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Ensuring prompt recognition and treatment of panic disorder

Pharmacologic and/or psychotherapeutic interventions are effective for most patients. But first, you must rule out organic causes of the patient's symptoms.

▶ THE CASE

Lorna D* was seen by her primary care physician (PCP) as follow-up to a visit she made to the emergency department (ED). The 37 year old had gone to the ED 4 times in the previous year. Each time she presented with tachycardia, dyspnea, nausea, numbness in her extremities, and a fear that she was having a heart attack. In spite of negative work-ups at each visit (electrocardiogram, cardiac enzymes, complete blood count, toxicology screen, Holter monitoring), Ms. D was terrified that the ED doctors were missing something. She was still "rattled" by the chest pain and shortness of breath she had experienced. Mild symptoms were persisting and she was worried that she would have a heart attack and die without the treatment she believed she needed.

○ HOW WOULD YOU PROCEED WITH THIS PATIENT?

**The patient's name has been changed to protect her privacy.*

MANY PANIC ATTACKS PROMPT AN ED VISIT

Panic disorder (PD) is characterized by the spontaneous and unexpected occurrence of panic attacks, and by at least one month of persistent worry about having another attack or significant maladaptive behaviors related to the attack. Frequency of such attacks can vary from several a day to only a few per year. In a panic attack, an intense fear develops abruptly and peaks within 10 minutes of onset. At least 4 of the following 13 symptoms must accompany the attack, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5)*:¹

- palpitations, pounding heart, or accelerated heart rate
- sweating
- trembling or shaking

- sensations of shortness of breath or smothering
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- feeling dizzy, unsteady, lightheaded, or faint
- de-realization (feelings of unreality) or depersonalization (being detached from oneself)
- fear of losing control or going crazy
- fear of dying
- paresthesia (numbness or tingling sensations)
- chills or hot flushes.

Lifetime incidence rates of panic disorder are 1% to 3% for the general population.² A closer look at patients presenting to the

ED with chest pain reveals that 17% to 25% meet criteria for panic disorder.^{3,4} And an estimated 6% of individuals experiencing a panic attack present to their primary physician.⁵ Patients with panic disorder tend to use health care resources at a disproportionately high rate.⁶

An international review of panic disorder research suggests the average age of onset for PD is 32 years.⁷ Triggers can vary widely and no single stressor has been identified. The exact cause of PD is unknown, but a convergence of social and biological influences (including involvement of the amygdala) are implicated in its development.⁶ For individuals who have had a panic attack, 66.5% will have recurrent attacks.⁷ Lifetime prevalence of panic attacks is 13.2%.⁷

Differential goes far beyond myocardial infarction

Many medical conditions can mimic panic disorder symptoms: cardiovascular, pulmonary, and neurologic diseases; endocrine diseases (eg, hyperthyroidism); drug intoxication (eg, stimulants such as cocaine, amphetamines); drug withdrawal (eg, benzodiazepines, alcohol, sedative-hypnotics); and ingestion of excessive quantities of caffeine. Common comorbid medical disorders include asthma, coronary artery disease, cancer, thyroid disease, hypertension, ulcer, and migraine headaches.⁸

When patients present with panic-like symptoms, suspect a possible medical condition when those symptoms include ataxia, altered mental status, or loss of bladder control, or when onset of panic symptoms occur later in life for a patient with no significant psychiatric history.

RULE OUT ORGANIC CAUSES

In addition to obtaining a complete history and doing a physical exam on patients with panic-like symptoms, you'll also need to ensure that the following are done: a neurologic examination, standard laboratory testing (thyroid function, complete blood cell count, chemistry panel), and possible additional testing (eg, urine toxicology screen and D-dimer assay to exclude pulmonary embolism).

If organic causes are ruled out, focus on a psychiatric assessment:⁹

- history of the present illness (onset, symptoms, frequency, predisposing/precipitating factors)
- psychiatric history
- history of substance use
- family history of psychiatric disorders (especially anxiety disorders)
- social history (life events, including those preceding onset of panic; history of child abuse)
- medications
- mental status examination
- safety (panic disorder is associated with higher risk of suicidal ideation).

