Panic disorder

Panic disorder is an anxiety disorder classified according to ICD-10 among other anxiety disorders. It is characterized by repeated paroxysms of massive anxiety (so-called panic attacks), which, unlike phobia, are not tied to any specific situation and usually cannot be predicted. A panic attack is accompanied by numerous vegetative symptoms, which is why it can be mistakenly interpreted as a physical illness. People suffering from this disease also often acquire the mistaken belief that they have fallen ill with a serious psychological or somatic disorder. Although the patient is usually sufficiently educated about his problems after the diagnosis of the disease, during an attack he is unable to control his state of will.

Epidemiology

The lifetime prevalence is between 1.4-3.5%, and the annual prevalence is around 1%. The first attack usually occurs during adolescence and early adulthood (15–24 years), or around the age of 50. The disease affects women twice as often.

Etiology and pathogenesis

Despite the small number of studies focused on the influence of genetic factors on this disease, it is possible to conclude that the disease has a clear genetic component (among other things, a higher concordance was clearly demonstrated in monozygotic twins than in dizygotic twins). In the autonomic nervous system, sympathetic tone is also increased and its inadequate reactions to mild stimuli are also evident. Other causes are also biological abnormalities in the CNS (dysregulation in the noradrenergic, dopamineergic and serotoninergic system). Disorders in the GABAergic neurotransmitter system and others also come into consideration (Praško et al. 2011).

Psychological theories attribute significance to pathological patterns of behavior

- in interpersonal relationships (psychoanalytic theories)
- when interpreting the symptoms of a normal stress reaction – e.g. palpitations, dizziness (cognitive behavioral model)

Course and Manifestations

A panic attack is accompanied by a number of vegetative and psychological symptoms.

Physical symptoms:

- Feelings of tightness in the chest or throat
- Increased muscle tone
- Tachycardia
- Chest or head pain
- Respiratory insufficiency
- Muscle tremors
- Vertigo
- Nausea
- Dry mouth
- Flushes of heat or cold
- Flashes before the eyes

Psychological symptoms:

- Mental tension
- Feeling of loss of control and self-control
- Catastrophic interpretations of bodily symptoms
- Feelings of fainting
- Fear of going crazy, dying, or disappearing
- Feelings of depersonalization or derealization

Video in English, definition, pathogenesis, symptoms, complications, treatment.

The first trigger of an attack can be various substances - so-called panicogens - lactate, yohimbine, caffeine, but also drugs - typically stimulants or marijuana. The sedative effect of alcohol can cause temporary relief (risk of addictioni). However, an attack can occur quite suddenly and seemingly for no reason. She has an intense fear that something terrible will happen. As a result, the sympathetic nervous system is excited and a state of "attack or flight" occurs, when the numerous vegetative and psychological manifestations mentioned above occur, which the person in question interprets as a sign of impending disaster (chest pain - I'm having a heart attack). This leads to stress, hyperventilation, respiratory alkalosis, feelings of fainting and again to the intensification of the original reaction (vicious circle). After a certain time (usually within a few minutes), the person becomes exhausted and stops hyperventilating, as a result of which the oxygen level in the body stabilizes again, the heart rate slows down and the anxiety subsides. After the attack,

the person may be exhausted, but there may also be a feeling of euphoria.

Despite the fact that panic disorder can be almost disabling, the patient is usually well socially adapted. During the attack, the person in question may not be visible, or may give the impression of fear, fright, nervousness or confusion.

Associated Phenomena

Among the most common complications associated with the anxiety itself are agoraphobia (comorbidity around 50-70%), depression and feelings of depersonalization (appearance of the unreality of one's self, physical body or part thereof) and derealization (the surrounding world appears alien, immaterial, non-existent). Since these are secondary symptoms, or the complication is that by curing the primary problem (PP), the second one will almost always disappear as well. The treatment is also complicated by the emergence of learned pathological thought patterns, which deepen the attacks, which also become more frequent. It is essentially "anticipatory anxiety" - a person suffering from the disorder is afraid that an attack will attack him in a place or situation where he has been attacked in the past and expects unpleasant consequences (that he will become socially disabled, urinate, etc., although this has never happened to him) – this leads to avoidant behavior (so-called anticipatory behavior), which in some cases leads to social isolation and the patient hardly leaves the apartment, etc. 7% of people suffering from PP attempt suicide, in the case of comorbidity with depression up to 20%.

Treatment

In the case of PP, the sooner treatment is started, the shorter and milder the course of the disease will be. Due to the large number of manifestations of the disease, it is appropriate to exclude other clinically serious diseases whose symptoms may coincide with the symptoms of an anxiety attack (myocardial infarction, asthma, epilepsy, [[intoxication]], tumor).

Pharmacotherapy

- **Antidepressants**: The drugs of first choice are antidepressants from the group of SSRIs (Sertraline, Citalopram) and SNRIs (Venlafaxine), or tricyclic antidepressants (Imipramine, Clomipramine). Their effects are usually seen in 3-6 weeks.
- **Benzodiazepines**: benzodiazepines are usually prescribed to manage acute anxiety, usually high-potency benzodiazepines with a dominant anxiolytic effect, i.e. alprazolam (Neurol, Xanax), or clonazepam (Rivotril). However, due to their high potential for habituation, their use is only suitable at the beginning of treatment, until the full effect of antidepressants is manifested (usually max. 6 weeks), or in case of a massive attack even during treatment. They should be withdrawn gradually, as a withdrawal syndrome (anxiety, rarely even epileptic seizures) occurs when the use of these drugs is suddenly stopped.
- **Antipsychotics**: In the case of a serious clinical picture and when antidepressants of any group did not help enough, antipsychotics (Sulpiride) can be used in addition to antidepressants.

Psychotherapy

In the case of psychotherapy, cognitive behavioral therapy is used most often. It is advisable to adequately educate the patient about his problems, possibly explain the vicious circle of anxiety and at the same time reassure him that he did the right thing by seeking help. It is also important to eliminate anticipatory behavior and practice the ability to find a rational insight into your panic thoughts. It is also in place to find and eliminate the causes in his private life, to which the patient reacts with a panic attack.

Prognosis

It depends on a lot of factors, the early intervention of a therapist who can bring relief to the patient with a combination of pharmacotherapy and psychotherapy is especially important. About 40% of patients have a chronic course despite treatment. Both spontaneous recovery and relapse after years without symptoms can occur. Treatment is usually long-term, lasting even years, exceptionally only months.

Links

Related Articles

- Anxiety Disorders
- Benzodiazepines
- Antidepressants

References

- PRAŠKO, John. , et al. Panic Disorder. *Practicus* [online]. 2011, vol. 10, no. 9, p. 11-17, Available from <http://www.practicus.eu>. ISSN 1213-8711.

- PRAŠKO, John, et al. *Panic disorder and how to manage it.* 1. edition. Prague : Galen, 2006. ISBN 80-7262-424-5.