Update on Management of Panic Disorder

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Panic Disorder

- One of the most common psychiatric disorders
- 12 months prevalence 2-7% & lifetime prevalence 4-7%
- Chronic, episodic & recurrent disorder
- Marked somatic features, therefore prevalence higher in patients, attending physicians and hospitals

- 3 times more common in women
- Age of onset – late adolescence to early adulthood
- Risk factors include heritability 40% with the rest accounted for by nurture & environmental factors
- Often associated with depression, other anxiety disorders and alcohol misuse

Symptoms of Panic Disorder

- Palpitations
- Tachycardia
- Chest pain
- Shortness of breath
- Nausea & abdominal distress
- Hyperventilation
- Trembling & shaking

- Sweating & Dizziness
- Numbness & tingling of fingers & lips
- Fear of having a heart attack
- Fear of dying
- Fear of going insane
- Fear of losing control

Biology of Panic Disorder

- 3 major components – acute panic attack, anticipatory anxiety & phobic avoidance
- Brain stem, amygdala & prefrontal cortex
- Numerous neurotransmitters most important being serotonin
- Decreased benzodiazepine-receptor density in perihippocampal & amygdala areas
- ‘Thermostat’ set too low

Assessment & Treatment

- Frequency, intensity & timing
- Relationship to events/situations
- Degree of agoraphobia
- Intensity of anticipatory anxiety
- Medical conditions can simulate panic attacks and even present concurrently
- Management in the bio-psycho-social framework

- Incorporate the utilisation of the chronic disease self management approach
- Education/information/reassurance/regular support
- Emphasise the medical model while empowering the patient

Psychotropic Medication

- Practical approach
  - SSRIs – low dose, titrate slowly; side-effects related to anxiety symptoms, gastro-intestinal discomfort & sexual dysfunction
  - TCAs – Imipramine has been used extensively; side-effects include sedation
  - Venlafaxine – where finance is not an issue
  - RIMAs – useful but too activating

- Benzodiazepines – worth co-prescribing with SSRIs for initial 2 weeks; danger of withdrawal, dependence & abuse
- Beta blockers not successful
- Major tranquilisers not successful, e.g. sulpiride
- Atypical antipsychotics currently only adjuvants

Psychological & Social Interventions

- Realistic treatment goals
- Educate patient & family about illness & resources available, e.g. support groups
- CBT
- Anxiety management techniques, e.g. relaxation techniques
- Empower patients by encouraging reading

- Attention to psychosocial stresses & their reduction
- ‘Non-medical’ approach – acupuncture, homeopathy, reflexology, hypnotherapy

Final Thoughts

Empower yourself and the patient with:

- Respect for process
- Creativity
- Health as a dynamic construct
- Compassion for ourselves & the world around us

The End

- Good Luck