TREATMENT INCLUDES CBT AND MEDICATION

PD is a chronic disease with a variable course, but the long-term prognosis is good. PD is usually treated in an outpatient setting. Consider hospitalization if the patient is suicidal, if the potential for life-threatening withdrawal symptoms is high (as with alcohol or benzodiazepines), or if the symptoms are severely debilitating or attempted outpatient treatment is unsuccessful. Pharmacologic and psychotherapeutic interventions are used for PD (FIGURE⁹), although there is not enough evidence to recommend one vs the other or combination therapy vs monotherapy.⁹

▶ CASE

For Ms. D, all medical test results came back negative, and the psychiatric assessment revealed that she met the *DSM-5* criteria for panic disorder. Counting on the strength of their relationship, her physician talked to her about PD and discussed treatment options, which included counseling, medication, or both. Ms. D agreed to a referral for cognitive behavioral therapy (CBT) with a psychologist embedded at her physician's primary care clinic and to begin taking medication. Her PCP started her on sertraline 25 mg/d.

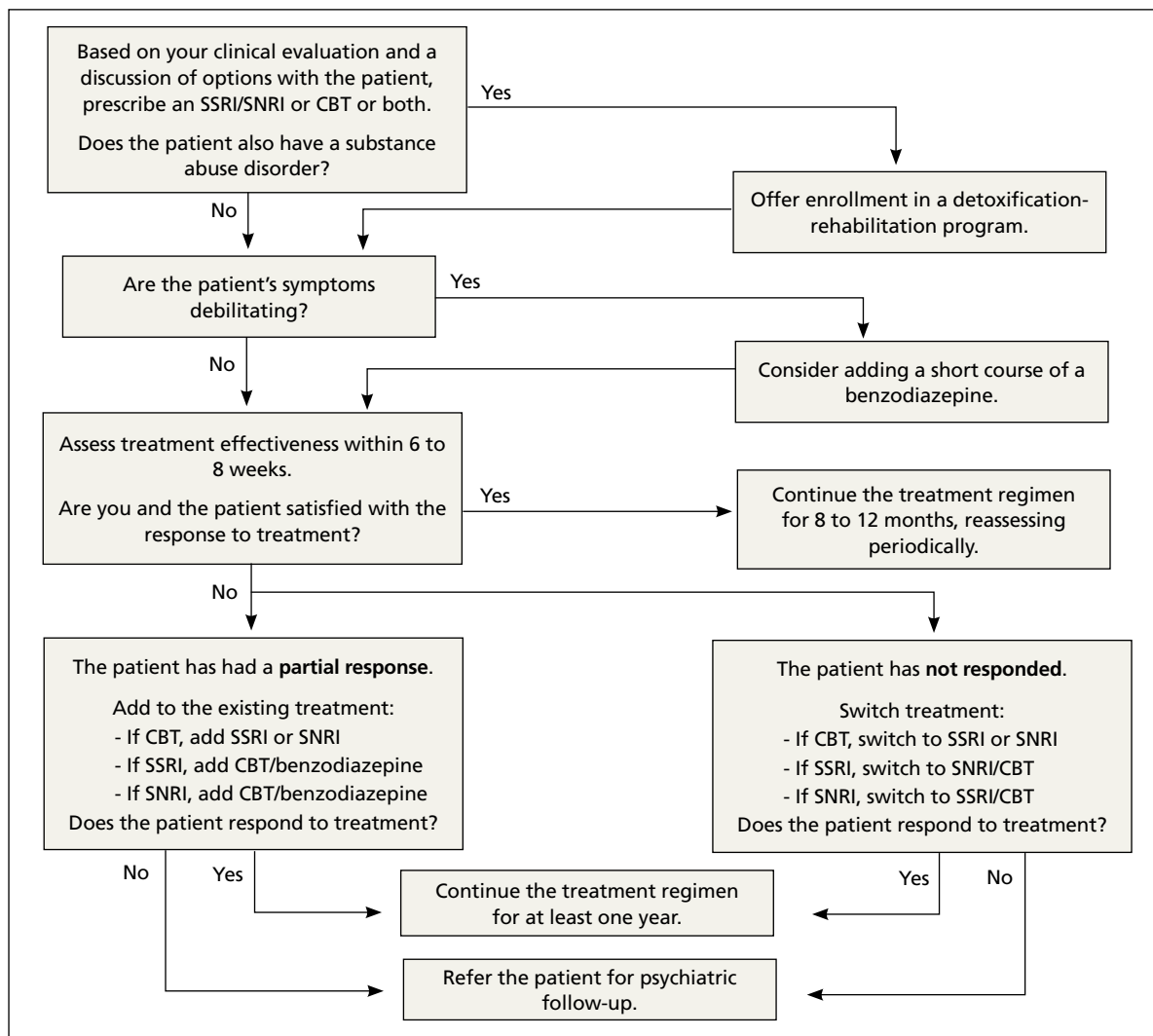
In CBT, Ms. D's psychologist taught her about "fight or flight" and explained that it was a normal physiologic response that could lead to panic. Ms. D. learned to approach her physi-



Spontaneous recurrences of panic may indicate panic disorder if the patient experiences at least 4 additional recognized symptoms.

