ISSUES IN THE MANAGEMENT OF DIFFICULT PANIC PATIENTS

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Panic disorder with or without agoraphobia is a common, debilitating psychiatric condition that will affect 1. 5- 2.5% of the general population at sometime in their lives (Pelissolo & Lepine 1988). Since its introduction in DSM III (Diagnostic and statistical Manual of Mental disorder) in 1980 lot of research have been done in panic disorder which has enabled the management of this disorder. However the most difficult problem faced by the clinician today is choosing the most appropriate treatment modality for non-responders to first line treartment or who creates some particularly difficult clinical problem

Diagnosis, differential diagnosis and comorbidity

Panic disorder is characterised by spontaneous, unexpected and recurrent panic attacks that are short lived (usually less than one hour) with intense fear, anxiety or discomfort. They are followed by at least one month of persistant fear of having other panic attacks (anticipatory anxiety) worry about the possible implications or consequences, or a significant behavioural change related to the attacks. Panic attacks secondary to effects of a substance or a general medical condition is an exclusion criteria in the diagnosis. The diagnostic criteria for a panic attack is listed in table1.

Table 1

Diagnostic Criteria for Panic Attack

A discrete fear or dicomfort in which four (or more) of the following symptoms devoloped abruptly and reached a peak within 10 minutes.

- *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, light-headed or faint*
- *Derealisation (feeling of unreality) or depersonalisation (being detached from oneself)*
- *Fear of losing control or going crazy*
- *Fear of dying*
- *Paraesthesias (numbness or tingling sensations)*
- *Chills or hot flushes*

Source - American Psychiatric Association (1994)

Two forms of panic disorder are codified in DSMIV with or withoout agoraphobia. Patients with agoraphobia avoids situations or places in which escape might be difficult or help may not be available in the event of a panic attack. The degree of phobic avoidance may be considerable, restricting the

switch medication to one of another class i.e. an SSRI, TCA or high potency BDZ. Another choice in case of partial response is a combination of existing drug with an add on TCA/ SSRI or high potency BDZ (Stabl, 1998). If the first drug used is an SSRI on consensus group had suggested trying another SSRI if there were no tolerance problems and some indication of partial response (Ballenger et al, 1998).

When several first or second line treatments are not fully effective MAOI may be considered especially phenelzine or tranylcypromine (Lepine et al, 1997). One of their advantages is a better antiphobic action though their use is restricted because of distinct side effect profile.

Other alternative propositions based on case reports or open study findings are use of buspirone, nefazodone, alproate, carbamazepine verapamil, baclofen, ondansetron and inositol either in monotherapy or in various combinations (Pelissolo & Lepine, 1999). Their use may be justified only in multidrug resistant patients.

Table - 3

Combination therapy for panic disorder

TCA + BZ MAOI+ BZ SSRI+ BZ SSRI+ BZ+Buspirone / fenfluramine / trazadone / nefazodone	+CBT

The basis of many combination therapy is high potency benzodiazepine. Added to this basis may be any number of antidepressants such as TCA combo, MAOI combo, an SSRI combo or possibly an SSRI plus the same serotonin boosters used in combination therapy for depression and for OCD. CBT can also be added to any of the these drug treatments.

Duration of treatment and long term pharmacotherapy

Natural history of panic disorder is chronic with remissions and relapses. However there are no data on the optimal duration of treatment. From a clinical point of view, length of treatment depends on severety of panic disorder and agarophobia. For mild disorder or illness of less than 6 months duration , 6months treatment may be appropriate. Severe and persistant panic disorder need at least 12 months treatment and probably upto 2 years. In all cases, discontinuation of medication can only be considered when full, Sustained remission is acheived, anxiety management skills are achieved, and when patients have a stable life situation. The drug must be tapered slowly over a period of 2-6 months with close supervision because of the risk of rebound and relapse (Ballenger et al, 1998).

Most controlled studies on the phrmacotherapy of panic disorder have been short term studies, but long term efficacy data are available for TCAs, paroxetine and aiprazolam for about 9 months maintenance treatment (den Boer, 1998). Further, some data indicates that improvement will continue with the prolonged administration of anitpanic agents (Londborg et al,1998) No loss of efficacy is reported when lowering the dose during maintenance phase (Noyes & Perry, 1990).

Psychological treatments (Pelissolo & Lepine, 1999)

Cognitive and behaviour therapy are commonly combined in the psychological treatment of panic disorder with or without agarophobia. Cognitive therapy focuses on identifying the cognitive distortions and modifying them, where as behaviour therapy attempts to modify patients responses often through explosure to situations or physiological stimuli that are associated with panic disorder. Behaviour therapy is the most effective in treating phobic avoidance and the

improvement will last longer than the drug treatment.

The ingredients of cognitive behaviour therapy for panic disorder are as follows:

- Detailed behaviour analysis of panic attacks, anxiety ,positive and negative reinforcements, agoraphobic behaviours and comorbid affective or anxiety disorders.

