

241 - 6E63 Secondary anxiety syndrome

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663 Secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere • certain infectious or parasitic diseases (e.g. neurosyphilis); • diseases of the immune system (e.g. systemic lupus erythematosus); • endocrine, nutritional or metabolic diseases (e.g. hyperadrenalism, hypocalcaemia, hypomagnesaemia, thyrotoxicosis, Wilson disease); • injury, poisoning or certain other consequences of external causes (e.g. brain injury, concussion, traumatic haemorrhage, injury of optic or acoustic nerve); • neoplasms (e.g. neoplasms of brain or meninges). Secondary anxiety syndrome Essential (required) features • The presence of prominent anxiety symptoms (e.g. excessive worry, intense fear that is out of proportion to actual danger, panic attacks) is required for diagnosis. • The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings (as opposed to being a psychological reaction to having the medical condition). This judgement depends on establishing the following. • The medical condition is known to be capable of producing the symptoms. • The course of the anxiety symptoms (e.g. onset, remission, response of the anxiety symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition. • The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. anxiety and fear-related disorders, mood disorders, disorders specifically associated with stress, obsessive-compulsive and related disorders) or the effects of a medication or substance, including withdrawal effects. • The symptoms are sufficiently severe to be a specific focus of clinical attention. Boundaries with other disorders and conditions (differential diagnosis) Boundary with anxiety and fear-related disorders Determining whether anxiety symptoms are due to a medical condition as opposed to manifestations of a mental disorder is often difficult because the clinical presentations may be similar. In some cases, the anxiety symptoms may reach the point of warranting a separate diagnosis of an anxiety or fear-related disorder, or a pre-existing anxiety or fear-related disorder may be exacerbated. Diagnosing secondary anxiety syndrome depends on establishing the presence of a medical condition that can cause anxiety symptoms and a temporal relationship between the medical condition and the anxiety symptoms. If the clinical features are atypical for anxiety and fear-related disorders (e.g. a new onset of unexpected panic attacks in an older adult),

secondary anxiety syndrome is more likely. 6E63 Secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere

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Boundary with anxiety symptoms that are precipitated by the stress of being diagnosed with or worrying about a medical condition Depending on the nature of the medical condition (e.g. a life-threatening type of cancer, a potentially fatal infection) or its onset (e.g. a heart attack, a stroke, a severe injury), anxiety symptoms can occur as a part of a psychological response to being diagnosed and/or having to cope with a severe medical condition. In the absence of evidence of a physiological link between the medical condition and the anxiety symptoms, a diagnosis of secondary anxiety syndrome is not warranted. Instead, the appropriate mental disorder can be diagnosed (e.g. an anxiety or fear-related disorder, adjustment disorder, hypochondriasis).

Boundary with delirium due to disease classified elsewhere Anxiety symptoms can occur in the context of delirium due to disease classified elsewhere. Delirium is characterized by disturbed attention (i.e. reduced ability to direct, focus, sustain and shift attention) and awareness (i.e. reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day, accompanied by other cognitive impairment such as memory deficit, disorientation or impairment in language, visuospatial ability or perception. In contrast, panic attacks or other anxiety symptoms in secondary anxiety syndrome occur in the absence of disturbed attention or severe cognitive impairment. If the anxiety symptoms are judged to be better explained by delirium due to disease classified elsewhere, an additional diagnosis of secondary anxiety syndrome is not warranted.

Boundary with dementia Anxiety symptoms can occur in the context of dementia, which is characterized by a decline from a previous level of cognitive functioning with impairment in two or more cognitive domains (e.g. memory, executive functions, attention, language, social cognition and judgement, psychomotor speed, visuo-perceptual or visuospatial abilities). In contrast, secondary anxiety syndrome is not accompanied by marked cognitive impairment. The presence of anxiety symptoms in the context of dementia can be recorded using the anxiety symptoms in dementia specifier. If the anxiety symptoms are judged to be due to the same medical condition as is causing the dementia, an additional diagnosis of secondary anxiety syndrome is not warranted.

Boundary with anxiety symptoms caused by substances or medications, including withdrawal effects When establishing a diagnosis of secondary anxiety syndrome, it is important to rule out the possibility that a medication or substance is causing the anxiety symptoms instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause anxiety symptoms at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the anxiety symptoms should be established (i.e. the anxiety symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and anxiety symptoms who are also using a psychoactive substance known to cause anxiety, in the context of either intoxication or withdrawal (e.g. panic attacks during anxiolytic or opioid withdrawal, physiological symptoms of excessive autonomic arousal in stimulant intoxication). In such cases, if the intensity or duration of the anxiety symptoms is substantially in excess of anxiety symptoms that are characteristic of the substance-specific intoxication or withdrawal syndrome, then substance-induced anxiety disorder is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

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