Conclusion

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Given the limitations of research to address the complexity of patient care, clinicians continue to rely heavily on consensus among experts for questions other than those on the specific efficacy of one treatment over another. In particular, choices of treatments, the "how to's" of prescribing, difficult patient and treatment issues and settings, and options for nonresponders all are addressed through dialogue among experts. Similarly, our understanding of the neurobiology of disorders, while growing, is still incomplete and awaits clues that will come from examining genetic differences between those affected and those not affected by specific disorders.

Brain systems mediating fear and arousal are likely central to the expression of panic disorder symptoms, but the dysregulations that predispose patients to panic disorder remain elusive. The pleomorphicity of the physical symptoms resulting from these physiologic disruptions accounts for the extensive misdiagnosis or late diagnosis of panic disorder in medical settings, which leads to unnecessary tests, ineffective treatment, unabated patient suffering, and continuing costs and patient demoralization. Yet, for the informed primary care physician, considerable professional satisfaction can follow from early recognition of and intervention for panic disorder. Especially for uncomplicated cases of panic disorder early in their course, the primary care physician can diagnose, explain, and treat many patients with currently available pharmacologic agents.

Increasingly familiar with serotonin selective reuptake inhibitor antidepressants for depression, the primary care physician is in a position to add panic disorder as an indication for their use, altering prescribing in this population mainly by initiating treatment with lower doses and gradually increasing doses if side effects, such as jitteriness and nausea, are mild or absent. Among most experts, serotonin selective reuptake inhibitors have replaced tricyclic antidepressants as the consensus antidepressant agents of choice for panic disorder.

Although antidepressants are effective for treating panic disorder and comorbid depression, their early side effects and delayed onset of effect (often several weeks) lead clinicians to consider high-potency benzodiazepines as a first-line alternative. These drugs have a more rapid onset of effect for anticipatory anxiety and panic attacks, and titration to effective doses is easily achieved as the initial sedative effects resolve. High-potency benzodiazepines do require slow downward titration, possibly supported with behavior therapy, to ease discontinuation-related symptoms. However, for many patients, the need for any treatment, whether antidepressant or benzodiazepine, will be chronic. High-potency benzodiazepines also allow rapid dose adjustment or as-needed use for emergencies or special situations. For maintenance treatment, the long-acting high-potency benzodiazepine clonazepam has achieved wide acceptance among psychiatrists, and its efficacy has been further established in large multicenter trials. The long half-life of clonazepam addresses the problem of interdose emergence of symptoms seen with shorter-acting agents, such as alprazolam. However, trade-offs must be made with all pharmacologic agents, and the use of high-potency benzodiazepines in alcohol-abusing patients with panic disorder remains controversial but not necessarily contraindicated. Given the persistent and impairing effect of panic disorder with agoraphobia for many patients, combination treatments are common in the ongoing quest for maximal quality of life and incremental therapeutic gains.

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Whether administered as a sole treatment or in combination, cognitive behavior therapies targeted specifically to cognitive and behavioral factors thought to mediate panic disorder symptoms and disabilities are a valuable and effective therapeutic modality. All clinicians who treat panic disorder can serve their patients best by understanding the rationale and techniques used in cognitive behavior therapy. As with drug treatment, many patients benefit, but few remain well over the long term. Clearly, cognitive behavior therapy is a first-line choice for patients who decline drug treatment and those who should avoid drugs (e.g., pregnant women). The specifically effective elements of cognitive behavior therapy remain to be defined and leave open the possibility that other psychological therapies, such as "emotion-focused" treatment, that are more similar to traditional dynamic therapy may prove effective.

The pressures of the managed care environment ensure that targeted, cost-effective therapies will continue to be ascendant in the coming years. Fortunately, with the availability of serotonin selective reuptake inhibitors and high-potency benzodiazepines, most patients with panic disorder will benefit, the majority substantially. Studies of the long-term course of panic disorder, however, offer the sobering news that, for most patients, this condition is not trivial or self-limiting. Thus, efforts must continue to develop new therapies. In the meantime, we are far from having maximized the usefulness of treatment already available in terms of recognizing panic disorder in primary care settings and selecting effective treatments and optimizing their use.

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