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ORIGINAL RESEARCH

Evaluation of panic attack among adults- A clinical study

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ABSTRACT

Background: Panic disorder is an anxiety disorder exhibited by repeated and sudden panic attacks which include palpitations, sweating, shortness of breath, chest discomfort, abdominal distress, dizziness, and fear of dying. The present study was conducted to assess cases of panic attack among adults.

Materials & Methods: 126 cases of panic attack of both genders were included. Parameters such as PDSS, APPQ, ASI- R and BDI was recorded. The instrument includes 7 items associated with symptoms accompanied by panic disorder.

Results: Out of 126 patients, males were 56 and females were 70.PDSS (total) score was 12.3, APPQ (total) was 51.8, agoraphobia score was 49.7, social phobia score was 50.2 and interoceptive fearscore was 50.9.Reasons of attack was depression in 36, hereditary in 30, low blood sugar in 20 and medicine withdrawal in 40 cases. The difference was significant ($P< 0.05$).

Conclusion: Reasons of panic attack was depression, hereditary, low blood sugar and medicine withdrawal.

Key words: Panic, Phobia, medicine withdrawal

Introduction

Panic disorder is an anxiety disorder exhibited by repeated and sudden panic attacks which include palpitations, sweating, shortness of breath, chest discomfort, abdominal distress, dizziness, and fear of dying.[1] Patients with panic disorder suffer from psychiatric comorbidities such as depression, substance abuse, and suicide ideation.[2]

Diagnostic criteria for panic disorder are among the most simple and clear in the DSM-III-R. Nevertheless, patients vary in the severity and frequency of panic episodes, anticipatory anxiety, and phobic avoidance.[3] Functional impairment varies, as does overall severity. Clinical and epidemiologic studies indicate a very high prevalence of comorbidity among patients with panic disorder. Populations seen in different settings may vary in the severity, characteristics and type, and prevalence of coexisting disorders. Consistent and complete characterization of samples is necessary for ensuring accuracy in the design of replication studies, generalizability of results, and confidence in the soundness of the database.[4]

Also, individuals in bereavement often show long-lasting psychological symptoms including panic attacks. Panic disorder frequently occurs with agoraphobia, which presents with fear and anxiety that caused by being in a place where it is difficult to get help or escape if a panic attack or similar symptom occurs.[5]Panic attack is a disorder of intense fear caused by various reasons. The panic attack is not life- threatening disease but not treated well it may lead to various diseases. The persons suffering from this disorder are fall under different categories.[6]The present study was conducted to assess cases of panic attack among adults.

Materials & Methods

The present study comprised of126 cases of panic attack of both genders. All were informed regarding the study and their written consent was obtained.

Data such as name, age, gender etc was recorded. Parameters such as PDSS, APPQ, ASI- R and BDI was recorded.The instrument includes 7 items associated with symptoms accompanied by panic disorder. Results thus obtained were subjected to statistical analysis. P value less than 0.05 was considered significant.

Results

Table I Distribution of patients

Total- 126		
Gender	**Males**	**Females**
Number	56	70

Table I shows that out of 126patients, males were 56 and females were 70.

Table II Assessment of parameters

Parameters	Mean
PDSS (total)	12.3
APPQ (total)	51.8
Agoraphobia	49.7
Social phobia	50.2
Interoceptive fear	50.9

Table II, graph I shows that PDSS (total) score was12.3, APPQ (total) was 51.8, agoraphobia score was 49.7, social phobia score was 50.2 and interoceptive fear score was 50.9.

