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LPC BULLETIN

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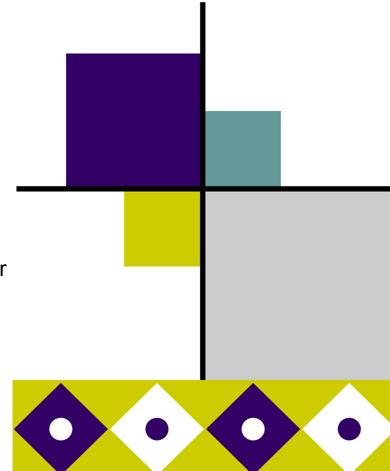
A SOURCE OF MENTAL HEALTH INFORMATION FOR GENERAL PRACTITIONERS



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In the next issue

- Hypochodriasis
- Postnatal Depression
- Bipolar 2 Disorder

Panic Disorder Some Facts

1.Characterized by recurrent unexpected surges of severe anxiety ('panic attacks'), with varying degrees of anticipatory anxiety between attacks.

2. Most patients develop a fear of having further panic attacks.

3. Around two-thirds of patients with panic disorder develop agoraphobia

4. Prevalence; One year 2.3%, Life time 3.8%

4. When assessing look for comorbid depression. If present treat depression.

5. CBT and pharmacological treatment equally effective in acute treatment

6. All SSRI (Citalopram, Escitalopram, Sertraline, Fluoxetine, Paroxetine) are effective.

SNRI (Venlafaxine) are also effective. Some TCAs(Clomipramine) and Imipramine are effective. Slow increase in dose is recommended to avoid initial side effects.

Benzodiazepines(Lorazepam, Diazepam, Clonazepam can be used for immediate releife from acute anxiety however these have addictive potential if used long term.

Treatment period of 12 weeks (after reaching the therapeutic dose) is needed to assess the efficacy.

After initial improvement continue the medications for 6 months.

Moreover consider adjunct CBT in long term.

When stopping the treatment reduce the dose of medication gradually and taper it off over the period

Diagnosing Panic Disorder

- It must be determined that panic attacks do not occur solely as a result of a general medical condition or substance use.
- It is crucial to determine if agoraphobia is present and to establish the extent of situational fear and avoidance.
- The presence of medical disorders, substance use, and other psychiatric disorders does not preclude a concomitant diagnosis of panic disorder.

A psychiatrist consider following points and psychiatric disorders when patient present with panic attacks

- Exposure to a specific feared situation or stimulus (specific phobia)
- Exposure to situations in which the patient fears negative evaluation (social phobia)
- Exposure to the focus of an obsession or a situation in which the patient was prevented from performing a compulsive behaviour (obsessive-compulsive disorder)
- Exposure to a reminder of a traumatic experience or to a situation in which the patient feels that safety is threatened (posttraumatic stress disorder)
- Intense bouts of worrying (generalized anxiety disorder)
- Exposure to separation from home or an attachment figure in children or adolescents (separation anxiety disorder)
- Hallucinations or delusional thinking (psychotic disorders)
- Use or withdrawal from use of a substance (substance use disorders; especially, intoxication with central nervous system stimulants or cannabis and withdrawal from central nervous system depressants)

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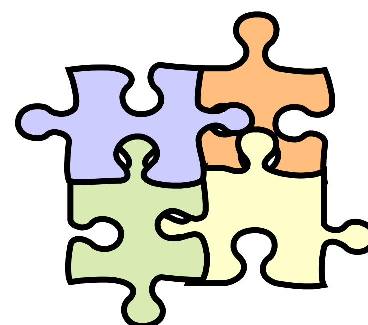
Social Anxiety disorder

It is also called Social Phobia. It is Characterized by the fear of humiliation and embarrassment in social and performance situations as well as avoidance of such social and performance situations. Public speaking tends to be the most common feared situation followed by situations such as meetings , social events (e.g. parties) and interacting with authority figures. Patients with social anxiety disorder are more likely than patients with panic disorder to report blushing, twitching and stammering. The mean age of onset of social anxiety disorder is around the mid to late teens years. The mean age at presentation for treatment of social anxiety disorder appears to be about 30 years. In recent studies the life time prevalence is 13 %. Female to male ratio is 1.5:1

Treatment

CBT, SSRI (Escitalopram, Fluoxetine, Paroxetine). SNRI (Venlafaxine), MAOI (Phenalzine) and RIMA (Maclobamide) are efficacious. Continuing medication fro 12 weeks to 24 weeks leads to overall increased response rate.

Public speaking tend to be the most common feared situation in Social Phobia



Generalized anxiety disorder (GAD)

Generalized anxiety disorder (GAD) is characterized by excessive and inappropriate worrying that is persistent (lasting some months in ICD-10, six months or longer in DSM-IV) and not restricted to particular circumstances. Patients have physical anxiety symptoms and key psychological symptoms (restlessness, fatigue, difficulty concentrating, irritability, muscle tension and disturbed sleep). Can be comorbid with major depression (but not arise solely in its context), panic disorder, phobic anxiety disorders and OCD in DSM-IV, but must not meet full criteria for these in ICD-10. Although generalized anxiety disorder (GAD) is amongst the most common mental disorders in primary care, and is associated with increased use of health services, it is often not recognized possibly because only a minority of patients present with anxiety symptoms (most patients with present physical symptoms), and doctors tend to overlook anxiety unless it is a presenting complaint. The disability associated with GAD is similar to that with major depression (Wittchen *et al.*, 2000).

Anxiety disorders are common, chronic and the cause of considerable distress and disability often unrecognised and untreated

Treatment of Generalized anxiety disorder

Systematic reviews and placebo-controlled RCTs indicate that some SSRIs (escitalopram, paroxetine and sertraline), the SNRI venlafaxine, some benzodiazepines (alprazolam and diazepam), the tricyclic imipramine, and the 5-HT1A partial agonist buspirone are all efficacious in acute treatment. Drug or psychological treatments, delivered singly, have broadly similar efficacy in acute treatment . Relapse rates are lower with cognitive behaviour therapy than with other forms of psychological treatment. Higher doses of SSRIs or venlafaxine may be associated with greater response rates Advise the patient that treatment periods of up to 12 weeks are needed to assess efficacy

Advise the patient that treatment periods of up to 12 weeks are needed to assess efficacy