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Panic Disorder in Adults: Information for Primary Care

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Sommaire : Panic disorder is a common, often debilitating condition that includes sudden onset panic attacks, anxiety and avoidance behaviour, and significant distress. Treatments include education about panic disorder, self-help, counselling/psychotherapy and medications.

Case

J. is a 30-yo female who shares an apartment with a roommate. It was the end of a long workday, and after a long ride on the subway, J. had just arrived home to her apartment. All of a sudden, out of the blue, she felt her heart racing and became out of breath. It felt as if she were having a heart attack. Luckily, her roommate was there, and was able to drive her to the local emergency department. Since that first episode, she has had a panic attack every 1 to 2 weeks. She has become increasingly anxious about triggering attacks. Due to her fears of having another attack, she taken a short-term leave of absence from work and spends her days at home.

Epidemiology

- Prevalence of 2-13% in primary care settings (Stein et al., 1999)
- Gender: Females > Males
- Onset: Late adolescence or early adulthood

More...

Screening

Consider screening patients with the following risk factors:

- Anxiety sensitivity (outlook to believe that symptoms of anxiety are harmful)
- History of “fearfull spells” (not full criteria of panic attack)
- Personal or family history of anxiety and/or panic attacks
- Smoking

Screening Questions

Consider using questions from the Autonomic Nervous System Questionnaire (ANSQ) (Stein et al., 1999) (high sensitivity 94%, however note low specificity 25%)

- Clinician:

1) In the past 6 months, did you ever have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy? Yes/No

2) In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath? Yes/No

If patient answers yes to 1) or 2), proceed to rest of ANSQ questions

3. Did any of these spells or attacks ever happen in a situation when you were the center of attention? If yes, then consider social anxiety / social phobia

4. How many times have you had a spell/attack in the past month? (0, once, 2-3 times, 4-10 times, more than 10 times)

5. In the past month, how worried have you been that spells or attacks might happen again? (Not at all worried, Somewhat worried, very worried)

Diagnosis

- Essential features:
    - Recurrent unexpected panic attacks
    - Anticipatory anxiety
    - Distress/dysfunction
      Diagnosis may be difficult to diagnose due to the potential seriousness of symptoms such as chest pain and shortness of breath (Ham et al., 2005)

DSM-5 Criteria

- Recurrent unexpected panic attacks: A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time 4 (or more) of the following symptoms occur:
    - Palpitations, pounding heart, or accelerated heart rate
    - Sweating
    - Trembling or shaking
    - Sensations of shortness of breath or smothering
    - Feelings of choking
    - Chest pain or discomfort
    - Nausea or abdominal distress
    - Feeling dizzy, unsteady, light-headed, or faint
    - Chills or heat sensations
    - Paresthesias (numbness or tingling sensations)
    - Derealisation (feeling of unreality) or depersonalization (being detached from oneself)
    - Fear of losing control or going crazy
    - Fear of dying

- At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
    - Persistent concern or worry about additional panic attacks or their consequences (losing control, having a heart attack, "going crazy")
    - A significant maladaptive change in behaviour related to the attacks (behaviours designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations)

- The disturbance is not attributable to the physiological effects of a substance (drug of abuse, a medication) or another medical condition (hyperthyroidism, cardiopulmonary disorders)

- The disturbance is not better explained by another mental disorder (the panic attacks do not occur only in

response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder)

Differential Diagnosis

Anxiety disorder due to another medical condition

- Hyperthyroidism
- Hyperparathyroidism
- Hypoglycemia
- Pheochromocytoma
- Vestibular dysfunctions
- Seizure disorders
- Cardiopulmonary conditions (arrhythmias, asthma, etc)
- Substance/medication-induced anxiety disorder
- CNS stimulants (cocaine, amphetamines, caffeine)
- Cannabis
- Withdrawal from CNS depressants (alcohol, barbiturates)

Other mental disorders with panic attacks as an associated feature

- Triggered by social situations (social anxiety disorder)
- Triggered by phobic objects or situations (specific phobia)
- Triggered by worry (generalized anxiety disorder)
- Triggered by separation from attachment figure (separation anxiety disorder)

Comorbidity

Comorbid psychiatric conditions in those with panic disorder:

- Depression (in 30-50% of patients with panic disorder)
- Suicide attempts (in 20% of patients with panic disorder)
- Agoraphobia (in 30-50% of patients with panic disorder)

Reference: CPA Guidelines, 2006; Vanin J et al., 1998

The following medical conditions are more common in those with panic disorder (Katzman et al., 2014):

- Thyroid disease
- Cancer
- Chronic pain
- Cardiac disease
- Irritable bowel syndrome
- Migraine
- Allergic and respiratory diseases

