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GUIDELINES

Recognition, assessment. and treatment of social anxiety disorder: summary of NICE guidance

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This is one of a series of *BMJ* summaries of new guidelines based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists.

Further information about the guidance, a list of members of the guideline development group, and the supporting evidence statements are in the full version on bmj.com.

Social anxiety disorder is one of the most persistent and common of the anxiety disorders, with lifetime prevalence rates in Europe of 6.7% (range 3.9-13.7%).[1] It often coexists with depression, substance use disorder, generalised anxiety disorder, panic disorder, and post-traumatic stress disorder.[2] It can severely impair a person's daily functioning by impeding the formation of relationships, reducing quality of life, and negatively affecting performance at work or school. Despite this, and the fact that effective treatments exist, only about half of people with this condition seek treatment, many after waiting 10-15 years.[3] Although about 40% of those who develop the condition in childhood or adolescence recover before adulthood,[4] for many the disorder persists into adulthood, with the chance of spontaneous recovery then limited compared with other mental health problems.

This article summarises the most recent recommendations from the National Institute for Health and Care Excellence (NICE) on recognising, assessing, and treating social anxiety disorder in children, young people, and adults.[5]

Recommendations

NICE recommendations are based on systematic reviews of the best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Development Group's experience and opinion of what constitutes good practice. Evidence levels for the recommendations are in the full version of this article on bmj.com.

Principles for working with all people with social anxiety disorder

- When a person is first offered an appointment, provide clear information in a letter about:
  - Where to go on arrival and where they can wait (offer the use of a private waiting area or the option to wait elsewhere—for example, outside the service's premises)
  - Location of facilities available at the service (for example, the car park and toilets)
  - What will happen and what will not happen during assessment and treatment.

When the person arrives for the appointment, offer to meet them or alert them (for example, by text message) when their appointment is about to begin.

- Offer to provide treatment in settings where children and young people and their parents or carers feel most comfortable—for example, at home or in schools or community centres.

Identification of adults with possible social anxiety disorder

- Ask the identification questions using the two-item generalised anxiety disorder scale (GAD-2)[6] in line with NICE guidance[7], and if social anxiety disorder is suspected:
  - Use the three-item mini-social phobia inventory (Mini-SPIN)[8] or
  - Consider asking the following two questions: Do you find yourself avoiding social situations or activities? Are you fearful or embarrassed in social situations?

If the person scores 6 or more on the Mini-SPIN or answers yes to either of the two questions above, refer for or conduct a comprehensive assessment for social anxiety disorder.

Identification of children and young people with possible social anxiety disorder

Professionals in primary care and education and in community settings should be alert to possible anxiety disorders in children and young people, particularly those who avoid school, social or group activities, or talking in social situations, or are irritable, excessively shy, or overly reliant on parents or carers. Consider asking the child or young person (or their parents or carers) about their feelings of anxiety, fear, avoidance, distress, and associated behaviours, to help establish if social anxiety disorder is present, using the following statement and questions:

"Sometimes people get very scared when they have to do things with other people, especially people they don't know. They might worry about doing things with other people watching. They might get scared that they will do something silly or that people will make fun of them. They might not want to do these things or, if they have to do them, they might get very upset or cross." Then ask:

- "Do you/does your child get scared about doing things with other people, like talking, eating, going to parties, or other things at school or with friends?"
- "Do you/does your child find it difficult to do things when other people are watching, like playing sport, being in plays or concerts, asking or answering questions, reading aloud, or giving talks in class?"

bmj.com Previous articles in this series
- Long term follow-up of survivors of childhood cancer: summary of updated SIGN guidance (*BMJ* 2013;346:f1190)
- Recognition, intervention, and management of antisocial behaviour and conduct disorders in children and young people: summary of NICE-SCIE guidance (*BMJ* 2012;346:f1298)
- Fertility (update): summary of NICE guidance (*BMJ* 2013;346:f650)
- Recognition and management of psychosis and schizophrenia in children and young people: summary of NICE guidance (*BMJ* 2013;346:f150)
- Ectopic pregnancy and miscarriage: summary of NICE guidance (*BMJ* 2012;345:e8136)

  – "Do you/does your child ever feel that you/your child can't do these things or tries to get out of them?"