- Self monitoring techniques of keeping a daily record of panic attacks and their limitation in certain activities. This will help to get a baseline assessment of illness severity as well as the progress of improvement.

- Relaxation techniques like respiratory control with diaphramatic breathing to control hyperventilation, progressive muscular relaxation and cue-controlled relaxation will help to apply their relaxation skills in daily life (such as attending a meeting or when travelling by train) and in fear provoking situations. This is known as applied relaxation.

- Graded exposure techniques with gradual desensitization to external stimuli till extinction of the anxious response is attained.
- Exposure to anxiogenic internal sensations such as hyperventilation with breathing retraining.
- Cognitive restructuration with special attention focussed on catastrophic misinterpretation of bodily and mental experiences.

Other forms of phychosoical treatments

Addressing the agoraphobic's interpersonal system, in combination with exposure treatment, can be useful particularly with difficult patients (Chambless & Gillis, 1994). Using spouse as co-therapist in educational and treatment interventions may help agoraphobic patient to carry out homework exercises (Cobb et al, 1994). Some forms of marital therapy such as couples communication and problem solving training in addition to exposure therapy may have positive effects on outcome (Arnow et al, 1985).

Combined drug and psychological treatments (Noyes et al 1993)

For severe forms of illness or for resistant patients a combination of psychological and pharmacological treatment is clearly necessary. Tailoring treatment programs to the individual patient is becoming the state of the art, although such combinations are generally inadequtely investigated in controlled trials. Quite often patients who are so anxious or depressed initially to participate in psychotherapy may be excluded from such sessions until they improve with medication. Some feel that BDZ interfere significantly with CBT as certain amount of anxiety must be present for CBT to be effective.

Special recommendation for the management of difficult patients

Even if majority of panic patients can be improved adequately with drug and/or psychological treatments, a significant number will be partial or complete non-responders to first line treatment. For e.g. 30-40% of patients fail to benefit completely from exposure therapy, 65% have partial recovery and may continue to seek pharmacological or psychological help after exposure therapy (Chambless & Gillis, 1994). Noyes et al (1993) in a 7 year follow up study have pointed out several predictors of poor outcome namely severe panic and agoraphobic symptoms, hospitalisation, longer duration of illness, comorbid depression, high personality sensitivity and a number of significant life events or

environmental factors such as separation from a parent by death or divorse, low social class and unmarried status. It is important to recognise these poor outcome factors early in the course of treatment so that suitable interventions can be applied.

Educating the patient about the symptomatology, course and treatment will improve patient's comprehension about their sensations or behaviours reduce demoralisation and improve doctor-patient relationship. Giving the patient the right to chose between various therapeutic strategies will make the patient more active and improve compliance. Management of medication side effects will also affect successful outcome by preventing rebound subsequent to drug stoppage. A possible residual symptomatology in the form of a limited panic attacks, minor phobic avoidance or anticipatory anxiety can lead to demoralising counteractions that disrupt full compliance with the treatment and hence facilitate relapse.

An important point is comorbidity which can alter the validity of diagnosis, influence patients compliance and modify treatment efficacy. A complete psychological and medical assessment is needed as 70% of panic patients may have comorbid conditions that should be considered when planning treatment (Wolf) & Maser, 1994). Even with severe psychiatric comorbidity, panic attack should be treated first because it is demoralising to the patients. Moreover, carefull assessment of substance abuse or dependence is also needed including alcohol, cannabis, opiates, coffeine, BDZ, cocaine, hallucinogens and over the counter drugs.

Comorbid conditions will influence the choice of treatment for panic. For e.g. in comorbid depression the choice will be antidepressant. In comorbid OCD the choice will be SSRIs. If there is history of BDZ abuse it should not be given to such patients. With comorbid personality disorders the choice of therapy must take the persomality takes special importance because of the behavioural and emotional instaliity and the high risk of suicide associated with this condition. Medical conditions that may affect the treatment schedule should also be treated concurrently. For e.g. condition with prominent, component of anxiety such as hyperthyroidism, polycythemia, lupus and chronic pulmonary insufficiency should be considered, Thirdly, conditions requiring medication that may cause or exacerbate anxiety such as vasoconstrictors, bronchodilators or steroids (Wolfe & Maser, 1994) should be avoided.

Though panic disorder is rare in elderly patients it is more difficult to manage as they are more vulnerable to certain antidepressants side effects (such as anticholinergic, orthostatic and sedative effects). They are also susceptible to the unwanted side effects of BDZs such as ataxia, amnesia, and confusion. For elderly SSRIs are safer and well tolerated.

Conclusion

Successful management of panic disoder starts from differentiation of this condition from panic attacks which occur in various medical and psychiatric disorders. The choice of treatment is individually tailored depending on the severety, comorbidity and previous response. Combination of drugs and psychological treatment are more effective in treatment resistant patients. The main concern in the management of difficult panic patients are comorbidity issues, compliance, patient education and relapse prevention.

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