Best Practice Guideline

I. Panic Disorder

II. Diagnosis and Screening

a. Perform a clinical interview inquiring about symptoms listed in DSM V for the diagnosis of Panic Disorder (see appendix A)
b. Review past medical history, past psychiatric history/treatment, social history, substance use history (including caffeine)
c. Review current medications- prescribed, over the counter, supplements. Rule out medication SE as cause of panic (ie. steroid, stimulant)
d. Rule out medical causes of panic symptoms
    i. Examples of common medical causes: Thyroid disease, Migraine, Cancer, Chronic Pain, Cardiac Disease, Mitral Valve Prolapse, IBS, Vestibular disorders, Allergic Conditions, Respiratory disease
    ii. Order lab work if medical etiology suspected. Lab work is not routinely ordered for diagnosis
e. Assess co-occurring psychiatric conditions and presence of general medical conditions. Coordinate care with other health care professionals treating/evaluating patient
f. Assess suicide risk- Panic disorder has been associated with elevated risk of SI and behavior, even in the absence of co-occurring major depression

III. Surveillance/Follow-up Interval

a. Effective treatment should decrease frequency/intensity of panic attacks, level of anticipatory anxiety, degree of agoraphobic avoidance, severity of interference and distress related to panic disorder
b. Follow up (phone or office) within 1-2 weeks after medication is initiated to assess tolerability/effect and then in 2-4 week intervals thereafter until dose is stabilized and symptoms have decreased.
c. Severity of co-occurring conditions should also be assessed at regular intervals as they can be impacted by and can impact panic disorder.
d. After acute response, maintain treatment with medication for at least 1 year to promote further symptom reduction and decrease risk of recurrence
e. Decision to discontinue pharmacotherapy should be made collaboratively with the patient. Discuss possible outcomes, including recurrence of symptoms
f. Taper medication gradually over several weeks or months**,** monitor for recurrence, reinitiate at previously effective dose if necessary.
    i. SSRI, SNRI, TCA – tapered by one dosage step every 1-2months. Can be tapered more quickly tolerated and necessary (ie. pregnancy)
    ii. Benzodiazepine- withdrawal and rebound side effects are common. Taper slowly (over 2-4 months) at rates no higher than 10% of the dose per week.

IV. Treatment

a. Psychoeducation
    i. Reassure that panic attacks are not life threatening
    ii. Enhance treatment adherence
        1. Assess and acknowledge potential barriers, work collaboratively with patient
        2. Educate when to expect improvement (4-6 weeks for SSRI, SNRI, TCA's) to avoid prematurely abandoned treatment

iii. Tailor Treatment plan to the individual patient. Encourage patient to keep a diary or calendar of symptoms, response to treatment
iv. Counsel on healthy lifestyle: exercise, sleep hygiene, decreased use of substances (ie. caffeine, tobacco, alcohol)

b. Psychopharmacological Treatment (See table above)
    i. Factors to consider when choosing treatment
        1. Side effects, cost, prior treatment history, co-occurring medical/psychiatric conditions, strength of evidence. In older adults, more consideration given to: Half-life, drug metabolism (CYP 450 isoenzymes), potential drug-drug interactions
    ii. SSRI/SNRI
        1. Best choice due to favorable safety and side effect profile
    iii. TCA
        1. Effective but side effect profile and greater toxicity in overdose often limits their clinical utility and acceptability to patients
        2. Caution should be used given cardiovascular and anticholinergic side effects, especially in older adults
    iv. Benzodiazepine
        1. May be preferred as monotherapy or in combination with SNRI/SSRI/TCA for impairing symptoms where rapid symptom control is critical
        2. Consider addition of a benzodiazepine in the short term (4-6 weeks) while titrating SNRI/SSRI/TCA. Plan to taper to discontinue once maintenance medication is therapeutic
        3. Regular dosing schedule rather than PRN basis for panic disorder. Goal to *prevent* panic attacks, reduce risk of abuse
        4. Goal for **short term** use due to risk of abuse and dependence

    v. **SSRI/SNRI/TCA are preferred** to benzodiazepine monotherapy with co-occurring depression, substance use, or a history of substance use

    vi. If response to first line treatment is unsatisfactory, consider possible contributing factors
        1. Underlying medical illness, co-occurring psychiatric/medical conditions, non-compliance, problems in therapeutic alliance, psychosocial stressors, motivational factors, inability to tolerate medication
    vii. If response remains unsatisfactory despite adequate trial, consider adding or switching to another first line treatment
        1. Augmentation is reasonable if some benefit was observed with the original treatment. Consider adding a benzo to SSRI/SNRI/TCA or combine pharmacotherapy with psychotherapy
        2. Switch in treatment if no alleviation of symptoms with original treatment
        3. If first and second line treatments have been exhausted, may try less well supported treatments – MAOI, gabapentin, second generation antipsychotic, or psychotherapy other than CBT

c. Psychotherapy
    i. Factors to consider when choosing psychotherapy
        1. Patient preference, cost, availability, treatment history, strength of evidence base for that type of psychotherapy, presence of co-occurring personality disorder
    ii. Factors favoring psychotherapy

1. Patient prefers non-medication treatment, able to invest time/effort necessary, pregnancy/nursing/planning for pregnancy, co-occurring personality disorder

iii. CBT is recommended with clinical confidence, supported by evidence. Group CBT and self-directed CBT (through use of self-help books) are supported by controlled studies. Exposure therapy is also well studied and recommended.