If the child or young person or parents or carers answer "yes" to one or more of the questions consider a comprehensive assessment for social anxiety disorder.

Comprehensive assessment for children, young people, and adults

- Obtain a detailed description of the person's current social anxiety and associated problems and circumstances including:
  – Feared and avoided social situations, and what they are afraid might happen in social situations (for example, looking anxious, blushing, sweating, trembling, or appearing boring)
  – Anxiety symptoms
  – View of self
  – Safety seeking behaviours
  – Anticipatory and post-event processing
  – Occupational, educational, financial, and social circumstances in adults
  – Family circumstances and support, friendships and peer groups, educational and social circumstances in children and young people
  – Medication, alcohol, and recreational drug use.

Delivering interventions for children, young people, and adults

All interventions should be delivered by competent practitioners. Psychological interventions should be based on the relevant treatment manual(s), which should guide their structure and duration. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should receive regular, high quality, outcome informed supervision; use routine sessional outcome measures; and monitor treatment adherence and practitioner competence (for example, using video and audio recordings, and external audit and scrutiny if appropriate).

Interventions for adults with social anxiety disorder

First line treatment

- Offer adults individual cognitive behavioural therapy (CBT) that has been specifically developed to treat social anxiety disorder (based on the Clark and Wells model or the Heimberg model[5]).
- Do not routinely offer group CBT in preference to individual CBT. Although there is evidence that group CBT is more effective than most other interventions, it is less clinically and cost effective than individual CBT.

Second line treatments

- For adults who decline CBT and wish to consider another psychological intervention, offer CBT based, supported self help.
- For adults who decline cognitive behavioural interventions and express a preference for a drug intervention, discuss their reasons for declining cognitive behavioural interventions and try to resolve any concerns.
- If the person wishes to proceed with a drug intervention, offer a selective serotonin reuptake inhibitor (escitalopram or sertraline). Monitor carefully for adverse reactions.

Third line treatments

- For adults who decline cognitive behavioural interventions and drug treatment, consider short term, psychodynamic psychotherapy specifically developed for social anxiety disorder. However, bear in mind the more limited clinical and cost effectiveness of this intervention.

The components of the recommended psychological therapies for children and young people can be found in the full NICE guideline.[5]

Interventions for children and young people with social anxiety disorder

- Offer individual or group CBT focused on social anxiety. Consider involving parents or carers for effective delivery of the intervention, particularly in young children.

The components of the recommended psychological therapies for children and small children can be found in the full NICE guideline.[5]

- Do not routinely offer drug interventions to treat social anxiety disorder in children and young people.

Overcoming barriers

The guideline deals with several potential barriers to people seeking treatment for social anxiety disorder: people may think that the social anxiety is part of their personality and cannot be changed (or, in the case of children, that they will grow out of it); they may fear negative evaluation by healthcare professionals if they disclose their problem; even after presentation, the disorder may not be recognised by healthcare professionals, especially in primary care.[9] The guideline advises healthcare professionals to be aware of barriers to people seeking treatment, and on how to identify the disorder in all age groups and how services can make themselves more accessible. It also recommends effective treatments and seeks to help commissioners identify the services that should be made available.

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EASILY MISSED?

Acute leg ischaemia

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This is one of a series of occasional articles highlighting conditions that may be more common than many doctors realise or may be missed at first presentation. The series advisers are Anthony Harnden, university lecturer in general practice, Department of Primary Health Care, University of Oxford, and Richard Lehman, general practitioner, Banbury. To suggest a topic for this series, please email us at easilymissed@bmj.com.

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- Pelvic inflammatory disease (*BMJ* 2013;346:f3189)
- Colorectal cancer (*BMJ* 2013;346:f3172)
- Delirium in older adults (*BMJ* 2013;346:f2031)
- Cushing's syndrome (*BMJ* 2013;346:f945)
- Chronic exertional compartment syndrome (*BMJ* 2013;346:f33)

A 55 year old man consulted his general practitioner complaining of persistent pain in his left leg for three days and a numb feeling in the foot. He was taking treatment for hypertension, had a history of low back pain, and was a smoker of 20 cigarettes a day. His foot looked normal, but sensation seemed mildly reduced. The general practitioner noted a weak dorsalis pedis pulse. A diagnosis of sciatica was made, diclofenac was prescribed, and the patient was invited to return a week later if no better. Six days later he presented to a local emergency department because of intolerable pain and was found to have a profoundly ischaemic left leg necessitating an above knee amputation.

