NHS
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Quick reference guide

Issue date: January 2011

Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults

Management in primary, secondary and community care

This updates and replaces NICE clinical guideline 22

NICE clinical guideline 113
Developed by the National Collaborating Centre for Mental Health and the National Collaborating Centre for Primary Care

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care' (NICE clinical guideline 113).

This guideline updates and replaces NICE clinical guideline 22 (published December 2004; amended April 2007). The recommendations for the management of generalised anxiety disorder have been updated. The recommendations for the management of panic disorder have not been updated.

For more information on how NICE clinical guidelines are developed, go to **www.nice.org.uk**

Who should read this booklet?

This quick reference guide is for healthcare professionals and other staff who care for people with generalised anxiety disorder or panic disorder.

Who wrote the guideline?

The recommendations on generalised anxiety disorder were developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists and the British Psychological Society. The recommendations on panic disorder were developed by the National Collaborating Centre for Primary Care, which was based at the Royal College of General Practitioners. Each Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), service users and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation (see page 23 for more details).

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Introduction

Generalised anxiety disorder (GAD) is a common disorder of which the central feature is excessive worry about a number of different events associated with heightened tension. It can exist in isolation but more commonly occurs with other anxiety and depressive disorders. The guideline covers both 'pure' GAD, in which no comorbidities are present, and GAD comorbid with other anxiety and depressive disorders in which GAD is the primary diagnosis.

Panic disorder is characterised by recurring, unforeseen panic attacks followed by at least 1 month of persistent worry about having another attack and concern about its consequences, or a significant change in behaviour related to panic attacks. Panic disorder can be diagnosed with or without agoraphobia.

Generalised anxiety disorder and panic disorder vary in severity and complexity, and both can follow chronic or remitting courses. Where possible, the goal of an intervention should be complete relief of symptoms (remission), which is associated with better functioning and a lower likelihood of relapse.

The guideline assumes that prescribers will use a drug's summary of product characteristics (SPC) to inform their decisions made with individual service users.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), this is indicated in the recommendation or in a footnote.

Person-centred care

Treatment and care should take into account people's individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow people to reach informed decisions about their care. Follow advice on seeking consent from the Department of Health or Welsh Assembly Government if needed. If the person agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Key priorities for implementation

The key priorities for implementation have been chosen from the updated recommendations on the management of GAD.

Step 1: All known and suspected presentations of GAD

Identification

- Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly.
- Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:
  - have a chronic physical health problem **or**
  - do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) **or**
  - are repeatedly worrying about a wide range of different issues.

Step 2: Diagnosed GAD that has not improved after step 1 interventions

Low-intensity psychological interventions for GAD

- For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer one or more of the following as a first-line intervention, guided by the person's preference:
  - individual non-facilitated self-help
  - individual guided self-help
  - psychoeducational groups.

Step 3: GAD with marked functional impairment or that has not improved after step 2 interventions

Treatment options

- For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions:
  - Offer either:
    - an individual high-intensity psychological intervention (see page 12) **or**
    - drug treatment (see page 13).
  - Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.
  - Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

High-intensity psychological interventions

- If a person with GAD chooses a high-intensity psychological intervention, offer either cognitive behavioural therapy (CBT) or applied relaxation.

continued

Key priorities for implementation *continued*

Drug treatment

- If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Consider offering sertraline first because it is the most cost-effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. Monitor the person carefully for adverse reactions.
- Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the 'British national formulary' on the use of a benzodiazepine in this context.
- Do not offer an antipsychotic for the treatment of GAD in primary care.

Inadequate response to step 3 interventions

- Consider referral to step 4 if the person with GAD has severe anxiety with marked functional impairment in conjunction with:
  - a risk of self-harm or suicide **or**
  - significant comorbidity, such as drug misuse, personality disorder or complex physical health problems **or**
  - self-neglect **or**
  - an inadequate response to step 3 interventions.

Principles of care for people with GAD

Information and support for people with GAD

- Build a relationship and work in an open, engaging and non-judgemental manner.
- Explore with the person:
  - their worries, in order to jointly understand the impact of GAD
  - treatment options, indicating that decision making is a shared process.
- Ensure that discussion takes place in settings in which confidentiality, privacy and dignity are respected.
- Provide information appropriate to the person's level of understanding about the nature of GAD and the range of treatments available.
- If possible, ensure that comprehensive written information is available in the person's preferred language and in audio format.
- Offer independent interpreters if needed.
- Inform the person about local and national self-help organisations and support groups.

