Editorial Open Acces

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## Introduction

In the United States, anxiety disorders are the most prevalent group of psychiatric disorders [1]. ey cause signi cant social and functional impairments in individuals who are a ected by these disorders [2]. Current data indicates that the prevalence of anxiety disorders in greater in the older adults than previously acknowledged [3]. e rates of anxiety symptoms that did meet the criteria for a psychiatric diagnosis in older adults were 15% to 20% in the general community and primary care samples [4]. e National Comorbidity Survey Replication (NCS-R) found that among adults older than 60 years in age, the prevalence of any anxiety disorder was 15.3%. Among the anxiety disorders, speci c phobia was the most prevalent (7.5%) followed by social phobia (6.6%), generalized anxiety disorder (GAD) (3.6%), posttraumatic stress disorders (PTSD) (2.5%), panic disorder (2%), agoraphobia without panic (1%) and obsessive compulsive disorder (OCD) (0.7%) [1].

### Risk factors

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of anxiety disorders indicate that three of the four benzodiazepines used in the studies are not available in the US (abecarnil, alpidem, Ketazolam) [22-25]. Also, these studies were of short duration as they lasted between 3 and 6 weeks. However, these drugs reduced anxiety to a greater extent than placebo and were fairly well tolerated.

Four RCTs of antidepressants indicates that these medications are helpful in the treatment of late life anxiety disorders [26-29]. In a study by Sheikh and Swales, twenty- ve older adults (55 to 73 years in age) with a DSM-III-R diagnosis of panic disorder were randomized to receive alprazolam, imipramine or placebo for eight weeks [26]. Both alprazolam and imipramine reduced the number of panic attacks per week and resulted in an improvement on the anxiety and depression scales at the end of the study when compared to baseline. Additionally, both drugs were well tolerated and their daily doses were about half the normal adult doses. In a pooled secondary analysis, Katz et al included data from one hundred and eighty four individuals 60 years in age with a DSM-IV diagnosis of GAD [27]. e participants received xed or exible doses of venlafaxine ER with a dose range of 37.5 to 225 mg a day or matched placebo. On the Clinical Global Impression of Improvement (CGI-I) 66% of the individuals in the venlafaxine ER group responded when compared with 41% in the placebo group ($P < 0.01$). Approximately, 23% of older adults in the venlafaxine ER group discontinued treatment prematurely when compared to 31% of the individuals in the placebo group. e investigators concluded that venlafaxine ER is safe and well tolerated in older adults for the treatment of GAD.

In a RCT, thirty-four participants 60 years in age with a DSM-IV diagnosis of anxiety disorder (mainly GAD) were randomly assigned to receive either citalopram or placebo for a period of eight weeks [28]. Eleven (65%) of the seventeen citalopram-treated participants responded by 8 weeks when compared to four (24%) of the seventeen placebo-treated participants. e most common side e ects in both groups were dry mouth, nausea and fatigue. e investigators concluded that citalopram shows e cacy in the treatment of late-life anxiety disorders. Alaka et al conducted a exible-dosed study to evaluate the e cacy and safety of duloxetine 30 to 120 mg once daily for the treatment of GAD in older adults [29]. At week 10, duloxetine was superior to placebo on mean changes from baseline on the rating scales ($P < 0.001$). Treatment-emergent adverse events occurred in 5% of duloxetine-treated individuals with a rate that was twice that of placebo including constipation, dry mouth and somnolence. e investigators concluded that treatment with duloxetine improved symptoms of anxiety and functioning in older adults with GAD and the drug s safety pro le was consistent with previous GAD studies.

In a sequenced treatment that combined pharmacotherapy with cognitive-behavioral therapy (CBT) for individuals with GAD who were 60 years of age, the participants initially received 12 weeks of open-label escitalopram [30]. en, these individuals were randomly assigned to one of four groups: 16 weeks of treatment with escitalopram (10 to 20 mg a day) plus modular CBT, followed by 28 weeks of maintenance escitalopram; escitalopram alone, followed by maintenance escitalopram; escitalopram plus CBT, followed by pill placebo; and escitalopram alone, followed by placebo. e investigators found that escitalopram augmented with CBT

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