Ward Medication Management
E- News
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From the Head of Clinical Development

Welcome to February's newsletter. I trust you are all back on board after the Christmas and New Year festivities.

This newsletter focuses on the non-pharmacological and pharmacological treatments of anxiety.

Anxiety is notoriously difficult to treat and it is easy to label individuals as being difficult if they suffer from anxiety.

People with no experience of anxiety have been heard saying things like

"Life's too short to be sad"

"It's all in your head"

"Why can't you just cheer up"

But unfortunately finding the courage isn't that easy to do.

Non-pharmacological therapies

Psychotherapy options

Clinicians often prescribe medication for elderly patients with generalized anxiety disorder. **Yet drugs may not be the best choice for older patients because people in this age group are more prone to side effects.** And older patients may typically prefer alternatives to drug treatment.

The literature most strongly supports the use of cognitive behavioural therapy (CBT) as the first-line psychotherapy for treating generalized anxiety disorder in the elderly. Response rates vary widely in different studies, but the Cochrane review found that overall, 46% of elderly patients with anxiety (including generalized anxiety disorder, but not restricted to this diagnosis) experienced symptom relief with CBT, compared with 14% of controls.

Examples of CBT for older adults include giving homework reminders, frequently reviewing relaxation techniques or other skills, and using concrete examples when discussing ways to reframe a situation. It's also likely that CBT is most effective as part of a multipronged treatment strategy that also includes medication.

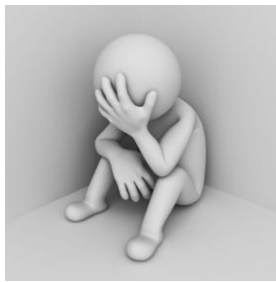
Drugs may not be the best choice for older patients

Low-dose medications

Age-related changes in the absorption and metabolism of drugs tend to make drugs linger longer in the body, increasing the risk for harmful effects in elderly patients, even at doses considered safe for younger people. Older adults also are more likely to use a variety of medications, and some of these drugs may interact with anxiety medications.

For these reasons, any drug treatment needs to be individualized. If medications are prescribed, doses may be lower than those prescribed for younger patients.

Mary Mickael, Clinical Pharmacist, Ward MM.



Feature Article:

Drug therapy for anxiety

Antidepressants:

- For GAD, SSRIs and related antidepressants (e.g. venlafaxine) are effective long-term treatment, even in the absence of depression. Starting doses should be low because their stimulating properties may initially exacerbate GAD symptoms. Allow 2–3 weeks for onset of beneficial effects.
- In panic disorder, antidepressants reduce symptoms compared with placebo. Both SSRIs and tricyclic antidepressants (TCAs) have good evidence for effectiveness.

Benzodiazepines

This large class of drugs includes long-acting agents such as diazepam and clonazepam that linger in the body, and shorter-acting agents such as lorazepam and oxazepam. Low-dose, short-acting benzodiazepines were once the treatment of choice in elderly patients with generalized anxiety disorder, but that has changed because of concern about side effects. These drugs can cause memory loss, impair movement, and increase risk of falls in all patients, and may cause incontinence or accelerate cognitive decline in the elderly.

If benzodiazepines are prescribed, the best idea is to find the lowest effective dose, and regularly monitor for side effects.

Beta-blockers

May be used to treat symptoms of GAD, such as tremor and palpitations; however, many older people have coexisting conditions where beta-blocker use may be difficult e.g. asthma. One of the most commonly used beta blockers for treating anxiety is propranolol

Duration of treatment

Antidepressant: continue for 6–12 months in the first instance; some people need ongoing medication. Beta-blocker: review requirement once anxiety abates Benzodiazepine: use for shortest time possible, generally no longer than 4 weeks.

Key points

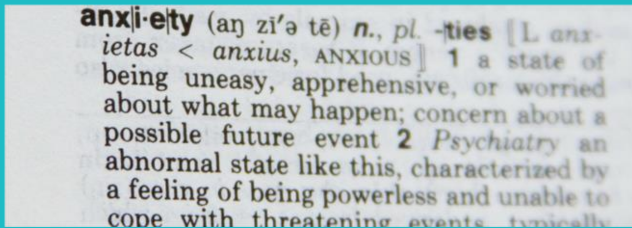
- Elderly patients with generalized anxiety disorder tend to experience more physical symptoms, and less intense emotional disruption.
- Drugs may not be the best choice for older patients because they are more prone to side effects.
- Cognitive behavioural therapy is a good first-line psychotherapy for treating generalized anxiety disorder in the elderly.
- Venlafaxine can cause dose-related hypertension; monitoring of blood pressure would be advisable.
- It's recommended to avoid using beta-blockers in patients with reversible airways disease, bradycardia, hypotension or uncontrolled heart failure, and to use with caution in patients with diabetes, peripheral vascular disease or hyperthyroidism.
- I would like to wrap up with Carole's inspirational words conquering the giant anxiety ghost:

  "I know my weaknesses, we all have those, but I've also found my strengths, and nobody can take those away from me. Take heart, you can lead a normal life. Remember there are lots of people who have the same problems – you're not alone, everyone has their own personal cross to carry, so learn to carry yours in whichever way is right for you. Be kind to others and it will be returned to you. Just remember, you're important, you are needed, you have been put here for a purpose." – Carole, 72, NS

Mary Mickael, Clinical Pharmacist, Ward MM.

