Panic disorder

Panic disorder - F41.0 (Clinical term: Panic disorder [episodic paroxysmal anxiety] Eu41.0)

Presenting complaints

One or more unexplained sudden physical symptoms (eg chest pain, dizziness, shortness of breath) or intense fear of impending collapse, heart attack or stroke.

Diagnostic features

Spontaneous episodes of severe anxiety that start suddenly, rise rapidly, and last from a few minutes to an hour. Such panic 'attacks' occur with physical sensations such as palpitations, chest pain, sense of choking, churning stomach, dizziness, feelings of unreality, or impending disaster (losing control, going mad, sudden death, heart attack). The patient fears further panics and avoids places where they have occurred.

Differential diagnosis and co-existing conditions

Many medical conditions can cause panic-like symptoms (eg arrhythmia, cerebral ischaemia, coronary disease, asthma, thyrotoxicosis) and can also co-exist with panic. History and physical examination should exclude many of these. Investigate any physical symptoms until confident there is no physical cause. Repeating investigations can increase anxiety and should be avoided.

- Drugs may induce panic, as may withdrawal from drugs such as benzodiazepines.
- Phobic disorders - F40 (when panics occur in particular situations).
- Depression -F32# (if low or sad mood is present). Depression may co-exist with panic.

Essential information for patient and family

- Panics are common and can be treated.
- Anxiety often causes frightening physical symptoms (eg chest pain, dizziness, shortness of breath) which do not indicate physical illness and will pass when anxiety subsides. Explain how the body's arousal causes these symptoms and how anxiety about them can create a vicious cycle.
- Panic causes frightening thoughts (eg fear of dying, that one is going mad or will lose control) and vice versa. These pass when anxiety subsides.
- Mental and physical anxiety reinforce each other.
- Withdrawing from or avoiding situations where panics occur may give immediate relief ('a quick fix') but worsen the problem in the long run.

General management and advice to patient and family

(ref 129)

- Advise the patient to learn to spot early warning signs of impending panic and do the following at their start:
  - If it is practical to do so, stay where you are until the panic passes, which may take up

to an hour (eg if you're in a car on a busy road, pull over and park where it is safe to do so; if panic starts on a train platform as your train comes in, get onto the train and complete your journey). Do not rush to a place of 'safety'.
- Tell yourself that the frightening thoughts and sensations are a sign of panic and will eventually pass. Note the time passing on your watch. It may feel like an eternity but it will usually only last a few minutes. Focus thinking on something visible and non-threatening (eg if in a supermarket, look at booklets there).
- Breathing too rapidly (hyperventilation) can worsen panic. Start slow deep breathing, counting slowly one-two-three on each breath in and on each breath out.

- Notice what you fear during a panic (eg that you're having a heart attack) and challenge it (eg remind yourself, 'This is not a heart attack; it is a panic that will pass in a few minutes').
- Alternatively, some patients improve by thinking the very worst and trying hard to faint on the spot, which they won't be able to do (paradoxical intention).
- Cut down caffeine intake (coffee, tea, street drugs).
- Avoid using alcohol or cigarettes to cope with anxiety.
- Self-help groups, books, tapes or leaflets may help people manage panic and overcome fears (ref 183) (see Anxiety, Dealing with anxious thinking).
- A few minutes of cognitive behavioural therapy advice improves panic patients enduringly. (ref 183)

References

129 Marson AG, Williamson PR, Hutton JL et al.; on behalf of the epilepsy monotherapy trialists. Carbamazepine versus valproate monotherapy for epilepsy (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Eight studies were analysed. There was some evidence to support the policy of using carbamazepine as the first treatment of choice in partial epilepsies, but no evidence to support the choice of valproate in generalized epilepsies. Confidence intervals were too wide to confirm equivalence, however.

183 Swinson RP, Soulios C, Cox BJ, Kuch K. Brief treatment of emergency-room patients with panic attacks. Am J Psychiatry 1992, 149: 944-946. (BIII) People presenting to Accident and Emergency with panic who went on to have psychoeducation and exposure instructions improved significantly more at follow-up compared with controls.

Medication

(ref 184)

Most patients benefit from the measures described above and need no medication, unless their mood is very low.

- If there is marked depression, tricyclics or SSRIs may help after some weeks (ref 185) (BNF section 4.3).
- It is best to face fears without medication or alcohol or street drugs. If the feared situation is rare (eg flying for someone who flies rarely), occasional short-term beta-blockers might help.

