Panic Disorder: Review Questions

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QUESTIONS

Choose the single best answer for each question.

1. **A 23-year-old woman presents to her primary care physician with a 6-month history of anxiety symptoms that started after she was promoted to a job requiring public speaking. Her new job requires her to give presentations to colleagues and customers on a regular basis. She states that when she begins a presentation, she "has a panic attack." She describes symptoms of rapid heart rate, shortness of breath, sweating, and tremor and reports being afraid of doing something "stupid" that will cause embarrassment. She states the discomfort is so intense that she is unable to speak articulately during presentations and that her job performance is significantly hampered by these attacks. When preparing for a presentation, worry keeps her awake at night and interferes with her concentration during the day. The patient reports that she does not worry excessively about anything other than the presentations. She does not have unexpected attacks of anxiety, fear of open spaces, or a history of exposure to any traumatic stressor. What is this patient's most likely diagnosis?**
   (A) Acute stress disorder
   (B) Generalized anxiety disorder (GAD)
   (C) Panic disorder without agoraphobia
   (D) Social phobia

2. **A 25-year-old man presents to a psychiatrist complaining of having severe panic attacks 3 to 4 times per week, each lasting 10 to 15 minutes. He meets criteria for a diagnosis of panic disorder with agoraphobia. Symptoms started about 6 months ago with 1 or 2 mild attacks per month, but the severity and frequency of the attacks have increased over the past 6 weeks. The patient reports severe anxiety over being in situations where he cannot escape or obtain assistance if he has a panic attack. He is particularly fearful of driving and riding the bus. Because of this anxiety, the patient often is unable to go to work and is afraid he will lose his job. He asks for something to control his symptoms quickly. The patient denies any history of substance abuse or other psychiatric conditions. What is the most appropriate initial treatment for this patient?**
   (A) Psychotherapy only
   (B) Selective serotonin reuptake inhibitor (SSRI)
   (C) SSRI and a benzodiazepine
   (D) Tricyclic antidepressant and a benzodiazepine

3. **Five days after starting fluoxetine 20 mg/day for newly diagnosed panic disorder, a 44-year-old woman calls her primary care physician complaining that her anxiety symptoms seem to be worsening. In particular, she notes anxiety, sweating, and tremor even when she is not having a panic attack. What is the most appropriate management of this patient's increased symptoms?**
   (A) Continue fluoxetine and add clonazepam 1 mg 3 times/day
   (B) Discontinue fluoxetine immediately
   (C) Increase fluoxetine to 40 mg/day
   (D) Reassurance and decrease fluoxetine to 10 mg/day

4. **A 32-year-old woman is evaluated by an internist and is found to meet diagnostic criteria for panic disorder. She reports that although her symptoms are bothersome, they only minimally interfere with her life. She states she would rather not take psychiatric medication and wonders if there are other treatment options available. Which of the following**

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is the most appropriate recommendation?
(A) Recommend no treatment since symptoms are not severe
(B) Refer for cognitive behavioral therapy
(C) Refer to a psychiatrist for a second opinion
(D) Strongly encourage psychopharmacotherapy

5. A 21-year-old man presents to the psychiatrist for a follow-up appointment. He was diagnosed with panic disorder and has taken citalopram 40 mg/day for 6 months. He reports that he has been symptom-free for approximately 3 months and has no side effects from the medication. The patient asks if he can stop taking citalopram since his symptoms have resolved. Which of the following is the most appropriate recommendation?
(A) Encourage continuation of citalopram for at least another 6 months
(B) Explain that a minimum of 5 years of treatment will be necessary
(C) Explain that lifelong treatment will be necessary
(D) Taper and discontinue citalopram

6. After 5 years of treatment with paroxetine 40 mg/day for panic disorder, a 40-year-old woman calls her primary care physician stating that she has forgotten to refill her prescription. She has not taken paroxetine for several days and is experiencing nervousness, insomnia, and dizziness but denies other symptoms. The patient reports that increased stress is the reason she did not notice that her prescription had run out. Which of the following is the most likely explanation of this patient's symptoms?
(A) Onset of GAD
(B) Onset of major depression
(C) Relapse of panic disorder
(D) SSRI discontinuation syndrome

7. A 36-year-old woman tells her family physician that she has been experiencing anxiety for approximately 4 weeks. She states that the anxiety is episodic and seems to occur as "attacks." During these attacks, the patient experiences increased nervousness and feels shaky. She describes frequent worry as well as daily insomnia, trouble concentrating, loss of appetite, and feelings of worthlessness. She also reports loss of interest in her job and friends. The patient occasionally drinks alcohol but denies alcohol or drug abuse. She states that about 5 years ago she was diagnosed with panic disorder; however, the symptoms resolved after treatment with an antidepressant. She denies agoraphobia. Which of the following is this patient's most likely diagnosis?
(A) Dysthymic disorder
(B) GAD
(C) Major depression
(D) Panic disorder without agoraphobia

