Panic Disorder with Agoraphobia

W Scott Huddleston, PGY3
ETSU Department of Psychiatry
Grand Rounds 10/8/10

Disclaimer
NEITHER THE PUBLISHER NOR THE AUTHORS ASSUME ANY LIABILITY FOR ANY INJURY AND OR DAMAGE TO PERSONS OR PROPERTY ARISING FROM THIS WEBSITE AND ITS CONTENT.

No financial bias of any kind.

Objectives
Participants should be able to:
- distinguish between various diagnoses related to panic attacks and agoraphobia
- initiate or recommend appropriate treatment for panic disorder and agoraphobia
Case presentation

- 68 yo female presenting to the clinic for “nerves”
  - Over the past 6 months, increasingly frequent “spells” and episodes of SOB, tachycardia, feelings of choking, and “‘fraid I’m agoin’ crazy.”
  - Reports prior tx (20+ years) on xanax. PCP change 6 months ago led to d/c, she self-tapered.

Panic attack (PA)

- Discrete period of intense fear or discomfort
- Abrupt onset reaching a peak in 10 minutes
- 4 or more of the following sx:
  - Palpitations, pounding heart, tachycardia
  - Sweating
  - Trembling
  - Shortness of breath
  - Feeling of choking
  - Chest pain or discomfort
  - Nausea or abd distress
  - Feeling dizzy, unsteady, lightheaded, or faint
  - Derealization/depersonalization
  - Fear of losing control or going crazy
  - Fear of dying
  - Paresthesias
  - Chills or hot flashes

Panic attack precipitants

- Unexpected
- Situational bound
- Situationally predisposed

Agoraphobia

- A) Anxiety about being in places or situations from which escape might be difficult/embarrassing or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like sx.
- B) The situations are avoided or else are endured with marked distress or with anxiety about having a PA or panic-like sx, or require the presence of a companion.
- C) The anxiety or avoidance is not better accounted for by another disorder.
History

- Jacob Mendes DaCosta in American Civil War
  - Irritable heart / DaCosta’s syndrome
- Freud
  - Acute anxiety neurosis
  - Linked panic attacks with agoraphobia
- Agoraphobia coined in 1871
  - Greek: *agora* and *phobos* - “fear of the marketplace”

History continued

- 1980s: DSM-III set up criteria familiar today
- DSM-IV linked agoraphobia to panic disorder.
- Some controversy persists about that linkage.
- Misinterpretation of bodily sensations

Neurobiology

- Variety of different hypotheses, typically arising from use of “panicogens”
- Neurotransmitters:
  - Norepinephrine (alpha-2 receptors)
    - Clonidine
    - Yohimbine
  - Serotonin
  - GABA

Panicogens

- Work well for people with panic problems
- Respiratory – CO2, bicarb, sodium lactate
  - Trigger asphyxie monitor
- Neurochemical
  - Variety, almost all working through either norepinephrine, serotonin, or GABA system.
Diagnostic permutations
- Panic disorder without agoraphobia
- Panic disorder with agoraphobia
- Agoraphobia without panic disorder

Panic disorder
- At least one unexpected panic attack
- At least one attack has been followed by 1 month of at least one of the following:
  - Persistent concern about having another
  - Worry about the implications of the attack
  - Significant change in behavior related to the attacks
- Standard exclusionary criteria.

Panic disorder with agoraphobia
- Same criteria as for panic disorder without, except that agoraphobia is present.

Agoraphobia
- A) Anxiety about being in places or situations from which escape might be difficult/embarrassing or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like sx.
- B) The situations are avoided or else are endured with marked distress or with anxiety about having a PA or panic-like sx, or require the presence of a companion.
- C) The anxiety or avoidance is not better accounted for by another disorder.
Agoraphobia without Panic Disorder

- Presence of agoraphobia
- Never met criteria for panic disorder
- "Panic-lite"
  - Few specific symptoms that lead to concern rather than "full-blown" panic attacks.
  - Does not have to be limited to classic PA symptoms – any potentially embarrassing or incapacitating symptoms.

Epidemiology

- Panic disorder with or without agoraphobia
  - Lifetime prevalence 1-3%
  - Prevalence rates substantially higher in medical settings
  - Typical age of onset is mid-late twenties
  - Strong family correlation
  - Gender differences
    - Panic without agoraphobia: 2:1 women:men
    - Panic with agoraphobia: 3:1 women:men

Epidemiology cont'd

- Agoraphobia without panic
  - Controversial
  - Rates up to 6% in some studies
  - Questionable distinction between specific phobias with avoidance and agoraphobia

Ψ Differential Diagnosis

- Complicated because panic attacks can be a strong component of a variety of other psychiatric disorders
- For panic disorder, unexpected attacks are the primary distinction.
- For agoraphobia, fear of panic-like symptoms.
Medical Differential
- Multitude of different possibilities
- Standard lab testing
  - EKG
  - CBC, CMP, TSH, T4,
  - UA, UDS

Comorbidities
- Numbers as high as 90% in some studies
- Other anxiety disorders frequently
- Depression common (10-15%)
  - two-thirds had panic symptoms first
- Substance abuse also common

APA Guidelines revised 2009
- First-line monotherapy
  - Psychotherapy
    - CBT
    - Panic focused Psychodynamic Psychotherapy (in special circumstances)
  - Pharmacology
    - SSRI
    - SNRI
    - Benzodiazepine (scheduled)
    - TCA

Guidelines cont'd
- Combination therapy not recommended for initial treatment
- If poor initial response, try combination of pharm and psychotherapies
- Adjunct treatment with benzodiazepine
- Multitude of limited-evidence options after that
Panic in the future

DSM-V
- Two separate diagnoses
- Panic disorder
- Agoraphobia
  - Still linked to panic-like symptoms though less restrictive in one proposed set of revisions.

References on request
huddlesw@mail.etsu.edu