CBT Effective in Pilot Study of GAD Patients

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — Data increasingly support the use of individualized cognitive-behavioral therapy in primary care as a treatment for late-life generalized anxiety disorder, Melinda A. Stanley, Ph.D., said at the annual meeting of the American Association of Geriatric Psychiatry.

"A CBT approach is time-limited, directive, and collaborative, which makes it more palatable," said Dr. Stanley, a psychologist of the department of psychiatry and behavioral sciences at Baylor College of Medicine, Houston. "We also have a fair amount of efficacy data now for younger adult populations with GAD that cognitive-behavior therapy can be effective."

In a pilot study that was published in 2003, Dr. Stanley and her associates enrolled 12 elderly patients with generalized anxiety disorder (GAD) and a Mini-Mental State Examination score of 24 or greater in a randomized trial of individualized CBT treatment vs. "usual care" for late-life GAD. Patients were recruited from primary care waiting rooms, physician referral, or self-referral.

The mean age of patients was 71 years; 83% were women and about 50% were white. Half of the study participants were using psychotropic medications, she said.

The six patients in the CBT group received 8-10 sessions of CBT that included components of problem-solving training, sleep management skills, and increased attention to learning and memory difficulties (Am. J. Geriatr. Psychiatry 2003;11:92-6).

"We also are able to administer the intervention with more flexibility, primarily because we're administering it to individuals rather than to groups," Dr. Stanley explained when describing the treatment approach, which continues to be studied.

"We can vary the number and scheduling of the sessions. We can do home visits if necessary, and we can change the emphasis on different treatment components as needed. For example, some patients come to us who don't have much in the way of [sleep] difficulty, so we don't spend much time teaching behavioral sleep skills," she explained.

Physicians can 'administer the intervention with more flexibility, primarily because we're administering it to individuals rather than to groups.'

The treatment lasted for an average of 8 weeks.

Patients in the control group received usual care with telephone follow-up. "We called them biweekly to make sure no emergency services were needed and to try and reduce hospital admission," she said.

Compared with controls, patients in the CBT group experienced statistically significant improvements in GAD severity, worry as measured by the Penn State Worry Questionnaire, and depression based on the Beck Depression Inventory, Dr. Stanley said.

In addition, patients in the CBT group experienced large effect sizes, compared with controls, in several measures: anxiety based on the Beck Anxiety Inventory; quality of life based on the Quality of Life Inventory; and perceived mental health, general health, and social functioning based on the 36-item short-form health survey (SF-36). However, these differences trended toward statistical significance.

There were no differences between the two groups in terms of the number of mental health referrals or visits, total number of medical visits, or number of new psychotropic medications.

On the basis of results of the pilot study, Dr. Stanley and her associates have launched a larger trial funded by the National Institute of Mental Health. The goal is to randomly assign 150 older primary care patients with GAD to receive either CBT or usual care with an evaluation of outcome made by an independent investigator.

"All of the baseline posttreatment follow-up assessments are being done by people who have no other connection to the study," she reported. "They're all being done via telephone, and we're following them for 1 year." No outcome data are available yet. ■

Long-Term Benzodiazepine Use Appears Safe in Elderly

BY KERRI WACHTER
Senior Writer

WASHINGTON — Chronic benzodiazepine use by the elderly does not necessarily lead to an increased risk of death, hospital readmission, institutionalization, or functional decline, Christophe J. Bula, M.D., said at the annual meeting of the Gerontological Society of America.

Dr. Bula of Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland, and his colleagues studied 304 patients admitted from the emergency department to the internal medicine department of an academic hospital over a 6-month period.

They found that the patients who were chronic users of benzodiazepines were no more likely to die, to be readmitted to the hospital, to be admitted to a nursing home, or to experience functional decline than were the nonchronic users.

Chronic users were more likely to improve their cognitive performance at 6 months, which suggests a temporary impairment at hospitalization.