Supporting families and carers

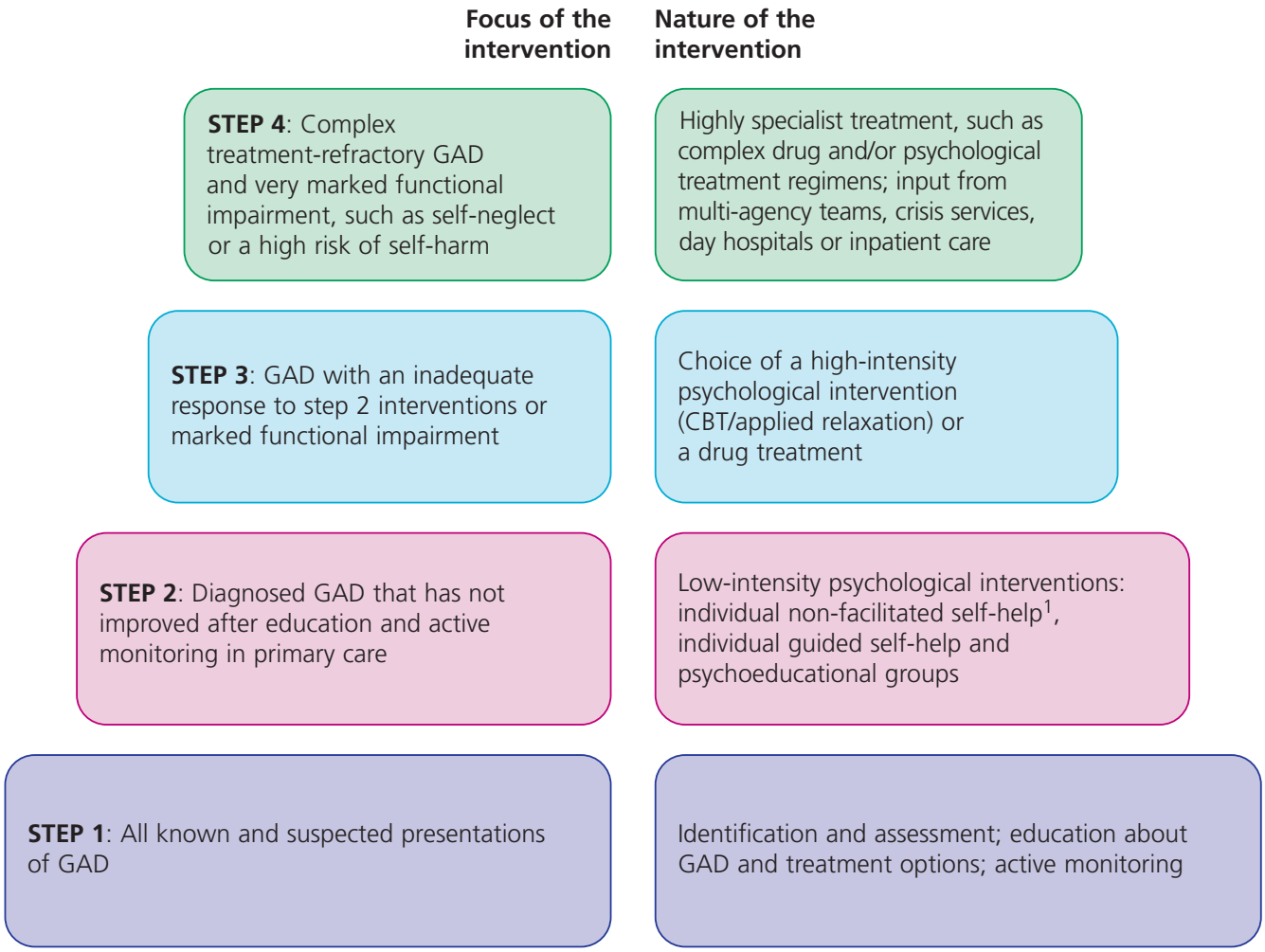
- When families and carers are involved in supporting a person with GAD, consider:
  - offering a carer's assessment of their caring, physical and mental health needs
  - providing information, including contact details, about family and carer support groups and voluntary organisations, and helping families or carers to access these
  - negotiating between the person with GAD and their family or carers about confidentiality and the sharing of information
  - providing written and verbal information on GAD and its management, including how families and carers can support the person
  - providing contact numbers and information about what to do and who to contact in a crisis.

Additional considerations for people with GAD and a learning disability or acquired cognitive impairment

- For people with a mild learning disability or mild acquired cognitive impairment, offer the same interventions as for other people with GAD, adjusting the method of delivery or duration of the intervention if necessary to take account of the disability or impairment.
- When assessing or offering an intervention to people with a moderate to severe learning disability or moderate to severe acquired cognitive impairment, consider consulting with a relevant specialist.