Investigations

- Panic disorder is a clinical diagnosis; there are no pathognomonic diagnostic tests
- Investigations are useful to eliminate other conditions based on patient symptoms:
    - CBC (haemoglobin to rule out syncope)
    - Electrolytes (rule out hypokalemia and acidosis)

- Glucose (rule out hypoglycaemia)
- TSH (rule out hyperthyroidism)
- Calcium (rule out hyperparathyroidism)
- Cardiac enzymes (rule out acute coronary events)
- D-dimers (rule out pulmonary embolism)
- Urine toxicology (amphetamine, cocaine, cannabis)
- ECG (ischemia, infarction, pericarditis, ventricular preexcitation)
- Holter monitor (suspected arrhythmias)

Physical Exam

- There are no physical signs specific for panic disorder
- The physical exam is to help rule out contributory medical conditions
- During an acute panic attack, physical signs may include:
  - Cardiac
    - Hypertension
    - Tachycardia
    - Examine for rhythm disturbances such as arrhythmia, supraventricular tachycardia
  - Respiratory
  - Increased respiratory rate
  - Examine for asthma (e.g. wheezes) and chronic obstructive pulmonary disease
  - Mild tremors
  - Dermatologic
  - Abdominal exam
  - out abdominal causes for possible complaints of epigastric pain
  - Rule out neurologic causes for possible complaints of headaches, vertigo/dizziness, and syncope symptoms
  - Neurologic
  - Clammy skin
  - Neurological exam

Management: Overview

- Goals of treatment:
  - Decrease frequency and severity of panic attacks
  - Reduce anticipatory anxiety and avoidance
  - Improve functioning
  - CBT alone or CBT with pharmacotherapy should be considered first-line management (Katzman et al., 2014)
- CBT alone may not be sufficient for patients with severe, frequent panic attacks, moderate-to-severe major depression, suicidal ideation, or worsening agoraphobia

Prognosis

- Panic disorder is generally chronic
- Although relapses can occur, they can nonetheless be treated

Management: Education about Panic Disorder including Self-Help Strategies

Educate the patient about Panic Disorder to include elements such as :

- The bad news:
    - Validate that the patient's experience is real, and that panic attacks are a very scary experience
    - Panic attacks happen when the body's alarm system (i.e. autonomic system) is activated, however, it is a false alarm.
- The good news:
- Let the patient know that panic attacks are not life-threatening, are almost never acutely dangerous, are not uncommon, and will get better over time
- Reassurance that there is no actual danger can be very reassuring
- Getting enough sleep
- Reducing use of caffeine, nicotine, alcohol and any other stimulants or recreational drugs
- Reading about panic disorder
- Treatment options such as
    - Counseling/therapy
    - Medications
- Self-help strategies such as

Educate family members about how to support their loved one with Panic Disorder :

- Ask the patient about how s/he would like to be supported
- During a panic attack, common support strategies include :
    - Helping me to get to a quiet place
    - Be with me
    - Staying calm
    - Breathing slowly with me
    - Don't say things like « Its all in your head », « Just get a grip on yourself », etc.

Management: Psychological

- Cognitive behaviour therapy (CBT)
    - CBT can be delivered in various formats, such as individual CBT, group CBT, minimal intervention format (self-help books), telephone, online CBT website, or online CBT therapist
- Elements of CBT include:
    - Education about Panic Disorder
        - Explain panic attacks and the panic cycle including body reactions and behaviours
        - Explain the plan for treatment including goals, and reading materials
    - Cognitive strategies
        - Describe the worry thoughts (e.g. catastrophic thinking) that often accompanies panic attacks
        - Work with the patient to come up with more helping coping thoughts
        - Challenges the unrealistic thoughts using behavioural experiments
    - Exposure
        - Help the patient to gradually expose him/herself to feared sensations and situations such as
        - Somatic symptoms experienced during a panic attack
        - Show the patient how symptoms (e.g. dizziness, breathlessness, heart racing) can be reproduced through hyperventilation
    - Real-life avoided situations in a graded format (typically between sessions)
- Coping strategies for anxiety such as
    - Deep breathing
        - Paced breathing can trigger panic type symptoms, which is the idea behind the classic breathing into a paper bag

    - Mindfulness practice to reduce anxiety
        - Teach patients how to focus on the present as opposed to the future
        - Teach patients to be in full awareness of their senses such as seeing, hearing, feeling, touch
    - Problem solving and relapse prevention
        - Panic disorder often occurs during or following periods of stressful life events, thus learning to problem-solve stresses is important
        - Help the patient identify what stresses they are facing in their life
            - E.g. “What stresses are you under these days? E.g. work, school, relationships, conflicts, etc.?”
        - Help the patient come up with strategies to deal with these stresses
        - E.g. “What do you wish different with this stress? What do you think you could do?”
- Help the patient come up with a plan on how to cope with future episodes or anxiety or panic
    - E.g. “Let’s problem-solve how you are going to cope if the panic attacks come back.”