Quick Tip

Anxiety Myths – Busted



Studies have shown that trying to suppress your thoughts can make them stronger and more frequent. So, avoidance techniques such as snapping a rubber band you are wearing around your wrist will not help prevent you from having unpleasant thoughts.

You will not pass out or lose control if you have a panic attack. During a panic attack your blood pressure is raised and this prevents you from fainting.

Paper bags can be considered a safety crutch but unfortunately sometimes this can lead to exaggerating your symptoms. Hyperventilating can be uncomfortable but isn't dangerous.

If you have an anxiety disorder, avoiding triggers can lead to reinforcing the anxiety. You can be anxious and still do what you have to do.

Sometimes eating a healthy diet, exercising, avoiding caffeine and alcohol can help to reduce your anxiety/stress levels. Anxiety is a recognised medical disorder so it will not just go away.

Having supportive family and friends is important. Use your support network to develop healthy strategies to manage your anxiety not as a crutch to maintain your fears.

Information source: The Anxiety and depression Association of America www.adaa.org

For support please consider the following websites:

www.beyondblue.com.au

www.sane.org

www.healthdirect.gov.au/anxiety

Natalie Soulsby, Head of Clinical Development Ward MM.

Latest News

Understanding Pain in Aged Care: The UNPAC Study

Chris Alderman, Natalie Soulsby, Trevor Ward and Leah Bisiani. Journal of Pharmacy Practice and Research (2018) 48 pp85-91.

This study aimed to quantify the use of analgesic medication in Australian aged care. This study used medication information obtained in Residential Medication Management Reviews (RMMRs) and recorded in the WardMM database. In total 22319 RMMRs were included from 227 aged care facilities across five states.

The key medications included in the analysis were opioids, simple analgesics, co-analgesics and medications to treat common adverse effects of pain medications (anti-emetics and aperients).

- The most common indication recorded for analgesia was osteoarthritis. Less than 15% of analgesic orders had an indication recorded.
- Paracetamol was the most prevalent analgesic.
- Oxycodone was the most common opioid analgesic ordered.
- Pregabalin was the most common co-analgesic medication followed.
- Docusate (56.0%) was the most common aperient closely followed by senna (50.4%).
- Metoclopramide was the most common anti-emetic ordered.
- All medications were prescribed at less than the average maintenance adult daily dose.

This study is one of the largest to be undertaken in Australia using RMMR data. It has shown that analgesia is widely prescribed in aged care with the most common indication osteoarthritis. Given the prevalence of use of analgesics in this population further research to optimise dosing and choice of analgesic should be a priority. This study has provided a solid knowledge base on which to build further research in this area.

Your Questions Answered

Notes from facilities serviced by Ward MM

It is quite common for us to receive similar enquiries from more than one facility in our network. In this section we summarise questions with a common basis – as a part of our "connect – network – share" ethos, we share the information with all of our facilities.

Q. "How do you recognise benzodiazepine toxicity and how is it treated?"

A. Benzodiazepine overdoses are common presentations at to emergency departments. The most common reasons for presentation include a deliberate overdose (suicide attempt), an accidental overdose (misunderstanding dosing instructions) and co-ingestion of medications with similar sedating effects such as alcohol or pain-relief medications (e.g. opioids). The elderly are more at risk of benzodiazepine toxicity, compared to the younger population, due to changes in their ability to clear drugs and the increased likelihood of being prescribed multiple medications with sedating or CNS suppressant effects.

Signs of benzodiazepine toxicity include sedation with impaired mental status (more than is usual for the resident), which can also manifest as impaired attention or memory. They may also present with slurred speech and ataxia (unsteady gait). Other physical signs may include nystagmus and decreased deep tendon reflexes. Some more subtle signs may include signs of impaired mental status including inappropriate behaviour or judgement. This clearly makes the diagnosis even more problematic for those residents prescribed benzodiazepines who already have impaired cognitive function.

Treatment is primarily symptom management as it is rarely life threatening. This would consist of ensuring that the patients airway is maintained and that they do not have respiratory depression. Should we mention withholding the offending medication on advice from the doctor?

Ideally benzodiazepines should only be prescribed for short periods of time as chronic use has been associated with cognitive impairment, falls, dependence and tolerance. Chronic use has also been associated with an increased risk of hip fractures, particularly in the elderly, where the risk is 60% within the first 2 weeks but this increases to 80% after one month of use.

Source: BMJ Best Practice Benzodiazepine Overdose Nov 2017

Natalie Soulsby, Head of Clinical Development, Ward MM.

Meet your Ward MM Team Member

Georgia Lakoumentas lives a happy, hectic whirlwind life of family and work. She juggles three paid jobs (retail pharmacist, clinical pharmacist, care coordinator) and one unpaid job (with husband Chris, two teenage kids Angelos and Ariana, and one teenage Cavoodle Xanthe). She started her working life with a B.Sc (Hons) in Genetics, worked in a research lab and ended up in pharmacy, both here and in the UK. She initially decided to join Ward MM to consolidate and streamline her HMR work. But it has actually opened up a wormhole of amazing opportunities with her Care Coordinator role, that she is finding makes her a better HMR pharmacist. She loves a travel adventure, the perfect cup of coffee, a good gym or Pilates workout and interior decorating.

Most meaningful moments… Any moment spent laughing with my family.

My biggest challenge… Surviving the next few years of menopause, teenage-hood and two rounds of VCE!

I'd be lost without… My phone….literally! 'Maps' is my best friend on the HMR road and 'Calendar' because if it ain't in there, it ain't happening!