Missed diagnoses of acute leg ischaemia, as in the case above, are common.[1 2] An analysis of data held by the NHS Litigation Authority (NHSLA), the Medical Defence Union (MDU), and the Medical Protection Society (MPS) identified 224 cases of acute leg ischaemia leading to limb loss over a 10 year period,[1] in all of which litigation had been initiated. Fifty one cases in which there had been delay in detecting and treating acute limb ischaemia were reported to the National Reporting and Learning System (NRLS) between 2003 and 2010.[2] I have written almost 30 medicolegal reports on cases in which there were allegations—usually against general practitioners or casualty officers—of a negligent delay in diagnosing acute leg ischaemia, often resulting in the avoidable loss of a limb.

What is acute leg ischaemia?

Leg ischaemia results from thrombotic, embolic, or traumatic arterial occlusion. It is considered to be acute if the symptoms and signs have developed over less than two weeks.[3 4] The term "acute ischaemia" does not of itself imply severe ischaemia, but the survival of an acutely ischaemic limb is often in immediate jeopardy.[2] The hallmarks of acute ischaemia that is limb threatening are reduced muscular power and reduced sensation in the limb.

How common is it?

In a 1996 questionnaire survey of members of the Vascular Surgical Society of Great Britain and Ireland, 86 out of 182 hospitals reported 539 episodes of acute lower limb ischaemia in a three month period.[4] In this study, acute lower limb ischaemia was defined as "a previously stable limb with sudden deterioration in the arterial supply for less than two weeks." In another study, an incidence as high as one per 7000 per annum has been quoted.[5] Medicolegal data[1] show that over 20 legal actions are initiated each year in the UK in relation to acute leg ischaemia, with delay in diagnosis or treatment figuring in 73% of the claims.

Why is it missed?

In the cases reported to the NRLS, the National Patient Safety Agency stated that causes of delay in detecting and treating acute limb ischaemia included diagnostic errors (such as misdiagnosis as a Baker's cyst or disc problem, as in the case scenario), acute limb ischaemia not being recognised as a surgical emergency, and apparently inconsistent clinical diagnosis and assessment. My own clinical and medicolegal experience indicates that there is often a failure to consider a diagnosis of acute leg ischaemia at all, especially if the patient is under 60 years old (as in the case scenario). By no means all patients with acute leg ischaemia have risk factors (such as atrial fibrillation, a history of smoking, or diabetes). It should therefore be considered in the differential diagnosis of all patients presenting with leg pain of sudden onset, irrespective of age and risk factors, and all such patients should undergo an assessment of the circulation to the limb.

The extent to which acutely ischaemic legs are pale (or discoloured) or cold or exhibit diminished power or sensation is variable, and subtle changes can be missed (as in the case above) if the examination is cursory. An error encountered in almost all cases of missed acute leg ischaemia, however, is that one or more doctors have purported to feel pulses that could not possibly have been present. Pulse palpation is an unreliable physical sign, with false positive palpation occurring in 14% of observations carried out by non-specialists.[6] A "weak" or "faint" ankle pulse, or one which the doctor "thinks" he or she can feel, is probably not present at all (as in the case history above). A simple rule will protect against this common error: "If you can feel a pulse you can count it; if you cannot count it, you are not feeling it."

Why does it matter?

Delay in diagnosis or referral was the sole or the principal cause of amputation in 59% of the patients identified from medicolegal data.[1] The interval between the onset of symptoms and irretrievable damage to the leg is variable but may be as little as six hours.[2 7] Acute leg ischaemia is associated with an amputation rate of 13% and a mortality of 10%.[8] Both are increased by delay in diagnosis and treatment.[8]

How is it diagnosed?

Acute leg ischaemia can only be diagnosed if it is included in the differential diagnosis of leg pain of recent onset. It should be considered in patients of all ages. Although usually encountered in patients over 60 years old, rare disorders (such as popliteal entrapment syndrome, cystic adventitial disease, and thrombophilias) may occasionally lead to its development in much younger individuals.