Graph IAssessment of parameters

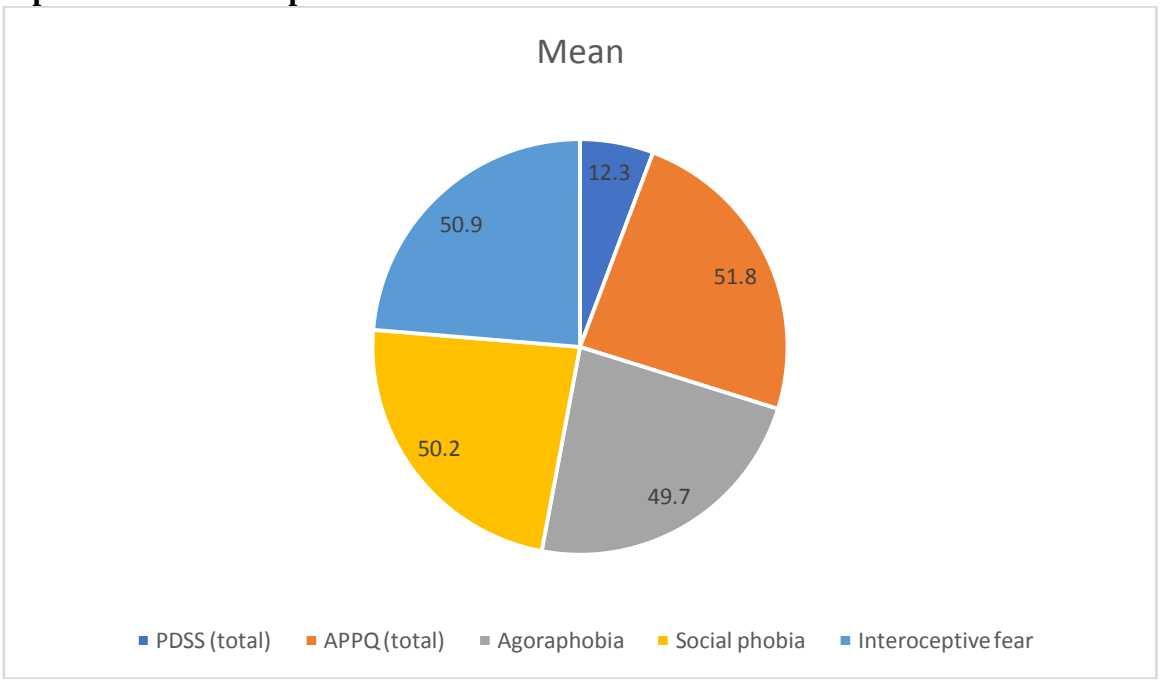
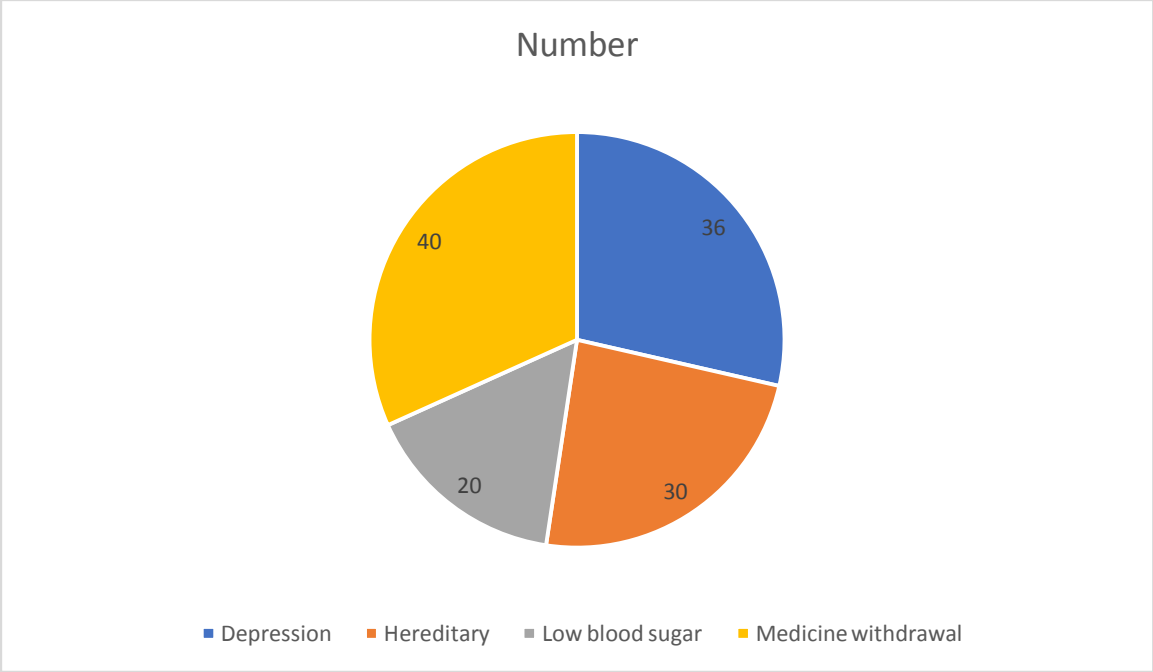


