Continued escitalopram reduces risk of relapse in people with generalised social anxiety disorder

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**Notes**
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Q Does continuing escitalopram treatment reduce relapse rates in people with generalised social anxiety disorder?

METHODS

Design: Open label followed by randomised controlled trial.
Allocation: Concealed.
Blinding: Double blinded in randomised controlled phase.

Follow up period: Twenty four weeks.
Setting: Seventy six centres in 11 countries (Canada, South Africa, and several countries in Europe) from January 2001 to June 2002.

Patients: 517 people with generalised social anxiety disorder (DSM-IV) aged 18-80 years entered into the open label phase. Inclusion criteria included: a score greater than 70 on the Leibowitz Social Anxiety Scale (LSAS), fear and/or avoidance behaviours in at least four social situations and a score greater than five on at least 1 of the subscales of the Sheehan Disability Scale. Exclusion criteria included: another axis I or an axis II DSM-IV diagnosis, suicidal thoughts, known SSRI non-responders, and psychoactive drug treatment or psychotherapy within two weeks of screening. 372 (72%) people responded after 12 weeks of treatment (a score of 1 or 2 on the Clinical Global Impressions-Improvement scale) and were randomised to escitalopram (191 people) or placebo (181 people).

Intervention: Open label treatment with escitalopram (10 or 20 mg/day) followed by placebo controlled, double blind treatment with escitalopram (10 or 20 mg/day).

Outcomes: Time to relapse during double blind phase. A relapse was defined as a greater than 10 point increase in the LSAS.

Patient follow up: 123 (65%) escitalopram and 75 (41%) placebo patients completed the 24 week randomised double blind phase.

MAIN RESULTS

Escitalopram reduced the risk of relapse compared with placebo (22% with escitalopram v 50% with placebo; p<0.001). The risk of relapse in the placebo group was nearly three times that in the escitalopram group (HR 2.83; 95% CI 1.95 to 4.11). Escitalopram reduced the risk of relapse even when the potential influence of discontinuation symptoms in the placebo group were taken into account.

CONCLUSIONS

Continued escitalopram reduces risk of relapse in people with generalised social anxiety disorder.

Commentary

This paper tackles the longer term pharmacotherapy of social anxiety disorder, addressing the specific question of whether response to escitalopram is maintained over time. A first question is whether social anxiety disorder (SAD) is worth studying. Some have argued that the construct of SAD is flawed; that social anxiety is a normal emotion, that with the help of the pharmaceutical industry it has been inappropriately medicalised. However, the evidence base provides a strong rationale for diagnosing and treating SAD. The condition is associated with significant comorbidity and morbidity, there is growing understanding of the relevant psychobiology, and specific pharmacotherapies and psychotherapies are able to decrease symptoms and improve functioning.

Is pharmacotherapy in general, and escitalopram in particular, worth initiating in SAD? There is particularly strong evidence for the efficacy and safety of the SSRIs. Several evidence based guidelines have therefore emphasised the role of these agents in the treatment of SAD. Furthermore, escitalopram, a highly selective serotonin reuptake inhibitor, with an apparently unique mechanism of action, has already been shown to be effective in short term SAD trials.

But is it worth maintaining pharmacotherapy in SAD? Given that SAD is a chronic disorder, there is an a priori argument for longer term treatment. Nevertheless, the evidence base addressing this issue is rather small, with only a limited number of previous relapse prevention trials. The current study is useful not only because of its methodological innovations (for example, providing a criterion for relapse that is based on the LSAS, analysing relapse on each escitalopram dose separately, repeating the analysis with early relapsers excluded), but also because of its clinically relevant findings; the data demonstrate that people on escitalopram maintenance continue to improve over time, whereas people receiving placebo are significantly more likely to deteriorate, and that long term escitalopram is well tolerated.

Additional questions are deserving of future study in SAD. There is a need to complement the efficacy studies with additional effectiveness studies in general settings. Such work could potentially address the question of how long to treat SAD; the current data indicate that nine months is a minimum, but it is possible that further improvement continues even after that time.

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