In all patients presenting with leg pain of sudden onset, look for the symptoms and signs of limb threatening ischaemia as characterised by the "six Ps" (see box). The patient will always have persistent pain and the ankle pulses will always be absent. The other Ps may or may

Leg ischaemia—the "6 Ps"

Pain—Always present, persistent

Pallor or cyanosis or mottling*

Perishing with cold (poikilothermia)*

Pulselessness—Always present. Can you count it?

Paraesthesia or reduced sensation or numbness*

Paralysis or reduced power*

*May be subtle. Compare left and right legs

not be present, depending on severity, and if present may be subtle (as in the case above). The presence or absence of risk factors for peripheral arterial disease is of limited usefulness. Limb threatening ischaemia may develop in individuals who have no known risk factors and are well under the age of 60.

The presence of acute leg ischaemia can be quickly, simply, and reliably confirmed or ruled out by measuring the ankle blood pressure with a pocket Doppler machine and a blood pressure cuff.[9] The absence of Doppler signals indicates a threatened limb, and the patient requires emergency referral to a vascular centre. Doppler assessment can be quickly learnt, is reproducible, and is easier than many other procedures routinely carried out in primary care (such as funduscopy). Pocket Doppler machines are cheap (approximately £300).

How is it managed?

If a patient has leg pain of recent onset and has impalpable pulses, immediate referral to a vascular surgical unit is mandatory. The management undertaken there will depend on the immediacy of the threat to the survival of the limb. The key clinical indicators of this are the presence and severity of reduced muscular power and reduced sensation. Depending on the urgency of the situation, the vascular unit may carry out imaging studies of the arteries supplying blood to the leg (duplex ultrasound, magnetic resonance angiography, computed tomographic angiography or intra-arterial angiography) as a basis for planning treatment. The options for treatment comprise endovascular procedures (angioplasty, thrombectomy, and intra-arterial thrombolysis) and surgery (embolectomy and bypass).[7] In an immediately threatened limb, emergency surgery will be required. Regrettably, some patients present with limbs that are already dead (profound paralysis and numbness, fixed mottling of the skin). In this situation revascularisation may be not merely futile but harmful, and primary amputation is necessary.[8]

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ANSWERS TO ENDGAMES, p 38

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CASE REPORT

A man with bilateral loin pain

1 Loin pain.
2 Factors that contribute to stone formation include age, sex, genetics (such as cystinuria, as in this case), climate, geographical location, occupation, and diet.
3 Renal tract stones are the main cause of loin pain. However, other causes need to be considered. Non-enhanced computed tomography is the ideal modality for the investigation of loin pain.
4 Staghorn calculi are best managed by percutaneous nephrolithotomy or nephrectomy.

STATISTICAL QUESTION

Selection bias versus allocation bias

Statements *a* and *c* are true, whereas *b* and *d* are false.

PICTURE QUIZ The acute abdomen

1 The erect chest radiograph shows a pneumoperitoneum with free gas under the diaphragm bilaterally.
2 The diagnostic sensitivity of this sign depends on its cause, varying from 8% in perforated appendicitis to 94% in perforated peptic ulcer disease. The overall sensitivity of detecting gas under the diaphragm on erect chest radiography in the context of a perforated hollow viscus is 69%.
3 Free gas on erect chest radiography in the context of acute onset abdominal pain indicates perforation of a hollow viscus until proved otherwise. The most common causes are perforated peptic ulcer (16%), perforated diverticular disease (16%), perforated carcinoma (sigmoid, rectal, or caecal; 14%), and perforation secondary to ischaemia (10%). Perforated appendix secondary to appendicitis is common, but is less likely to cause a substantial amount of gas under the diaphragm.
4 The patient should be resuscitated according to advanced life support principles of "airway, breathing, and circulation" (ABC), and sepsis should be treated according to the sepsis six care bundle. When stable, computed tomography may be performed to aid in diagnosis and guide further management; alternatively, the patient may require an emergency laparotomy without further imaging.
5 Definitive treatment depends on the cause. Patients often need surgery—either a laparoscopic wash-out or laparotomy. In some instances, a confined perforation is self limiting and can be treated non-operatively with antibiotics, bowel rest, and regular surgical review.