Letters to the Editor

Panic Disorder

We read with interest the recent case report on "Panic Attack Syndrome" *(i)* and wish to share more recent information on panic disorder in childhood.

Compared to other anxiety disorders of childhood, panic disorder is a less studied condition. A methodologically more sound epidemiological catchment area study in US reported peak onset of panic disorder between 15 to 19 years. Onset before age of 10 years was found in 18% adult panic disorder patients and a further 7% had onset between 10 to 15 years. Onset prior to age of 17 years was associated with increased risk of alcohol use disorders, suicide and more emergency room visits.

The manifestations resemble those in adult panic disorder, namely, palpitations, breathlessness, choking sensation, chest pain, dizziness, faintness, trembling, sweating, tingling and numbness, depersonalization, fear to death, fear of going crazy or losing control. The symptoms occur spontaneously, recurrently and episodically. They typically reach peak within ten minutes and may last from half an hour to two hours. Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994) criteria require that the symptoms should lead to persistent concerns about having additional attacks or cause worry about the implications of the attack or its consequences, or cause a significant change in behavior related to the attacks. Important differential diagnoses include bronchial asthma, hyperthyroidism, hyperventilation syndrome, complex partial seizures and mitral valve prolapse (MVP).

Contrary to earlier investigations, recent studies suggest that a minority of panic disorder patients may have MVP. However, the prevalence of MVP in panic disorder does not differ significantly from that in general population and identification of MVP in panic disorder patients has little or no clinical or prognostic significance. The diagnosis of panic disorder can be made in presence of MVP. One Indian study of adult panic disorder found MVP in only two of the 50 patients (Gaikwad and Vankar, Personal Communication, 1994).

Some authors have argued that children are incapable of having spontaneous panic attacks as they lack the necessary cognitive development. They may attribute the symptoms of panic to an external event or object. Alternatively, preadolescent panic episodes are deemed exogenous (resulting from exposure to traumatic events) rather than biological.

Currently panic disorder is considered a biopsychosocial disorder. In view of possible induction of experimental panic attacks in patients with this disorder by panicogens like sodium lactate, carbon dioxide and sodium bicarbonate and blockade of panic attacks with anti-panic agents, the biological etiology is being increasingly emphasized. The first degree relatives of panic disorder patients are at a greater risk for developing panic disorder, the transmission may be complex.

Pharmacological agents effective in adult panic disorder have been used in childhood panic disorder patients also, but

controlled trials are scarce. Drugs (tricyclic antidepressants, fluoxetine, alprozolam and monoamine oxidase inhibitors) are effective in treatment of panic disorder. Propranolol has no role in panic disorder. Pharmacotherapy combined with cognitive behavior therapy is widely recommended.

Interested readers may refer to recent reviews of the subject(2-4).

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