- Relapse is higher after discontinuation of an antidepressant or SSRI157,(ref 186,187) or a benzodiazepine (ref 188) than after discontinuation of pill placebo or of cognitive behaviour therapy.

References

184 Kumar S, Oakley-Browne. Panic disorder. Clinical Evidence 2002, 8: 1003-1009. (AI) Selective-serotonin reuptake inhibitors and tricyclic antidepressants are effective in Panic disorder.

185a American Psychiatric Association. Practice guideline for the treatment of patients with panic disorder. Am J Psychiatry 1998, 155(Suppl): 1-26. (AII) Tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors, monoamine oxidase inhibitors and benzodiazepines had roughly comparable short-term efficacy in patients with panic disorder. Benzodiazepines help in the very short term if very rapid control of symptoms is critical. TCA side-effects might be problematic. Discontinuation of medication commonly leads to relapse, so longer-term use is recommended - 2-18 months -after which period, the relapse rate is unknown.

185b A Cochrane review will be available soon. Mendes HA, Lima MS, Hotopf MH. Serotonin reuptake inhibitors and new generation antidepressants for panic disorder (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Oxford: Update Software.

186 Barlow DH, Gorman JM, Shear KM et al. Cognitive behavioural therapy, imipramine or their combination for panic disorder: a RCT. JAMA 2000, 283: 2529-2536. (BII) Combining imipramine and cognitive behaviour therapy (CBT) appears to confer limited advantage acutely but more substantial advantage by the end of maintenance. Each treatment worked well immediately following treatment and during maintenance; CBT appeared durable in follow-up.

187 Haug TT, Blomhoff S, Hellstrom K et al. Exposure therapy and sertraline in social phobia: 1-year follow-up of a randomised controlled trial. Br J Psychiatry 2003, 101: 312-318. (BII) Exposure therapy alone yielded a further improvement during follow-up, whereas exposure therapy combined with sertraline and sertraline alone showed a tendency towards deterioration after the completion of treatment.

188 Marks I, Swinson P, Basoglu M et al. Alprazolam and exposure alone and combined in panic disorder with agoraphobia. A controlled study in London and Toronto. Br J Psychiatry 1993, 162: 776-787. (BII) Where agoraphobic fear and avoidance is present, with panic, exposure - a behavioural treatment - proved to be twice as effective as alprazolam.

Referral

See general referral criteria.

Avoid unnecessary medical referral and investigations for physical symptoms if the diagnosis is clear.

Consider self-help/voluntary/non-statutory services.

Resources for patients and families

Solving problems and achieving goals

Learning to relax

Dealing with anxious thinking

Anxiety

Triumph Over Phobia (TOP) UK 01225 330 353
Email: triumphoverphobia@compuserve.com; website: http://www.triumphoverphobia.com.
Structured self-help groups for sufferers from phobias or obsessive-compulsive disorder. It produces self-help materials.

No Panic 01952 590 545 (helpline 10am¡V10pm), 0808 808 0545 (gives numbers of volunteers for the day)
Website: http://www.no-panic.co.uk
Helpline, information booklets, local self-help groups (including telephone recovery groups) for people with anxiety, phobias obsessions and panic.

Social Anxiety UK
Website: http://www.social-anxiety.org.uk.
Information and support for sufferers of social anxiety and related problems. The site has a chat room and details of local meetings across the UK.

First Steps to Freedom 01926 851 608 (24-hour helpline)
Email: info@firststeps.demon.co.uk; website: http://www.first-steps.org
Runs self-help groups.

Stresswatch Scotland 01563 528 910 (helpline 10am-1pm, Monday-Friday, excluding Wednesday)
Advice, information, materials on panic, anxiety, stress and phobias.
Living with Fear, 2nd edition, by Isaac Marks. McGraw-Hill, 2001. Tel: 01628 252 700; Email: orders@mcgraw-hill.co.uk.
Self-help manual.

Overcoming Panic- A Self-Help Guide Using CBT by Derrick Silove and Vijaya Manicavasagar. Constable & Robinson, 1997.
Self-help manual.

Who's Afraid.....? Coping With Fear, Anxiety and Panic Attacks by Alice Neville. Arrow Books, 1991.
Mind Publications produces the booklet How To Cope With Panic Attacks. MIND, Granta House, 15-19 Broadway, London E15 4BQ, tel: 020 8519 2122, and The Mental Health Foundation, 83 Victoria Street, London SW1H 0HW tel: 020 7802 0300.