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Assessment of cases of panic attack among 174 patients

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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.
Materials and Methods: 174 cases of panic attack of both genders were included. Employment status, age of onset, education, PDSS, APPQ, ASI- R and BDI was recorded.
Results: Out of 174 subjects, males were 84 and females were 90. 66 were employed and 108 unemployed, onset age was 35.3 years, PDSS (total) score was12.5, APPQ (total) was 51.6, Agoraphobia score was 49.2, Social phobia score was 50.6 and interoceptive fear score was 50.1. The causes of attack was hereditary in 56, depression in 76, low blood sugar in 24 and medicine withdrawal in 18 cases. The difference was significant ($P < 0.05$).
Conclusion: Panic attack was most commonly seen in females and among unemployed.

Keywords: Agoraphobia, panic, phobia

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. Patients with panic disorder suffer from psychiatric comorbidities such as depression, substance abuse, and suicide ideation [1]. 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 [2].

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 [3].

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. A D Faye et al made an effort to explore Anxiety symptoms and its severity. Patients with bronchial asthma are taken for study. The work has limitation that Panic disorder persons with Psychiatry comorbidities are not analysed. Anxiety disorder is a minor mental disorder in comparison with major mental disorder like schizophrenia [4]. The Shirodhara has a good effect on panic attack disorder. The Patient with Panic attack symptoms reports low energy level, sleeplessness and moodiness even though the person is non-alcoholic. 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 [5]. The present study was conducted to assess cases of panic attack.

Materials and Methods

The present study was conducted among 174 cases of panic attack of both genders reported to the department of Psychiatry. All were informed regarding the study and their written consent was obtained. Demographic data was recorded in case history proforma which comprised of name, age, gender etc. Parameters such as employment status, age of onset, education, PDSS, APPQ, ASI- R and BDI was recorded. The ASI-R is a self-reported questionnaire used to measure the degree of fear arising from believing that body sensations will produce dangerous consequences.

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The PDSS is a standard measurement scale for panic disorder. The instrument includes 7 items associated with symptoms accompanied by panic disorder. The APPQ is a scale designed to assess three types of fear related to panic disorder. The scale consisted of 27 items is categorized into 3 subscales: 1) agoraphobia, 2) social phobia, 3) and interoceptive fear. Results thus obtained were subjected to statistical analysis. P value less than 0.05 was considered significant.

Results

Table 1: Distribution of subjects

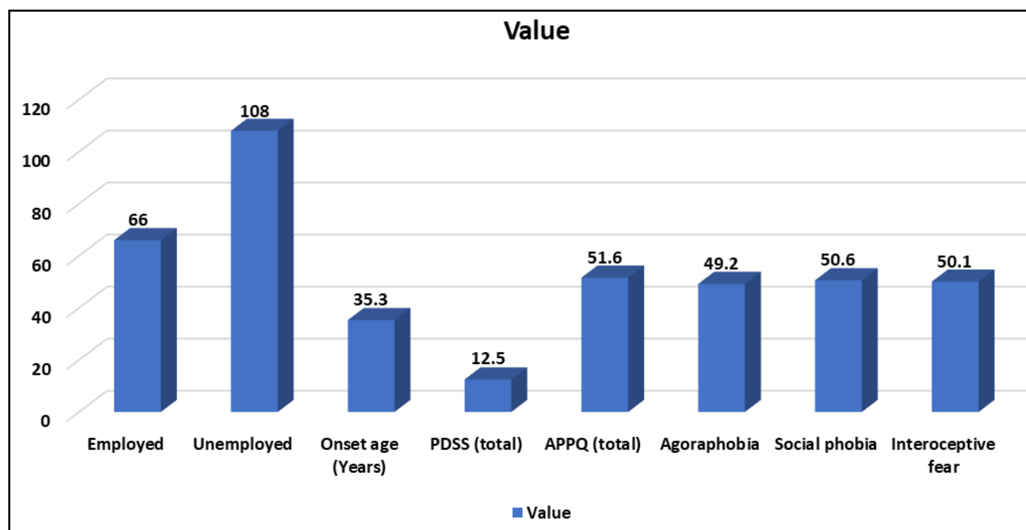
Total- 174		
Gender	**Males**	**Females**
Number	84	90

Table I shows that out of 174 subjects, males were 84 and females were 90.

Table 2: Assessment of parameters

Parameters	Value
Employed	66
Unemployed	108
Onset age (Years)	35.3
PDSS (total)	12.5
APPQ (total)	51.6
Agoraphobia	49.2
Social phobia	50.6
Interoceptive fear	50.1

Table II, graph I shows that 66 were employed and 108 unemployed, onset age was 35.3 years, PDSS (total) score was12.5, APPQ (total) was 51.6, Agoraphobia score was 49.2, Social phobia score was 50.6 and interoceptive fear score was 50.1.



Graph 1: Assessment of parameters

Table 3: Causes of panic attack

Causes	Number	P value
Hereditary	56	0.01
Depression	76	
Low blood sugar	24	
Medicine withdrawal	18	

Table III shows that causes of attack was hereditary in 56, depression in 76, low blood sugar in 24 and medicine withdrawal in 18 cases. The difference was significant ($P<$ 0.05).

Discussion

The relationship between agoraphobia and panic disorder remains not been clearly established. Regarding this issue, 2 hypotheses have been proposed. It has been suggested that agoraphobia is a subtype of panic disorder [6]. Grant *et al.* [7] reported that panic disorder accompanied by agoraphobia could be a severe complication of panic disorder and agoraphobia was considered to result from recurrent panic attacks. On the other hand, agoraphobia could be a distinct disease independent of panic disorder. Recently, in the DSM-5, agoraphobia has been separated from panic disorder as an independent condition, based on the following findings [8]. Agoraphobia could occur without panic symptoms, is not always secondary to panic symptoms, and there are differences in prevalence, sex specific incidence rate, and treatment outcome between agoraphobia and panic disorder. There are evidences that presence of agoraphobia in panic disorder patients carries significant clinical implications, however, few comprehensive assessment has been reported how comorbid agoraphobic symptoms affects the patient with panic disorder in terms of symptoms severity, psychological comorbidity and clinical course [9]. The present study was conducted to assess cases of panic attack.

In present study, out of 174 subjects, males were 84 and females were 90. Shin et al. [10] 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.

We found that 66 were employed and 108 unemployed, onset age was 35.3 years, PDSS (total) score was12.5, APPQ (total) was 51.6, Agoraphobia score was 49.2, Social phobia score was 50.6 and interoceptive fear score was 50.1. Brook et al. [11] 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 support that antidepressants augmented with atypical antipsychotics could result in a superior therapeutic effect than antidepressant monotherapy for treatment-resistant panic disorder.

We observed that causes of attack was hereditary in 56, depression in 76, low blood sugar in 24 and medicine withdrawal in 18 cases. Panic disorder is associated with several psychiatric conditions, such as depression and other anxiety disorders. About a third of patients with depression present with panic disorder. Over a lifetime, about half of patients with panic disorder will develop depression and about half of depressed patients will develop panic disorder. Patients may misuse alcohol or drugs (or both) to cope with panic, and, in turn, the use of these substances may unleash panic disorder. Importantly, the risk of suicide is raised in patients with panic disorder, especially those with comorbid depression [12].

Conclusion

Authors found that panic attack was most commonly seen in females and among unemployed.

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