The stepped-care model for GAD

- Follow the stepped-care model shown below, offering the least intrusive, most effective intervention first.



[1] A self-administered intervention intended to treat GAD involving written or electronic self-help materials (usually a book or workbook). It is similar to individual guided self-help but usually with minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes.

Step 1: All known and suspected presentations of GAD

Identification

- Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly.
- Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:
  - have a chronic physical health problem **or**
  - do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) **or**
  - are repeatedly worrying about a wide range of different issues.

- For people seeking reassurance about a chronic physical health problem or somatic symptoms and/or repeated worrying, consider with them whether some of their symptoms may be due to GAD.

Assessment

- Conduct a comprehensive assessment that does not rely solely on the number, severity and duration of symptoms, but also considers the degree of distress and functional impairment.

- Consider how the following factors might have affected the development, course and severity of the person's GAD:
  - any comorbid depressive disorder or other anxiety disorder
  - any comorbid substance misuse
  - any comorbid medical condition
  - a history of mental health disorders
  - past experience of, and response to, treatments.

People with GAD and a comorbid depressive or other anxiety disorder

- Treat the primary disorder first (that is, the one that is more severe and in which it is more likely that treatment will improve overall functioning) (see 'Related NICE guidance', page 23).

People with GAD who misuse substances

- Be aware that:
  - substance misuse can be a complication of GAD
  - non-harmful substance use should not be a contraindication to the treatment of GAD
  - harmful and dependent substance misuse should be treated first (see 'Related NICE guidance', page 23) as this may lead to significant improvement in the symptoms of GAD.

Education and active monitoring

- Provide the person with education about the nature of GAD and the options for treatment, including the 'Understanding NICE guidance' booklet' (see 'Further information', page 23).
- Actively monitor the person's symptoms and functioning.
- Discuss the use of over-the-counter medications and preparations, and explain the potential for interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

Step 2: Diagnosed GAD that has not improved after step 1 interventions

Low-intensity psychological interventions

- For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer one or more of the low-intensity psychological interventions in the table below, guided by the person's preference.

Type of intervention	Intervention should:
Individual non-facilitated self-help	• Include written or electronic materials of a suitable reading age (or alternative media). • Be based on the treatment principles of cognitive behavioural therapy (CBT). • Include instructions for the person to work systematically through the materials over a period of at least 6 weeks. • Usually involve minimal therapist contact, for example an occasional telephone call of no more than 5 minutes.
Individual guided self-help	• Include written or electronic materials of a suitable reading age (or alternative media). • Be supported by a trained practitioner, who facilitates the self-help programme and reviews progress and outcome. • Usually consist of five to seven weekly or fortnightly face-to-face or telephone sessions, each lasting 20–30 minutes.
Psychoeducational groups	• Be based on CBT principles, have an interactive design and encourage observational learning. • Include presentations and self-help manuals. • Be conducted by trained practitioners. • Have a ratio of one therapist to about 12 participants. • Usually consist of six weekly sessions, each lasting 2 hours.

- Practitioners providing individual guided self-help and/or psychoeducational groups should:
  - receive regular high-quality supervision
  - use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment.

Step 3: GAD with marked functional impairment or that has not improved after step 2 interventions

Treatment options

- For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions, offer either:
  - a high-intensity psychological intervention (see below) **or**
  - drug treatment (see page 13).
- Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.
- Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

High-intensity psychological interventions

- If a person with GAD chooses a high-intensity psychological intervention, offer either CBT or applied relaxation (see the table below).

- Practitioners providing high-intensity psychological interventions for GAD should:
  - have regular supervision to monitor fidelity to the treatment model, using audio or video recording of treatment sessions if possible and if the person consents
  - use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment.
- Consider providing all interventions in the preferred language of the person with GAD if possible.

Type of intervention	Intervention should:
CBT	• Be based on the treatment manuals used in the clinical trials of CBT for GAD. • Be delivered by trained and competent practitioners. • Usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour.
Applied relaxation	• Be based on the treatment manuals used in the clinical trials of applied relaxation for GAD. • Be delivered by trained and competent practitioners. • Usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour.

Drug treatment

- If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Consider offering sertraline first because it is the most cost-effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. Monitor the person carefully for adverse reactions.

- If sertraline is ineffective, offer an alternative SSRI or a serotonin–noradrenaline reuptake inhibitor (SNRI), taking into account the following factors:
  - tendency to produce a withdrawal syndrome (especially with paroxetine and venlafaxine)
  - side-effect profile and potential for drug interactions
  - the risk of suicide and likelihood of toxicity in overdose (especially with venlafaxine)
  - the person's prior experience of treatment with individual drugs (particularly adherence, effectiveness, side effects, experience of withdrawal syndrome and the person's preference).
- If the person cannot tolerate SSRIs or SNRIs, consider offering pregabalin.

- Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the 'British national formulary' on the use of a benzodiazepine in this context.
- Do not offer an antipsychotic for the treatment of GAD in primary care.

- Before prescribing any medication, discuss the treatment options and any concerns the person has about taking medication. Explain fully the reasons for prescribing and provide information on:
  - the likely benefits of different treatments
  - the different propensities of each drug for side effects, withdrawal syndromes and drug interactions
  - the risk of activation with SSRIs and SNRIs, with symptoms such as increased anxiety, agitation and problems sleeping
  - the gradual development, over 1 week or more, of the full anxiolytic effect
  - the importance of taking medication as prescribed and the need to continue drug treatment after remission to avoid relapse.

Managing risks and side effects

- Take into account the increased risk of bleeding associated with SSRIs, particularly for older people or people taking other drugs that can damage the gastrointestinal mucosa or interfere with clotting (for example, NSAIDs or aspirin). Consider prescribing a gastroprotective drug in these circumstances.
- For people aged under 30 who are offered an SSRI or SNRI:
  - warn them that these drugs are associated with an increased risk of suicidal thinking and self-harm in a minority of people under 30 **and**
  - see them within 1 week of first prescribing **and**
  - monitor the risk of suicidal thinking and self-harm weekly for the first month.
- For people who develop side effects soon after starting drug treatment, provide information and consider one of the following strategies:
  - monitoring symptoms closely (if the side effects are mild and acceptable to the person) **or**
  - reducing the dose of the drug **or**
  - stopping the drug and, according to the person's preference, offering either:
    - an alternative drug (see page 13) **or**
    - a high-intensity psychological intervention (see page 12).
- Review the effectiveness and side effects of the drug every 2–4 weeks during the first 3 months of treatment and every 3 months thereafter.

- If a drug is effective, advise the person to continue taking it for at least a year as the likelihood of relapse is high.

Managing an inadequate response to step 3 interventions

- If a person's GAD has not responded to a full course of a high-intensity psychological intervention, offer a drug treatment (see page 13).
- If a person's GAD has not responded to drug treatment, offer either a high-intensity psychological intervention (see page 12) or an alternative drug treatment (see page 13).
- If a person's GAD has partially responded to drug treatment, consider offering a high-intensity psychological intervention (see page 12) in addition to drug treatment.

Referral to secondary care

- Consider referral to step 4 (see page 15) if the person with GAD has severe anxiety with marked functional impairment in conjunction with:
  - a risk of self-harm or suicide **or**
  - significant comorbidity, such as substance misuse, personality disorder or complex physical health problems **or**
  - self-neglect **or**
  - an inadequate response to step 3 interventions.

Step 4[2]: Complex, treatment-refractory GAD and very marked functional impairment or high risk of self-harm

Assessment

- Offer the person a specialist assessment of needs and risks, including:
  - duration and severity of symptoms, functional impairment, comorbidities, risk to self and self-neglect
  - a formal review of current and past treatments, including adherence to previously prescribed drug treatments and the fidelity of prior psychological interventions, and their impact on symptoms and functional impairment
  - home environment
  - support in the community
  - relationships with and impact on families and carers.
- Review the needs of families and carers and offer an assessment of their caring, physical and mental health needs if one has not been offered previously.
- Develop a comprehensive care plan in collaboration with the person with GAD that addresses needs, risks and functional impairment and has a clear treatment plan.

Treatment

- Inform people with GAD who have not been offered or have refused the interventions in steps 1–3 about the potential benefits of these interventions, and offer them any they have not tried.
- Consider offering combinations of psychological and drug treatments, combinations of antidepressants or augmentation of antidepressants with other drugs, but exercise caution and be aware that:
  - evidence for the effectiveness of combination treatments is lacking **and**
  - side effects and interactions are more likely when combining and augmenting antidepressants.

- Combination treatments should be undertaken only by practitioners with expertise in the psychological and drug treatment of complex, treatment-refractory anxiety disorders and after full discussion with the person about the likely advantages and disadvantages of the treatments suggested.

- When treating people with complex and treatment-refractory GAD, inform them of relevant clinical research in which they may wish to participate, working within local and national ethical guidelines at all times.

[2] Step 4 normally refers to community mental health teams but may include specialist services and specialist practitioners in primary care.

