PANIC DISORDER IN PAIN SYMPTOMS: A STUDY FROM A GENERAL HOSPITAL IN INDIA

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ABSTRACT

Objective: To evaluate panic disorder in patients with pain symptoms.

Design: Cross-sectional study.

Place and Duration of Study: The study was conducted at General hospital at Wayanad, Kerala, India; from October 2000 to October 2001.

Subjects and Methods: We have evaluated 115 patients with pain symptoms to find out the rate and clinical profile of panic disorder (PD) as per the Diagnostic Criteria for Research (DCR) criteria of ICD – 10. Forty three percentage had PD and non cardiac chest pain was the most common presenting symptom. Female to male ratio was 5:1. Onset of PD was in 3rd decade in both sexes.

Results: Agoraphobia was the most common co morbidity. Low dosage response to combination of Tricyclic Antidepressants and Benzodiazepines were observed and 56% were in remission when followed up for a period of 6 months to 1 year.

Conclusion: The study points out the high rate of PD in patients with pain symptoms and also emphasizes the need of high rates of physician recognition of this common and costly phenomenon in medicine.

Key words: Panic disorder (PD), Pain symptoms, Non cardiac chest pain, Physician recognition.

INTRODUCTION

Most of the patients with panic disorder do not initially present to psychiatrist, but to other health care professionals like cardiologists, emergency room physicians or general practitioners due to diverse symptomatology[1].

Studies have reported that one fifth of the PD patients presented with five or more medically unexplained symptoms, which include pain symptoms, especially non cardiac chest pain[2].

Prevalence of PD in patients with non cardiac chest pain ranges from 25 to 57% [3-5]. Data from India also shows that 30% of the out patients and 50% of the inpatients with non cardiac chest pain had PD[6].

Many of these non cardiac chest pain patients undergo expensive and extensive cardiologic investigations which shows the low rates of physician recognition of PD[5].Due to the poor recognition and explanation, these patients may suffer a chronic course and there by significant psychosocial disability[2].

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Data regarding prevalence of PD in other pain symptoms are largely unknown. So this study was an attempt to find out the rate of PD and to evaluate its assessment and management in patients presenting with pain symptoms in a general hospital setting.

SUBJECTS AND METHODS

This study was conducted in a general hospital at Wayanad, Kerala, India. All the patients (N=115) with pain symptoms referred to psychiatry OPD during the period of October 2000 to October 2001 were included in the study. These patients were initially seen and evaluated by the physician (AKD) and those who did not have any organic basis after a thorough clinical examination and investigation (ECG, X-Ray Chest, routine examination and Thyroid function test in relevant patients) were referred to the psychiatry OPD.

Patients were evaluated by the psychiatrist (SJ) in terms of physical examination and a detailed psychiatric interview. Diagnosis was arrived as per the DCR guidelines of ICD-10.These patients were followed up for a period of 6 months to 1 year.

RESULTS

Out of 115 patients, 50 (43%) received a diagnosis of PD. Forty two (84%) were females and 8 (16%) males. Majority of the patients were married (90%) and 10 % were unmarried. Mean age of onset of PD was 35 years (35.82 $\pm$ 15.16).Average duration of pain duration was 1.5 years. Non cardiac chest pain (82%) was the most frequently encoun-

Table 1
Mode of Presentation

Chest pain	82%
Abdominal Pain	32%
Head Ache	30%
Burning Sensation	18%
Autonomic Symptoms	18%
Unresponsive	10%

tered presenting symptom and abdominal pain, headache (32% and 30% respectively) were the next common.(See Table 1 and Table 2).Somatoform disorder was the second common diagnosis(25%) and the rest includes dissociative disorder (11%), anxiety disorder unspecified (10%) and depressive disorders (4%).

Thirty (60%) had more than 4 panic attacks (PA) in a month and 20 (40%) had 4 PA per week. Most of them had unexpected PA (61%) (See table 3) agoraphobia (20%) was the most common psychiatric co morbidity. Only 6% of patients had a co morbid physical disorder. These include bronchial asthma (2%), rheumatic heart disease (2%) and epilepsy (2%).

Mean dosage of tricyclic antidepressants like amitriptyline, imipramine, clomipramine or nortriptyline and benzodiazepine (both given in combination) alprazolam were 27mg. (27 +/- 7.9) and 0.79mg (0.79 +/- 0.37) respectively. When followed up for a period of 6 months to 1 year 28 (56%) were observed to be in remission (85% were on pharmacological treatment), 6 (12%) had 1 to 2 PA per month, 2 (4%) were unchanged and 14 (28%) did not come for follow up.

DISCUSSION

In the present study all the patients were referred from a medical out patient illustrates the route of the PD patients to

Table 2
Symptom Analysis as per the Diagnostic Criteria for Research

Chest Pain	82%
Palpitation	81%
Feeling unsteady, dizzy, faint	70%
Dry mouth	66%
Fear of Dying	58%
Sweating	42%
Trembling/Shaking	36%
Difficulty in breathing	36%
Abdominal Symptoms	20%
Hot flushes, cold chills	06%
Numbness or Tingling	04%

Table 3
Frequency of Nature of Panic Attacks (PA)

Frequency of Panic Attacks (PA) PD moderate (4 PA in a month)	60%
PD Severe (4 PA per week in a month)	40%
Mean duration of PA (mins???)	27.19 $\pm$ 33.73
Nature of Panic Attacks (PA) Unexpected	61%
Situational	39%
Anticipatory Anxiety	24%

the psychiatric care. Non cardiac chest pain (a somatic rather than psychological symptom) was the most common presenting symptom which justifies the high utility of the medical out patient services by these patients. Analysis of data from the ECA study indicated that patients with PD were 5 to 8 times more likely than non affected individuals to be high users of medical Services[2].

Present study also gives a high rate of PD in pain symptoms (43%).Nearly 30% of patients each had abdominal pain, and headache as the presenting symptom showing the diverse mode of presentation of the PD. This also warrants a careful assessment of other pain symptoms in the diagnosis of PD. This is also supported by the relatively low rates of somatoform disorders in the present study.

Female to male ratio is 5:1 when compared to the 3:1 in the existing literature. Age at onset in the 3rd decade in both the sexes, was in agreement with the previous findings[7]. As reported earlier[8], present study also finds agoraphobia as the most common psychiatric comorbidity.

Remission rates in the present study were in comparable range with the previous observations[9]. Response to low dosage of TCA and BNZ, in this study may not agree with majority of the western literature, but fewer studies had reported significant response to low dose strategy of both TCA and BNZ in PD[10, 11].

Although the findings of this study is largely in consensus with the existing literature, it points out the high utility of medical out patient services and the need of a high rates of physician recognition of PD in patients with pain symptoms. Simple label of non cardiac chest pain or 'functional pain' often insufficient to reassure the patient with PD, but a proper recognition and a prompt referral to psychiatry care is required to relieve the patient. Without a specific explanation or treatment the patient may suffer chronically[12].

The study has few limitations also, as it did not use ant structured diagnostic instrument or detection instrument to improve the physician recognition. Studies[5] reports that the physician recognition can be improved by using instruments like Agoraphobia Cognition questionnaire or Short Form McGill pain questionnaire. Psychosocial disability is also need to be explored more systematically. In future studies with

larger sample size and improved methodology may throw more light in this area.

Finally to conclude the recognition and treatment of PD in general, medical setting is critical, given the association of the disorder with adverse effects across multiple domains of functioning and the demonstration that early recognition, prompt referral to psychiatry care and appropriate treatment results in symptomatic relief, improvement in role functioning, decreased use of medical resources, and thereby reduction on overall costs.

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