07 - Anxiety disorders

Anxiety disorders

Drug treatment of psychiatric symptoms in the context of other conditions CHAPTER 10 are more effective than placebo in the treatment of depression in PLWH16 and may improve adherence to ART.17 Selective serotonin reuptake inhibitors (SSRIs) are preferred as first-line agents. Escitalopram/citalopram18,19 probably have lower risk of pharmacokinetic interactions, although one study found no difference between the efficacy of escitalopram and placebo, possibly because of a large placebo response.20 Electrocardiogram (ECG) monitoring is recommended when citalopram/escitalopram is co-administered with ART that prolongs the QT interval.9,21 Mirtazapine is effective22,23 and may be beneficial in coexisting HIV wasting and depression24 or in reducing methamfetamine use among active users.25 The serotonin–noradrenaline reuptake inhibitors (SNRIs) duloxetine and venlafaxine were found to be as effective as SSRIs for depressive symptoms in PLWH.26 Bupropion was effective with similar tolerability to SSRIs in a 6-week open-label study in a small number of HIV-positive, depressed out-patients.27 The adverse effect burden of tricyclic antidepressants (TCAs) may limit efficacy and compliance, although their use may be appropriate, particularly in patients troubled with insomnia, irritable bowel disease or painful neuropathy related to HIV or ART. Constipation and dry mouth are frequently reported in PLWH on TCAs.16 Monoamine oxidase inhibitors (MAOIs) are not recommended in PLWH. Bipolar affective disorder Mania in PLWH can be primary (pre-existing bipolar affective disorder) or, rarely, secondary (‘HIV mania’ associated with late-stage HIV infection). Treatment of bipolar disorder in HIV is similar to that in the general population.27 Lithium is renally excreted and so cytochrome P450 (CYP) interactions are unlikely. However, its use can be problematic in renal impairment, something which is often seen in PLWH. Lithium may be used cautiously in PLWH for primary bipolar disorder with close monitoring to avoid development of toxicity. Carbamazepine should be avoided because of significant drug interactions with ART and the risk of blood dyscrasias.28 Valproate is a known teratogen and should not be used in women of childbearing age.29 Its use is also best avoided with other hepatotoxic drugs (e.g. nevirapine, rifampicin)28 and where there is infection involving the liver (e.g. hepatitis C, mycobacterium avium complex30). Mood-stabilising antipsychotics such as risperidone, quetiapine, aripiprazole and olanzapine may be preferred. Secondary mania (‘HIV mania’) Secondary mania may infrequently be seen in advanced illness in the context of HIV-associated neurocognitive disorders or central nervous system (CNS) opportunistic infections. The primary aim is to identify and treat the potential underlying cause (infections, substance misuse, alcohol withdrawal, metabolic abnormalities). Secondary mania may respond to quetiapine, olanzapine, aripiprazole or ziprasidone31 but their efficacy has not been demonstrated in clinical trials. Anxiety disorders Anxiety disorders, including generalised anxiety disorder, obsessive compulsive disorder, panic disorder and post-traumatic stress disorder (PTSD), are highly prevalent in PLWH.32 Treatment follows standard guidelines for the management of anxiety disorders, with

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