Principles of care for people with panic disorder

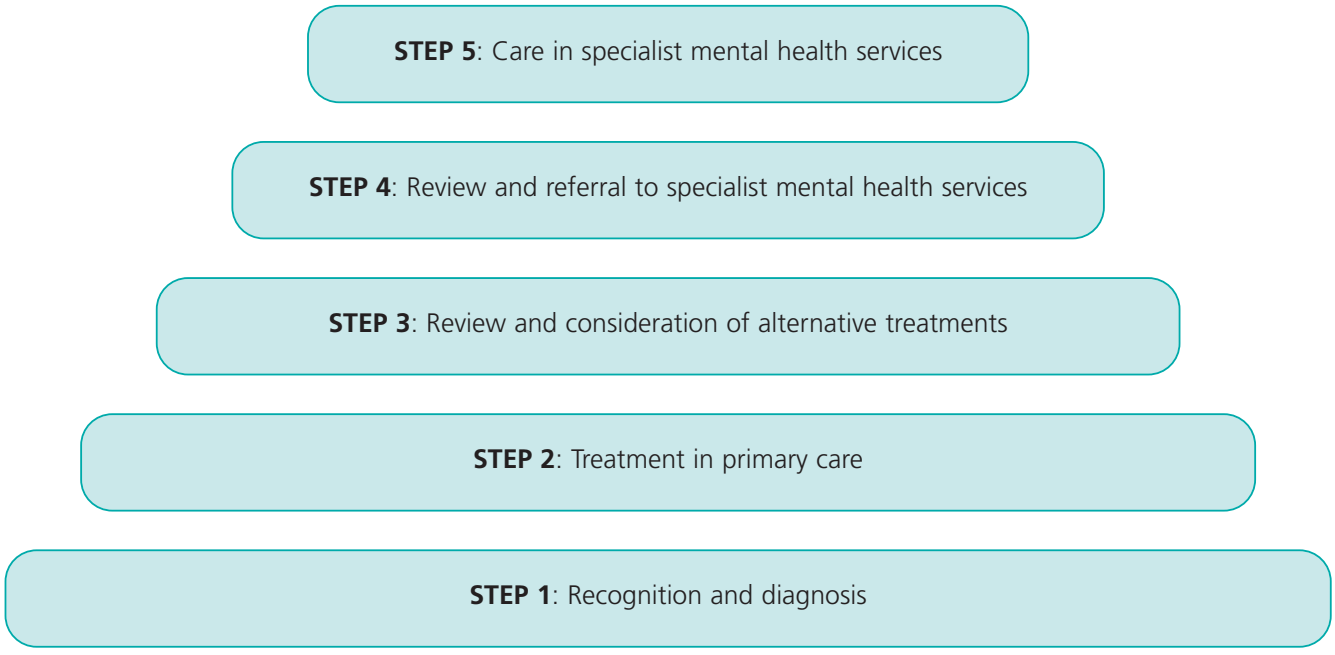
Shared decision-making and information provision

- Shared decision making between the individual and healthcare professionals should take place during diagnosis and all phases of care.
- To facilitate shared decision making:
  - provide evidence-based information about treatment
  - provide information on the nature, course and treatment of panic disorder, including the use and likely side-effect profile of medication
  - discuss concerns about taking medication, such as fears of addiction
  - consider the person's preference and experience and outcome of previous treatments
  - offer information about self-help groups and support groups for people with panic disorder, their families and carers
  - encourage participation in self-help and support groups.

Language

- Use everyday, jargon-free language, and explain any technical terms.
- Where appropriate, provide written material in the language of the person, and seek interpreters for people whose first language is not English.
- Where available, consider providing psychotherapies in the person's own language if this is not English.

The stepped-care model for panic disorder



Step 1: Recognition and diagnosis of panic disorder

Consultation skills

- A high standard of consultation skills is needed so that a structured approach can be taken to the diagnosis and management plan.

Diagnosis

- Ask about relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care.