Table III Reasons of panic attack

Reasons	Number	P value
Depression	36	0.01
Hereditary	30	
Low blood sugar	20	
Medicine withdrawal	40	

Table III, graph II shows that reasons of attack was depression in 36, hereditary in 30, low blood sugar in 20 and medicine withdrawal in 40 cases. The difference was significant (P< 0.05).

Graph IIReasons of panic attack



Discussion

The Panic attack occurs due to the frightening event happened in the person life. Panic disorder is nothing but the panic attack which is occurring frequently.[7]Patients with bronchial asthma are taken for study. The work has limitation that panic disorder persons with Psychiatry comorbidities are not analysed.[8] Anxietydisorder is a minor mental disorder in comparison with major mental disorder like schizophrenia.[4] The Patient with Panic attack symptoms reports low energy level, sleeplessness and moodiness even though the person is non-alcoholic.[9]The use of antidepressant together with benzodiazepines will lead to rapid recovery from panic attack. In addition to medicine phycho therapy also plays an important role in the treatment.[10]The present study was conducted to assess cases of panic attack among adults.

We found that out of 126 patients, males were 56 and females were 70. Kessler et al[11] found that lifetime prevalence estimates are 22.7% for isolated panic without AG (PA only), 0.8% for PA with AG without PD (PA-AG), 3.7% for PD without AG (PD only), and 1.1% for PD with AG (PD-AG). Persistence, lifetime number of attacks, and number of years with attacks increase monotonically across these 4 subgroups. All 4 subgroups are significantly comorbid with other lifetime DSM-IV disorders, with the highest odds for PD-AG and the lowest for PA only. Scores on the Panic Disorder Severity Scale are also highest for PD-AG (86.3% moderate or severe) and lowest for PA only (6.7% moderate or severe). Agoraphobia is

associated with substantial severity, impairment, and comorbidity. Lifetime treatment is high (from 96.1% for PD-AG to 61.1% for PA only), but 12-month treatment meeting published treatment guidelines is low (from 54.9% for PD-AG to 18.2% for PA only).

We found that PDSS (total) score was 12.3, APPQ (total) was 51.8, agoraphobia score was 49.7, social phobia score was 50.2 and interoceptive fearscore was 50.9.Reasons of attack was depression in 36, hereditary in 30, low blood sugar in 20 and medicine withdrawal in 40 cases.Shin et al[12] included 87 patients with panic disorder which were divided into two groups depending on the presence of agoraphobia: patients with agoraphobia (PDA, n=41) and patients without agoraphobia (PD, n=46). Agoraphobia subscale score of the Albany Panic and Phobia Questionnaire was used to identify correlations between agoraphobia and panic and affective symptoms. The PDA group showed more severe panic and affective symptoms than the PD group. Patients with PDA were more likely to be younger at the age of onset, take benzodiazepines for longer durations, and be treated with antipsychotics augmentation. Agoraphobia subscale was associated with panic symptoms, depression, anxiety, and the duration of benzodiazepines use. The findings suggest that patients with PDA experienced more severe panic symptoms, more profound psychiatric comorbidity, and worse illness progression than those with PD.

Brook et al[13] reported that 35% of patients with PDA took BZD whereas only 8% of patient with PD were prescribed BZD. Tiller also reported that doses of BZD and antidepressants to alleviate symptoms in patients with PDA were higher than those for patients with PD only. Antipsychotic augmentation for the treatment of panic disorder in relation with agoraphobia has not been reported previously. Evidence supported that antidepressants augmented with atypical antipsychotics could result in a superior therapeutic effect than antidepressant monotherapy for treatment-resistant panic disorder.

Conclusion

Authors found that reasons of panic attack was depression, hereditary, low blood sugar and medicine withdrawal.

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