Medication	Starting Dose (mg/day)	Target Dose (mg/day)	Common Side Effects	Clinical Notes
Selective serotonin reuptake inhibitors (SSRI)	Lower than for depression	Same or > depression	Headache and GI in the first 7-10 days, Sexual SE (~ 30% of pts)	• SIADH is a side effect in elderly patients • Monitor for SI. Can increase risk of suicidal ideation and behavior in persons < 24 yo. • Start with ½ the dose as for depression. Maintain for a several days then increase gradually to full therapeutic dose as tolerated by patient. • Increased risk of upper GI bleeding when used with NSAIDs.
Fluoxetine (Prozac)	5-10	20-40		• Avoid if patient is on Coumadin and Tamoxifen because of 2D6 metabolism. • Can be activating
Paroxetine (Paxil)	10	20-40	Weight gain, sedation	• Avoid use during first trimester because of risk of cardiac malformations. • Consider in patients with vasomotor symptoms of menopause • Strong 2D6 inhibitor • Taper to d/c slowly- short half-life/withdrawl SE
Sertraline (Zoloft)	25	100-200	GI side effects (diarrhea)	• Consider as first choice for pregnancy and post-partum • Higher doses needed for panic and anxiety than depression
Citalopram (Celexa)	10	20-40		• Lowest drug-drug interaction risk (except with Omeprazole) • Consider in geriatric population
Escitalopram (Lexapro)	5-10	10-20		• Lower side effect profile
Serotonin norepinephrine reuptake inhibitors (SNRI)			Can result in elevated blood pressure	• Monitor for SI. Can increase risk of suicidal ideation and behavior in persons < 24 yo
Venlafaxine, extended release (Effexor XR)	37.5	150-225	Sustained hypertension in small proportion of patients	• Assess BP during tx, especially at higher doses • Avoid Immediate release because of risk of withdrawal

				side effects
Duloxetine (Cymbalta)	20-30	60-120		• Consider if comorbid pain symptoms • Avoid in glaucoma patients
TCA's			Anticholinergic side effects (dry mouth, constipation, etc.), sleep disturbance, dizziness, weight gain, worse in elderly. Cardiovascular risks	• Risk of falls and fractures worse in elderly. • Avoid use in acute Narrow angle glaucoma or prostatic hypertrophy. • Consider baseline ECG for preexisting cardiac conduction abnormalities. • Significant cardiac toxicity and fatality in overdose
Imipramine	10	100-300		• See above
Clomipramine	10-25	50-150		• See above
Desipramine	25-50	100-200		• See above
Nortriptyline	25	50-150		• See above
Benzodiazepines			Sedation, fatigue, memory difficulties, increased rate of falls and MVA's With ongoing use, physiologic dependence develops	• More immediate onset of action. • Best to schedule for panic disorder rather than using on PRN basis. • Consider bridging when starting SSRI/SNRI/TCA • Increase rate of falls and fractures in elderly • Additive effects of benzo's and alcohol (sedative, respiratory) • Potential for misuse or relapse of substance use disorder
Alprazolam	0.75-1.0mg	2-4mg	Drowsiness, irritability, dependence, withdrawal.	• Short acting, Half-life 11.2h • Split into 3-4 doses given through the day • Must be tapered off if on for long term.
Clonazepam	0.5-1.0	1-2	Drowsiness	• Long acting, half-life 20-50h • Split into 2 doses given in morning and evening
Lorazepam	1.5-2.0	4-8	Intermediate acting	• Short acting, Half-life 14 hours • Split into 3-4 doses given through the day

V. Indications for Psychiatry Consult

a. Safety concerns, suicidality
b. Co-morbid psychiatric diagnoses
c. Failure of first and second line treatments at appropriate doses for adequate length of time

VI. References:

a. Reference: Practice Guideline for the Treatment of Patients With Panic Disorder, Second Edition. American Psychiatric Association. 2010.

Appendix A: DSM V Criteria for Panic Disorder

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time 4 or more of the following symptoms occur. Note that the abrupt surge can occur from a calm or an anxious state.
    a. Palpitations, pounding heart, or accelerated heart rate
    b. Sweating
    c. Trembling or shaking
    d. Shortness of breath or sensation of smothering
    e. Feelings of choking
    f. Chest pain or discomfort
    g. Nausea or abdominal distress
    h. Feeling dizzy, unsteady, light headed, or faint
    i. Chills or heat sensations
    j. Parasthesias (numbness or tingling sensations)
    k. Derealization (feelings of unreality) or depersonalization (feeling detatched from oneself)
    l. Fear of losing control or “going crazy”
    m. Fear of dying
B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
    a. Persistent concern or worry about additional panic attacks or consequences (ie. losing control, having a heart attack, “going crazy”)
    b. Significant maladaptive change in behavior related to the attacks (ie. behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations)
C. The disturbance is not attributable to the physiological effects of a substance (ie. drug of abuse or medication) or another medical condition (ie. hyperthyroidism, cardiopulmonary disorders)
D. The disturbance is not better explained by another mental disorder (ie. the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in OCD; in response to reminders of traumatic events, as in PTSD; or in response to separation of attachment figures, as in separation anxiety disorder.