8. Which of the following is the most appropriate initial treatment for a patient with new-onset panic disorder with no comorbid psychiatric, substance abuse, or medical disorders?
(A) Bupropion 300 mg/day
(B) Citalopram 5 mg/day
(C) Clonazepam 2 mg 3 times/day
(D) Haloperidol 5 mg/day

ANSWERS AND EXPLANATIONS

1. (D) Social phobia. The patient's anxiety symptoms meet criteria for a panic attack but not panic disorder. Anxiety symptoms only occur when the patient is in specific situations (ie, speaking to groups) in which she is exposed to possible scrutiny of others. The limitation of attacks to this specific situation and her fear of embarrassment are characteristic of social phobia. For a diagnosis of panic disorder, panic attacks must be unexpected, with or without agoraphobia. For a diagnosis of acute stress disorder, the patient must be exposed to a traumatic stressor. A diagnosis of GAD would require excessive worry about events or activities in addition to being embarrassed in public.[1]

2. (C) SSRI and a benzodiazepine. Both SSRIs[2,3] and benzodiazepines[4,5] are effective for the treatment of panic disorder with agoraphobia. Based on this patient's severity of symptoms and associated impairment, rapid symptom reduction is critical. Thus, using a benzodiazepine for rapid symptom control as well as initiating an SSRI for long-term management is the treatment of choice. Discontinuation of the benzodiazepine may be considered in the future once symptoms are under control. Tricyclic antidepressants are effective for panic disorder but are considered second-line therapy because of possible adverse effects, such as weight gain, dizziness, headache, and somnolence as well as serious side effects, such as cardiac dysrhythmia.[6,7] Due to the severity of symptoms, psychotherapy alone would not be recommended for this patient.

3. (D) Reassurance and decrease fluoxetine to 10 mg/day. Patients with panic disorder are extremely

sensitive to the activating side effects of SSRIs.[7] This patient is most likely experiencing side effects of activation rather than an increase in anxiety symptoms. For this reason, SSRIs should be started at low doses (eg, ≤ 10 mg/day for fluoxetine).[7] In this case, decreasing the dose will likely resolve symptom exacerbation. Increasing or discontinuing fluoxetine would not be recommended as initial management. If the patient is unable to tolerate even a low dose of fluoxetine, a trial of a different agent or augmentation with a benzodiazepine should be considered.

4. **(B) Refer for cognitive behavioral therapy.** Cognitive behavioral therapy has been shown to be effective as monotherapy for panic disorder[8] and likely would provide symptom remission without the need for pharmacotherapy. Referral for a second opinion is not indicated in this case.

5. **(A) Encourage continuation of citalopram for at least another 6 months.** Maintenance treatment of panic disorder is recommended for at least 12 to 24 months,[7] and longer treatment may be necessary. Discontinuing the medication is reasonable after 12 months, with reinstitution of treatment if symptoms return. Discontinuing treatment before 12 months is more likely to result in relapse. Although lifelong or multiple years of treatment might be required, it is impossible to predict which patients will require longer treatment.

6. **(D) SSRI discontinuation syndrome.** SSRI discontinuation syndrome may occur with abrupt cessation of SSRIs.[9,10] This syndrome occurs in approximately one third of patients who suddenly stop paroxetine. Symptoms include nausea, dizziness, insomnia, headache, and nervousness and can be confused with relapse of panic disorder. Before suspecting relapse of panic disorder or onset of another condition, discontinuation syndrome must be ruled out by restarting the agent and determining if symptoms resolve. Reinstatement of the discontinued SSRI will resolve symptoms associated with discontinuation syndrome within 48 hours.[10]

7. **(C) Major depression.** This case illustrates the importance of not relying solely on a patient's terminology and the necessity of completing a thorough evaluation. While this patient reports "anxiety attacks," these episodes actually include only 1 symptom (feeling shaky) included in the DSM-IV-TR criteria for panic disorder.[1] In contrast, her symptoms (ie, anhedonia, insomnia, feelings of worthlessness, anorexia, difficulty concentrating) meet criteria for major depressive disorder. This patient's symptoms do not meet the duration criteria for either GAD or dysthymic disorder.[1]

8. **(B) Citalopram 5 mg/day.** Citalopram is effective for the treatment of panic disorder.[2] Although 20 mg/day or higher may be required for symptom control, patients with panic disorder should be started at low doses (5–10 mg/day), as this group tends to be very sensitive to the activating effects of SSRIs.[7] Clonazepam is also effective for panic disorder;[5] however, 2 mg 3 times daily would be excessive as a starting dose. Bupropion and haloperidol are not used to treat panic disorder.

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