Patients were included in the study if they were 75 years or older, lived in the community, had a hospital stay of at least 12 hours, and had basic insurance. At baseline, patients underwent a bedside interview and a geriatric assessment—including cognitive, affective, and physical components—by a trained research nurse. Utilization data (hospital and nursing home admissions) were obtained from the state centralized billing office records.

The patients were followed with a phone interview at 3 months and a home visit at 6 months. The home visit involved the same interview and assessment as at baseline, Dr. Bula said.

For this study, benzodiazepines included any drug from groups N05B (anxiolytics) and N05C (hypnotics and sedatives) of the Anatomical Therapeutic Chemical classification system. Chronic use was defined as self-reported use at least three times per week in the previous month. The validity of this definition was assessed in a small subgroup by repeating the drug use portion of the interview and by urine analysis. Both showed good agreement.

Almost half (45%) of the patients were chronic users of benzodiazepines. Following multivariate analysis, chronic users were more likely to be women (OR 2.4), to have a high school education (OR 1.9), to have in-home help (OR 2.3), and to have depressive symptoms (OR 1.7).

"We think that the baseline differences between chronic benzodiazepine users and the others suggest a strong prescribing bias, where practitioners seem to avoid prescribing benzodiazepines to the frailest elderly," Dr. Bula said at the meeting.

Interestingly, chronic users were more likely to improve their cognitive performance at 6 months (adjusted OR 2.4). Improved cognition among chronic users suggests a temporary impairment in cognitive performance at hospitalization, he said.

"This could be consistent with what we know about the increased risk of chronic users to become delirious when they are hospitalized," he noted. ■

New Epilepsy Drugs Cause Fewer Side Effects Than Carbamazepine

BY MARK BLOOM
Contributing Writer

BOSTON – A Veterans Affairs cooperative study of epilepsy in the elderly has found that two newer agents are as effective as carbamazepine at controlling seizures but are far less likely to cause unpleasant side effects in this age group than the old standby antiepileptic agent.

The newer antiepileptic drugs (AEDs), gabapentin (Neurontin) and lamotrigine (Lamictal), were matched against the enzyme inducer, carbamazepine, in an 18-center randomized double-blind study of 593 patients that lasted 1 year, said A. James Rowan, M.D., a professor of neurology at Mount Sinai School of Medicine, New York.

Of the two newer drugs, lamotrigine was significantly superior to gabapentin in terms of patient retention over the length of the study. Neither of the newer agents was significantly better than carbamazepine in preventing seizures, said Dr. Rowan, who was codirector of the VA study.

The trial also found that optimal doses of AEDs may be lower in elderly patients, he reported at a meeting on epilepsy in the elderly sponsored by Boston University. The mean plasma levels of all three drugs were low "but that seems to be enough for this population," he said.

The patients were 60 years or older (mean age 72.8 years) with a history of one or more seizures and no previous AED therapy, or inadequate therapy. Aside from patients with medical conditions that suggested they would not survive for a year, "we took all comers, with multiple illnesses and multiple medications—the real world," Dr. Rowan said.

The patients were titrated to the target doses: 600 mg for carbamazepine, 1,500 mg for gabapentin, and 150 mg for lamotrigine. Clinicians had the flexibility to titrate further for tolerability, and after 12 months the mean doses were 582 mg for carbamazepine, 1,614 mg for gabapentin, and 152 mg for lamotrigine. "It was very much like office practice," he said.

At the end of 12 months, "carbamazepine had significantly more side effects than lamotrigine or gabapentin," which led to earlier termination of therapy, according to Dr. Rowan.

In the nursing home world, he added, adverse side effects and drug interactions, which are often promptly noted and reported in younger epilepsy patients, may be unnoticed or underreported among the elderly.

Of the 197 original carbamazepine patients, 72 finished the study (37%). That compared with 95 of 193 gabapentin patients (49%) and 114 of 197 patients in the lamotrigine arm (58%).

Among the neurologic side effects, carbamazepine led to sedation for 51% and cognitive symptoms for 32%. In the gabapentin arm, 46% of patients reported sedation and 29% had cognitive symptoms. Of lamotrigine patients, 40% reported sedation and 23% cognitive symptoms. ■