Comorbidities

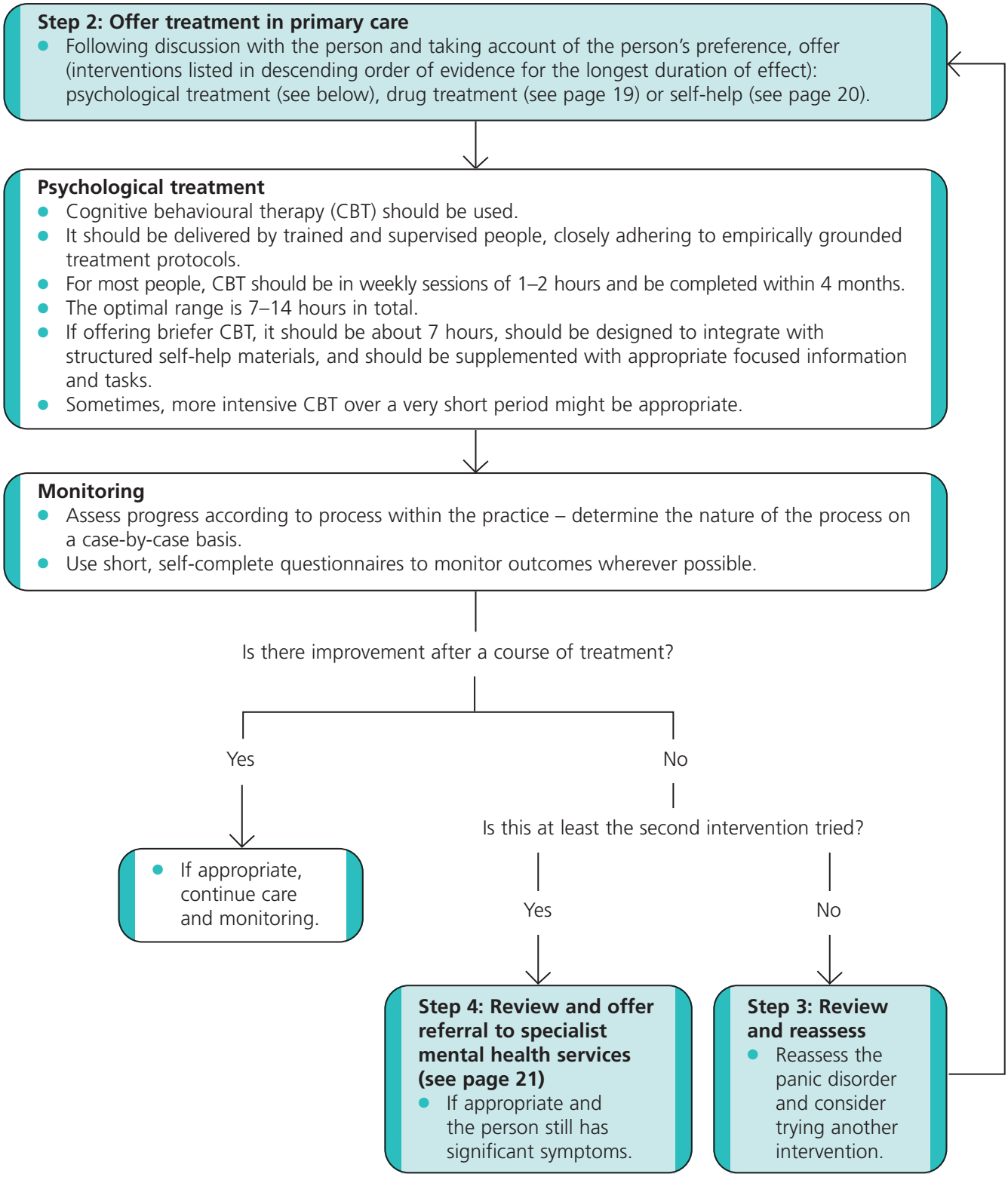
- Be alert to comorbidity, which is common.
- Identify the main problems through discussion with the person.
- Clarify the sequence of the problems to determine the priorities of the comorbidites – drawing up a timeline to show when different problems developed can help with this.

Presentation with a panic attack in accident and emergency departments or other settings

- If a person presents with a panic attack, he or she should:
  - be asked if they are already receiving treatment for panic disorder
  - undergo the minimum investigations necessary to exclude acute physical problems
  - not usually be admitted to a medical or psychiatric bed
  - be referred to primary care for subsequent care, even if assessment has been undertaken in the accident and emergency department
  - be given appropriate written information about panic attacks and why they are being referred to primary care
  - be offered appropriate written information about sources of support, including local and national voluntary and self-help groups.

Steps 2–4: Management of panic disorder in primary care

Psychological treatment, drug treatment and self-help



Step 2: Offer treatment in primary care

- Following discussion with the person and taking account of the person's preference, offer (interventions listed in descending order of evidence for the longest duration of effect): psychological treatment (see page 18), drug treatment (see below) or self-help (see page 20).

Drug treatment

When prescribing

- Offer an SSRI licensed for panic disorder, unless otherwise indicated.
- If an SSRI is not suitable or there is not improvement after a 12-week course, and if further medication is appropriate, consider imipramine[3] or clomipramine[3].
- Inform the person, at the time treatment is initiated, about:
  - potential side effects (including transient increase in anxiety at the start of treatment)
  - possible discontinuation/withdrawal symptoms (see box on page 22)
  - delay in onset of effect
  - time course of treatment
  - need to take medication as prescribed (this may be particularly important with short half-life medication in order to avoid discontinuation/withdrawal symptoms).
- Written information appropriate for the person's needs should be made available.
- Side effects on initiation may be minimised by starting at a low dose and slowly increasing the dose until a satisfactory therapeutic response is achieved.
- Long-term treatment and doses at the upper end of the indicated dose range may be necessary.