FIGURE

Treatment algorithm for panic disorder⁹



CBT, cognitive behavioral therapy; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor.

cal symptoms in a different way, and how to breathe in a way that slowed her panic reaction.

Consider SSRIs and SNRIs

First-line medication is a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) due to the better tolerability and lower adverse effect profile of these classes compared with the tricyclic antidepressants or monoamine oxidase inhibitors. MAOIs are usually reserved for patients in whom multiple medication trials have failed.

■ **Special considerations.** American Psy-

chiatric Association guidelines advise starting with a very low dose of an SSRI or SNRI, such as paroxetine 10 mg/d (although many clinicians start lower, at 5 mg/d), to avoid hypersensitivity reactions. Gradually titrate the dose upward within 3 to 7 days after initiation until a therapeutic dose is reached over 2 to 6 weeks. Schedule follow-up visits for every one to 2 weeks at the beginning of treatment and every 2 to 4 weeks until the therapeutic dose is reached. Assess safety/suicidality at each visit.

Keep in mind that the onset of therapeutic effect is between 2 and 4 weeks, but that clini-

cal response can take up to 8 to 12 weeks. Continue pharmacotherapy for at least one year. When discontinuing the medication, taper it slowly, and monitor the patient for withdrawal symptoms and recurrence of PD.⁹

■ **Consider adding a benzodiazepine** if symptoms are debilitating.⁹ Keep in mind, though, that the potential for addiction with these medications is high and they are intended to be used for only 4 to 12 weeks.⁸ Onset of action is within the first week, and a scheduled dosing regimen is preferred to giving the medication as needed. The starting dose (eg, clonazepam 0.25 mg bid)⁹ may be increased 3 to 5 days following initiation.

The evidence supports the use of CBT for panic disorder

CBT is an evidenced-based treatment for panic disorder.¹⁰⁻¹³ Up to 75% of patients treated with CBT are panic free within 4 months.¹⁰ Other techniques proven effective are progressive muscle relaxation training, breathing retraining, psycho-education, exposure, and imagery.¹⁴

Treatment with medications and CBT either combined or used individually is effective in 80% to 90% of cases.¹⁵ CBT has been shown to decrease the likelihood of relapse in the year following treatment.¹⁵ Good premorbid functioning and a brief duration of symptoms increase the likelihood of a good prognosis.¹⁵

WHEN TO REFER TO A PSYCHIATRIST

Consider referral to a psychiatrist when patients have a comorbid psychiatric condition that complicates the clinical picture (eg, substance abuse disorder), if the diagnosis is uncertain, or if the patient does not respond to one or 2 adequate trials of medication and psychotherapy. Although psychiatric follow-up is sometimes difficult due to a lack of psychiatrist availability locally, it is a best-practice recommendation.

▶ CASE

Ten days after Ms. D started the sertraline 25 mg/d, she called the PCP to report daily diarrhea. She stopped the sertraline on her own and asked for another medication. She also expressed her frustration with the severity of the symptoms. She was having 3 to 5 panic attacks daily

and had been missing many days from work.

On the day of her follow-up PCP appointment, Ms. D also saw the psychologist. She reported that she'd been practicing relaxation breathing, tracking her panic attacks, limiting caffeine intake, and exercising regularly. But the attacks were still occurring.

The PCP switched her to paroxetine 10 mg/d and, due to the severity of the symptoms, prescribed clonazepam 0.5 mg bid. Two weeks later, Ms. D reported that she was feeling a little better, had returned to work, and was hopeful that she would be her "normal self again." The PCP planned to encourage continuation of CBT, titrate the paroxetine to 20 to 40 mg/d based on symptoms, and to slowly taper the clonazepam toward discontinuation in the near future. **JFP**

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To treat panic disorder with medication, start with a very low dose of an SSRI or SNRI, such as paroxetine 10 mg/d.