

## Evaluation and Treatment of Anxious Patients: Review Questions

*Julia B. Frank, MD*

### QUESTIONS

Choose the single best answer for each question.

#### Questions 1 and 2 refer to the following case study.

A 32-year-old married woman seeks evaluation for rapid heartbeat, dizziness, and pressure in her chest. The symptoms cluster and are associated with a feeling of doom. She also describes shortness of breath and trembling. The episodes, which began in her late 20s after she was fired from a job, vary in frequency from daily to a few times per month. The episodes begin suddenly and resolve in approximately 20 minutes, but she describes feeling tired for hours afterwards. She associates some episodes with feeling trapped (eg, being in a long line, being in a car in traffic) but says they are unrelated to exertion. Her vital signs are normal, and cardiovascular examination is normal except for a midsystolic click, suggestive of mitral valve prolapse (MVP). MVP is subsequently confirmed by echocardiogram.

- 1. Which of the following factors must be present to establish a diagnosis of panic disorder?**
  - A) Intense restlessness with the attacks
  - B) A family history negative for heart disease
  - C) Excessive worry about having future episodes
  - D) Episodes that wake the patient from sleep
  - E) A family history of mental illness
- 2. Further evaluation of this patient should include which of the following tests?**
  - A) A 24-hour urine screen for catecholamine metabolites
  - B) Thyroid function tests
  - C) Ventilation-perfusion scan
  - D) A 5-hour glucose tolerance test
  - E) All of the above

#### Questions 3 and 4 refer to the following case study.

A 40-year-old man who is undergoing a contested divorce requests medication for anxiety. He says that for the past 2 months, he has been worried and can't fall asleep until approximately 2 AM. His work has suffered because of daytime fatigue. He has trouble "catching his breath," sighs excessively, and feels constant tension in his back and neck. He sometimes feels angry when he has contact with his wife. He denies excessive consumption of alcohol according to the CAGE questionnaire. He describes himself as a man prone to worry about money and work demands prior to the divorce but cannot recall having similar symptoms that lasted more than 1 or 2 days. He denies any past abuse of his wife or any current intention to hurt her.

- 3. What is the most likely diagnosis in this patient?**
  - A) Generalized anxiety disorder
  - B) Acute stress disorder
  - C) Adjustment disorder with anxiety
  - D) Panic disorder without agoraphobia
  - E) Posttraumatic stress disorder
- 4. All of the following treatments might be helpful to this patient EXCEPT:**
  - A) A benzodiazepine, especially at bedtime
  - B) Brief psychodynamic psychotherapy
  - C) Cognitive behavioral psychotherapy
  - D) Buspirone
  - E) Propranolol

*(turn page for answers)*

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*Dr. Frank is Associate Professor of Psychiatry and Behavioral Sciences, George Washington University School of Medicine, Washington, DC.*

#### EXPLANATION OF ANSWERS

**1. (C) Excessive worry about having future episodes.**

The diagnosis of panic disorder requires the presence of panic attacks, anticipatory anxiety or fear of having an attack, and functional impairment. In a panic attack, patients experience four or more of 13 criteria: palpitations/pounding heart, sweating, trembling, shortness of breath/smothering sensations, feelings of choking, chest pain or discomfort, dizziness/lightheadedness, derealization/depersonalization, gastrointestinal distress, fear of losing control or going crazy, fear of dying, paresthesias, chills/flushes. Attacks peak within 10 minutes and subside in less than 1 hour. This patient clearly meets criteria for panic attacks; the next step is to determine whether she also has anticipatory anxiety. Her family history might be helpful as a risk factor for either heart disease or mental illness but is not necessary for the diagnosis of panic disorder. Restlessness is a common associated symptom of panic attacks, but this symptom does not rule in or rule out panic disorder. Panic attacks that occur during sleep do not differentiate among anxiety disorders or between panic disorder and heart disease. MVP is an incidental finding, not a causal factor.

**2. (B) Thyroid function tests.** A simple screen consisting of a physical examination, complete blood count, fasting glucose, electrolytes (including calcium, phosphorus, and protein/albumin), an electrocardiogram, and thyroid function tests rules out the common medical causes of panic in the typical population of women between ages 20 and 40 years. Onset of panic disorder after age 40 years is atypical and requires more extensive screening.<sup>1</sup> A 24-hour urine screen for catecholamine metabolites characteristic of pheochromocytoma is unproductive in a normotensive patient with panic disorder, because patients with known pheochromocytomas do not typically fulfill the full criteria for panic disorder despite their paroxysmal symptoms. Glucose tolerance testing for reactive hypoglycemia is also likely to be misleading. Reactive hypoglycemia is not uncommon in young women, but panic attacks have not been correlated with hypoglycemia, even in patients with abnormal glucose tolerance tests. If suspicion of pulmonary emboli is warranted (eg, the patient takes oral contraceptives and smokes), pulse oximetry is the appropriate screening test, not a ventilation perfusion scan. Stress testing and Holter monitoring may be indicated if the patient has other major risk factors for or classic symptoms of cardiovascular disease, but these tests are not indicated on the basis of panic disorder symptoms alone.

**3. (C) Adjustment disorder with anxiety.** The diagnosis of adjustment disorder is warranted when a patient experiences symptoms and functional impairment in close

proximity to an identifiable stressor. Diagnosis of generalized anxiety disorder requires that symptoms be present more than 6 months and that the patient be worried about more than one problem. This patient's symptoms are not characteristic of panic attacks, excluding the diagnosis of panic disorder without agoraphobia. Both acute stress disorder and posttraumatic stress disorder require that the precipitating stress imply a grave threat to the patient's (or close associate's) life or physical well-being and that the patient respond with horror or helplessness. Also, the patient with acute stress disorder or posttraumatic stress disorder must have intrusive symptoms (eg, forced recollection, nightmares, flashbacks), avoidance symptoms (eg, loss of emotional range, loss of interest in activities, estrangement), and arousal (eg, disrupted sleep, irritability, enhanced startle, decreased sleep). Acute stress disorder further requires dissociative symptoms and subsides within 1 month.<sup>1</sup> Although this patient has some of these symptoms, divorce per se is not considered a traumatic stress. If the patient describes being in fear for his life because of his partner's reaction to divorce or having been subjected to domestic violence during the marriage, posttraumatic stress disorder could be considered. These fears occur more frequently in women than in men, and the presence of any anxiety, especially in a woman, should prompt screening for domestic violence.<sup>2</sup>

**4. (E) Propranolol.** Adjustment disorders are highly responsive to most types of psychological or psychopharmacologic intervention. Generally, such disorders occur in patients who lack sufficient naturally occurring social support and who are distressed by the negative meanings that they attach to the stressor. Psychotherapy provides support and helps patients reinterpret their experience in more positive ways. Occasional use of benzodiazepines is often very effective and rarely leads to dependence or abuse in patients with no history of alcohol abuse.<sup>1</sup> Buspirone may be effective and carries no risk for dependence or abuse, but it requires 3 weeks or more to be effective. Although propranolol may slow heart rate and reduce tremor in anxious patients, this drug seems to have little effect on the subjective distress that constitutes the core feature of adjustment disorder with anxiety and all anxiety disorders.

#### REFERENCES

1. Nesse RM, Zamorski MA: Anxiety disorders in primary care. In *Primary Care Psychiatry*. Knesper DJ, Riba MB, Schwenk TL, eds. Philadelphia: WB Saunders, 1997: 132–163.
2. Frank JB, Radowski MF: Review of psychological issues in victims of domestic violence seen in emergency settings. *Emerg Med Clin North Am* 1999;17:657–677.