[3] At the time of publication (January 2011) imipramine and clomipramine did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

Before prescribing, consider:

- age
- previous treatment response
- risks of deliberate self-harm or accidental overdose (tricyclic antidepressants are more dangerous in overdose than SSRIs)
- tolerability
- possible interactions with concomitant medications (check appendix 1 of the 'British national formulary')
- the person's preference
- cost, where equal effectiveness.
- **Benzodiazepines, sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder.**

Monitoring

- Review efficacy and side effects within 2 weeks of starting treatment and again at 4, 6 and 12 weeks.
- Review at 8–12 week intervals if drug used for more than 12 weeks.
- Follow the summary of product characteristics for all other monitoring required.
- Use short, self-complete questionnaires to monitor outcomes wherever possible.

Has there been an improvement after 12 weeks of treatment?

Yes

Ongoing management

- Use with appropriate monitoring for 6 months after optimal dose reached: then dose can be tapered.
- When stopping, reduce the dose gradually over an extended period.

- If appropriate, continue care and monitoring.

No

Is this at least the second intervention tried?

Yes

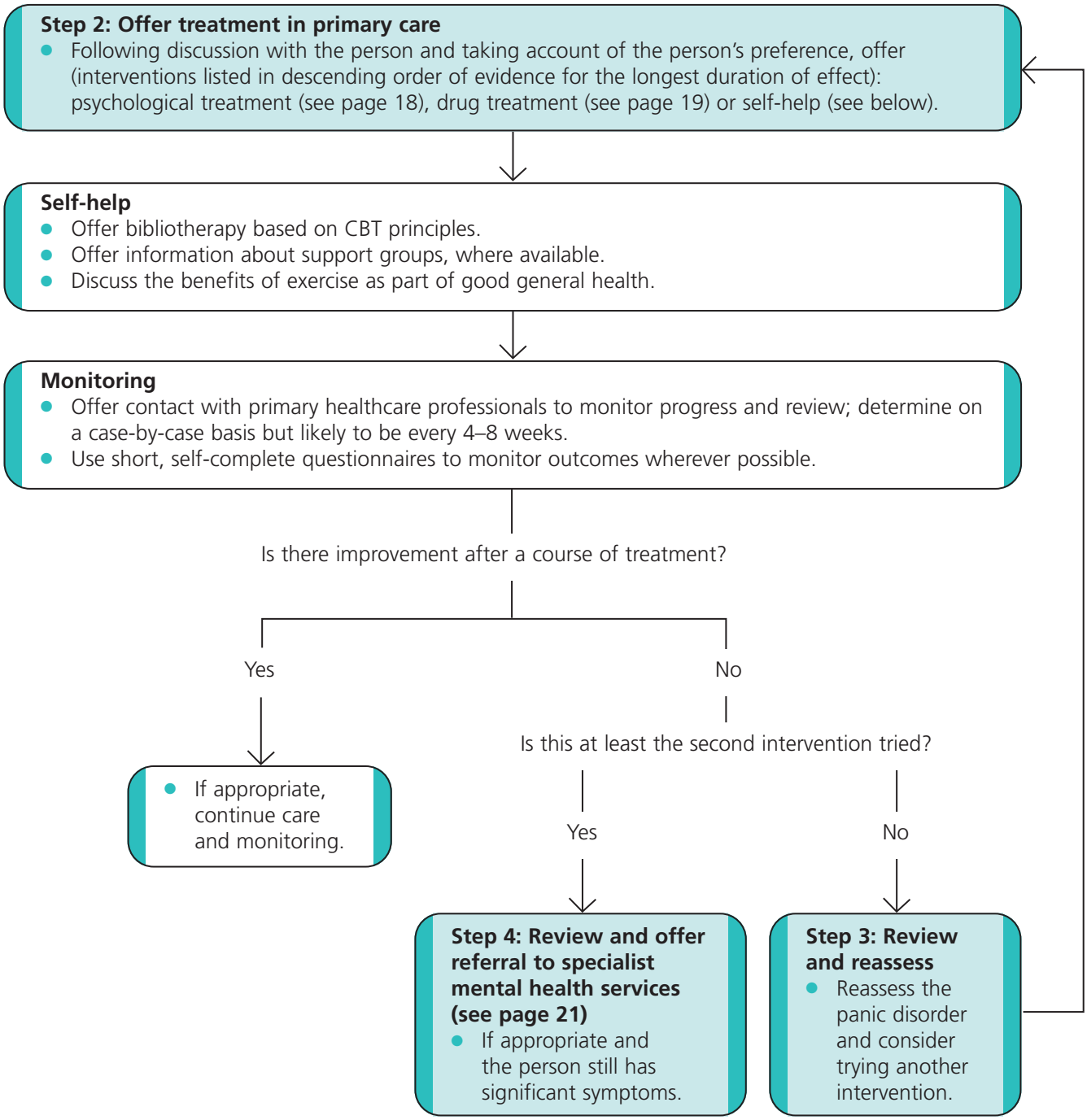
Step 4: Review and offer referral to specialist mental health services (see page 21)

