this unlikely. Hypomania presents with symptoms including poor sleep and concentration impairment, and patients may appear excessively alert but the absence of ‘core’ symptoms such as pressure of speech, flight of ideas, mood changes or physical restlessness or disinhibition also makes this unlikely. An adjustment reaction may be present, with a number of symptoms emerging in the context of ongoing stressor tests. However, the multiple symptoms reported would not be typical of an adjustment process. A somatoform disorder (a history of repeated physical complaints with no physical basis) could be considered, but the cluster of symptoms could be most accurately diagnosed as representing generalised anxiety disorder (GAD).

GAD is an anxiety disorder characterised by excessive, uncontrollable and irrational worry, plus a range of accompanying physical symptoms, which cause significant distress and functional impairment. It is generally free-floating and persistent in nature and is not clearly associated with specific triggers (as is the case for other anxiety disorders such as agoraphobia and social phobia). It is often accompanied by feelings of apprehension as well as symptoms of muscle and psychic tension.

It is a very common condition; the estimated point prevalence of GAD in the population is 5 per cent. Patients commonly present with physical complaints and, unlike in panic disorder, the anxiety, particularly the worry symptoms, are often not spontaneously reported by the patient. GAD is often present in, and can complicate, conditions such as irritable bowel syndrome, tension headache and fibromyalgia. The diagnostic criteria are outlined in Table 1. GAD is also associated with several psychiatric conditions including: other anxiety disorders (panic disorder, agoraphobia, social phobia), major depressive disorder, substance misuse and dysthymia. A number of medical conditions may also be associated with anxiety-like symptoms (see Table 2).

Cognitive behavioural therapy has emerged as a major treatment for anxiety disorders

Twenty years ago, the most commonly used drug treatments for GAD were the tricyclic antidepressants, monoamine oxidase inhibitors and benzodiazepines. However, today the serotonin selective reuptake inhibitors (SSRIs), the serotonin and noradrenergic reuptake inhibitors (SNRIs) and pregabalin appear to be the current drug treatments of choice in GAD.

As with any clinical scenario where anxiety is significant, starting doses should be kept low when initiating treatment in GAD, as higher starting doses (such as those used in depression) may temporarily exacerbate anxiety and thus lead to patients prematurely stopping treatment. Escitalopram 5mg, duloxetine 30mg or venlafaxine 37.5mg daily are appropriate starting doses; a slow titration up to a therapeutic dose can be done over a number of weeks.

Although generally well-tolerated, SSRIs and SNRIs may cause anxiety as a side-effect. They are also often prescribed for other conditions, and thus lead to patients permanently exacerbating anxiety. CBT can be used as a major treatment for anxiety disorders. In GAD, CBT focuses both on the underlying abrant worry process, through challenging and restructuring the maladaptive cognitions and thoughts that underlie the condition. CBT can also use anxiety management techniques such as progressive muscular relaxation, use of positive mental imagery, and instruction in breathing control. However, the limited availability of CBT remains an issue. Generic anxiety management programmes employing a group model are widely-used in Ireland, and these generally combine both psycho-education and instruction in anxiety management techniques.

Lifestyle modifications, such as avoidance of excessive caffeine or alcohol, attendance to sleep hygiene, and mild to moderate aerobic exercise are also beneficial.

Table 1: DSM-IV diagnostic criteria for assessing generalised anxiety disorder in patients

- A. At least six months of ‘excessive anxiety and worry’ about a variety of events and situations
- B. There is significant difficulty in controlling the anxiety and worry
- C. The presence for most days over the previous six months of three or more of the following symptoms:
  - Feeling wound-up, tense or restless
  - Easily becoming fatigued or worn-out
  - Concentration problems
  - Irritability
  - Significant tension in muscles
  - Difficulty with sleep
- D. The symptoms are not part of another mental disorder
- E. The symptoms cause ‘clinically significant distress’ or problems functioning in daily life.
- F. The condition is not due to a substance or medical issue

Table 2: Medical conditions commonly associated with anxiety-like symptoms in a patient

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Anxiety-like symptoms in a patient</th>
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<tbody>
<tr>
<td>Cardiovascular:</td>
<td>arrhythmias, ischaemic heart disease (IHD), cardiac failure, mitral valve disease</td>
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<tr>
<td>Respiratory:</td>
<td>asthma, COPD, pulmonary embolus, hypoxia</td>
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<tr>
<td>Neurological:</td>
<td>temporal lobe epilepsy (TLE), vestibular nerve disease</td>
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<tr>
<td>Endocrine:</td>
<td>hypothyroidism, hypoglycaemia, hypoparathyroidism</td>
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<tr>
<td>Miscellaneous:</td>
<td>anaemia, SLE/lupus, porphyria</td>
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</tbody>
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