Management: Medications

- Consider medications if non-medication strategies have not been successful
- Onset of action: With SSRIs, improvement may be seen as early as 1-week, though significant improvement usually takes several weeks (up to 6-8 weeks)
- If medication successful
    - Continue medication until patient is no longer avoiding feared situations
    - Continue therapy for 8 to 12 months
        - When discontinuing medication
    - Taper dosage gradually over 8 weeks, for example reducing the dosage by 25% each 1-2 weeks
    - Continue CBT strategies such as exposure / relaxation during this period

Medications for Panic Disorder

First line

- Citalopram: Start 20 mg daily; max daily 40-60 mg
- Escitalopram: Start 5-10 mg daily; max daily 20 mg
- Fluoxetine: Start 20 mg daily; max daily 80 mg
- Fluvoxamine: Start 50 mg daily; max daily 300 mg
- Paroxetine: Start 20 mg daily; max daily 60 mg
- Sertraline: Start 50 mg daily; max daily 200 mg
- Venflaxine XR: Start 37.5-75 mg daily; max daily 225 mg

Second-line

- Clomipramine: Start 25 mg daily; max daily 200 mg
- Imipramine: Start 25 mg daily; max daily 150 mg
- Mirtazapine: Start 15 mg daily; max daily 45 mg
- Reboxetine: Start 4 mg twice daily, max 12 mg daily

Benzodiazepines

- Alprazolam: Start 0.5 mg three times daily; average effective dose 5-6 mg daily
- Lorazepam: Start 0.5 mg daily; max daily 3-4 mg
- Diazepam: Start 2.5 mg daily; max daily 10 mg
- Clonazepam: Start 0.25 mg twice daily; target dose 1 mg daily; max daily 4 mg

Table. Medications Commonly Used for Panic Disorder. Dosages from CPA Practice Guidelines, 2006; CPS Monographs, 2014.

	Start	Max
First line		
· Citalopram (Celexa)	20 mg daily	40-60 mg daily
· Escitalopram (Cipralex)	5-10 mg daily	20 mg daily
· Fluoxetine (Prozac)	20 mg daily	20 mg daily
· Fluvoxamine (Luvox)	50 mg daily	300 mg daily
· Paroxetine (Paxil)	20 mg daily	60 mg daily
· Sertraline (Zoloft)	50 mg daily	200 mg daily
· Venlafaxine XR (Effexor)	37.5-75 mg daily	225 mg daily
Second line		
· Clomipramine (Anafranil)	25 mg daily	200 mg daily
· Imipramine (Tofranil)	25 mg daily	150 mg daily
· Mirtazapine (Remeron)	15 mg daily	45 mg daily
· Reboxetine (Duloxetine)	4 mg twice daily	12 mg daily
· Benzodiazepines		
· Alprazolam	0.5 mg three times daily; target dose 5-6 mg daily	6 mg daily
· Lorazepam (Ativan)	0.5 mg daily	3-4 mg daily
· Diazepam (Valium)	2.5 mg daily	10 mg daily
· Clonazepam	0.25 mg twice daily; target dose 1 mg daily	4 mg daily

The following medications are NOT recommended for panic disorder:

- Buspirone
- Trazadone
- Propranolol
- Tigabine
- Carbamazepine

When to Refer

Consider referring to mental health professionals if

- Unclear diagnosis
- Risk of self-harm or harm to others
- Multiple psychiatric or medical co-morbidities
- Initial attempts at treatment have been unsuccessful.
- There is a need for counselling/therapy such as CBT.

1. In a patient with panic disorder, what is the most likely comorbid psychiatric condition that they might have?

- ○ Schizophrenia
- ○ Depression
- ○ Bipolar disorder
- ○ Borderline personality disorder
- ○ Obsessive compulsive disorder

2. Which statement is true?

- ○ Benzodiazepines are first line treatment for panic disorder
- ○ Panic attacks are not part of the diagnostic criteria for panic disorder
- ○ Panic disorder is more common in males
- ○ To make the diagnosis of panic disorder, you must rule out that the symptoms are attributed to the effects of a substance or another medical condition.

Clinical Practice Guidelines

- Katzman MA, Bleau P, Blier P, et al. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorder. BMC Psychiatry. 2014; 14(Suppl1): S1.
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About this Document

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