- If appropriate and the person still has significant symptoms.

No

Step 3: Review and reassess

- Reassess the panic disorder and consider trying another intervention.


Step 2: Offer treatment in primary care
Following discussion with the person and taking account of the person's preference, offer (interventions listed in descending order of evidence for the longest duration of effect): psychological treatment (see page 18), drug treatment (see page 19) or self-help (see below).
Self-help
Offer bibliotherapy based on CBT principles.
Offer information about support groups, where available.
Discuss the benefits of exercise as part of good general health.
Monitoring
Offer contact with primary healthcare professionals to monitor progress and review; determine on a case-by-case basis but likely to be every 4–8 weeks.
Use short, self-complete questionnaires to monitor outcomes wherever possible.
Is there improvement after a course of treatment?
Yes
If appropriate, continue care and monitoring.
No
Is this at least the second intervention tried?
Yes
Step 4: Review and offer referral to specialist mental health services (see page 21)
If appropriate and the person still has significant symptoms.
No
Step 3: Review and reassess
Reassess the panic disorder and consider trying another intervention.

Step 5: Care for people with panic disorder in specialist mental health services

- Reassess the person's panic disorder, their environment and their social circumstances. Evaluate:
  - previous treatments, including effectiveness and concordance
  - any substance use, including nicotine, alcohol, caffeine and recreational drugs
  - comorbidities
  - day-to-day functioning
  - social networks
  - continuing chronic stressors
  - the role of agoraphobic and other avoidant symptoms.
- Undertake a comprehensive risk assessment.
- Develop an appropriate risk management plan.

- To carry out these evaluations, and to develop and share a full formulation, more than one session may be required and should be available.

- Consider:
  - treatment of comorbid conditions
  - CBT with an experienced therapist if not offered already, including home-based CBT if attendance at clinic is difficult
  - structured problem solving
  - full exploration of pharmacotherapy
  - day support to relieve carers and family members
  - referral for advice, assessment or management to tertiary centres.

- Ensure accurate and effective communication between all healthcare professionals – particularly between primary care clinicians (GP and teams) and secondary care clinicians (community mental health teams) if there are existing physical health conditions that also require active management.

Antidepressant discontinuation/withdrawal symptoms

- Inform people with panic disorder that:
  - although antidepressants are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.
  - the most commonly experienced discontinuation/withdrawal symptoms are dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances.
  - they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms.
- Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms. To minimise the risk of discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period of time.
- Mild discontinuation/withdrawal symptoms: reassure the person and monitor symptoms.
- Severe discontinuation/withdrawal symptoms: consider reintroducing the antidepressant (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms.

Further information

Ordering information

You can download the following documents from **www.nice.org.uk/guidance/CG113**

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for people with generalised anxiety disorder or panic disorder and their families or carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N2409 (quick reference guide)
- N2410 ('Understanding NICE guidance').

Implementation tools

NICE has developed tools to help organisations implement this guidance (see **www.nice.org.uk/guidance/CG113**).

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see **www.nice.org.uk**

Published

- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100. (2010) Available from **www.nice.org.uk/guidance/CG100**
- Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010). Available from **www.nice.org.uk/guidance/PH24**
- Depression in adults with a chronic physical health problem: treatment and management. NICE clinical guideline 91 (2009). Available from **www.nice.org.uk/guidance/CG91**
- Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009). Available from **www.nice.org.uk/guidance/CG90**
- Medicines adherence. NICE clinical guideline 76 (2009). Available from **www.nice.org.uk/guidance/CG76**
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Under development

NICE is developing the following guidance (details available from **www.nice.org.uk**):

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline. Publication expected February 2011.
- Common mental health disorders. NICE clinical guideline. Publication expected Summer 2011.
- Self-harm (longer term management). NICE clinical guideline. Publication expected November 2011.

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at **www.nice.org.uk/guidance/CG113**

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