Utilization of Non-Psychiatric Medical Services by a Sample of Egyptian Patients with Panic Disorder.

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Abstract

Panic disorder is a common disorder among general population. Lifetime prevalence ranges between 1.5 percent to 5 percent. It constitutes a health problem because of the failure of diagnosis by the non-psychiatric physicians. The Aim of the work: is to investigate the characteristics of clinical presentations of panic disorder in the period prior to their first psychiatric consultation. The services delivered to those patients prior to psychiatric services were assessed. Methods: Thirty consecutive patients were collected from outpatient private clinic in Cairo within one year. Most of them were referred cases from non-psychiatric physicians. It is a retrospective study depending on the collection of all-clinical data form previous records and information from the patients and their families. Hamilton anxiety rating scale was also done. Results: Showed the characteristic somatic presentations of panic disorder and a very long series of investigations and consultations and also traditional healing before psychiatric consultations in most of the cases.

The results are discussed in the light of position of psychiatry among other branches of medicine, and the burden of PD on the economics of health services in Egypt.

Introduction:

Panic disorder (PD) has its roots in the concept of irritable heart syndrome, which Jacob Da Costa described and named it Da Costa syndrome. The syndrome included many psychic and somatic symptoms that have become included among the diagnostic criteria for panic disorder in the different psychiatric disciplines. ***(Uhde and Nemiah, 1989).***

Panic disorder is a very common psychiatric disorder among general population, The most recent studies have reported lifetime prevalence of 1.5 to 5 percent for panic disorder and 3 to 5.6 percent for panic attacks. Women are 2 to 3 times more likely to be affected than are men. The most common age of onset is around 25 years for panic disorder. ***(Kaplan and Sadock, 1998).***

Psychiatric comorbidity is nearly the rule in panic disorder. Agoraphobia occurs in 75 %, depression in 42 %, alcohol and substance abuse in 42 %, OCD in 9 %, and social phobia in 20 % of the conditions ***(Massion et al, 1993).***

Suicide and suicidal thoughts are also very important and common among panic disordered patients. Suicidal thoughts may reach up to 20 %. ***(Regier et al 1984, Weisman et al 1989, and Cox et al 1994).***

Panic disorder constitutes one of the most important bridges between psychiatry and other branches of medicine because of its unique acute physical presentation and its high prevalence. However it is still under estimated and even ignored by many non-psychiatric physicians especially in the developing countries where psychiatric education and services are still limited.

Primary care and non-psychiatric health services constitute the central arena for

delivery of services for those patients because of its characteristic presentation. Unfortunately general practitioners (GPs) and other physicians usually report that these disorders are very low in their practice. This means they unrecognized and consequently give inappropriate or inadequate treatment for those patients. ***(Kirmayer et al, 1993).*** Based on this attitude and its consequences panic disordered patients are burden on the general health services in any country especially the poor countries.

Objective:

The goal of this work is to investigate the common presentations of panic disorder, the help seeking behavior and the unnecessary non-psychiatric medical services utilized by patients of this disorder in Egypt.

Subjects and Methods:

Thirty patients were recruited in this study. They were collected over one year from private clinic in Cairo. They constituted all consecutive patients with diagnosis of panic disorder according to both DSM IV and ICD10 criteria. They were 16 male and 14 female. Age range was 20 to 35 years.

The following was done

1. Semi-structured interview to explore all symptoms and criteria of panic attacks and the associated mental symptoms.
2. Thorough physical examination.
3. Thorough medical history taking and collecting all the previous records and notes of medical treatment prior to first psychiatric encounter.
4. Hamilton Anxiety Rating Scale.

Results

1. Socio demographic characteristics (Table 1) :

Table (1) shows that the sample consists of both males (53.3 %) and females (46.7 %). They are of adult age group (28.5 ±5.5 Years) . Duration of illness was long (16.5 ± 30 months) before they came to psychiatric consultation. Most of the sample are married (76.7 %) and few were divorced (16.6 %) and only (6.7 %) were single.

2. Clinical characteristics (Tables 2, 3, 4, 5) :

Table (2) shows the source of referral of the patients to psychiatric clinic. It is observed that few patients (10 %) came on their own seeking for help without referral from a physician. Also few patients (10 %) were referred from their GPs who recognized their psychiatric disorder while others (90 %) who consulted their GPs failed to either recognize the psychiatric nature of the disease or referred them to incorrect specialty especially to neurologists and cardiologists.

Table (3) shows that the chief presentation of panic disorder is the cardiopulmonary picture in 73.4 % of the sample and then 13.4 % of the condition with somatosensory picture including parasthesia and dizziness.

Tables (4, 5) show the frequency of both somatic symptoms and psychological symptoms. The cardiovascular symptoms constitute the most frequent somatic symptoms with the sense and fear of impending death is the most frequent psychological symptom.

3. Non-psychiatric medical services:

Table (6) shows that 93.3 % of the patients tried at first their GPs and 83.3 % consulted

specialist of internal medicine and 66.6 % consulted cardiologists and 26.6 % consulted chest specialists. It is also observed that one third of the patients had consulted audiologists for their feelings of dizziness. It was also unexpectedly that three quarters of the patients had tried treatments from traditional healers either beside their medical treatment or after they stopped medical treatment.

Table (7) shows how panic disordered patients excessively utilize the various types of investigations especially the cardiac investigation in all cases followed by brain investigations and hormonal assessments. Table (7) also shows that 73 % of patients had visited the emergency room (ER) and 26.6 % were admitted to inpatients wards and 13.3 % were admitted to Intensive Care Unit (ICU).

Table (1): Sociodemographic characteristics of the PD patients group.

Variable	
Gender :	
Male	16 = 53.3 %
Female	14 = 46.7 %
Age :	
Mean ± SD	28.5 ± 5.5 years
Age of onset :	
Mean ± SD	25.5 ± 7.8 years
Duration of illness :	
Mean ± SD	16.5 ± 30 months
Marital status :	
Married	23 = 76.7 %
Divorced	5 = 16.6 %
Single	2 = 6.7 %

Table (2): Source of referral of the PD patients group.

	No	%
Neurologist	13	43.3
Cardiologist	7	23.4
Audiologist	4	13.3
Self referral	3	10
GP	3	10
Total	**30**	**100**

Table (3): Chief presenting complaints of the PD patients group.

	No	%
Cardiopulmonary	22	73.4
Abdominal	2	6.6
Psychological	2	6.6
Somatosensory	4	13.4

Table (4) : Frequency of somatic symptoms in PD patients group. (n = 30)

	No	%
Dizziness	23	76.6
Palpitation	22	73.3
Chest pain	20	66.6
Parasthesia	20	66.6
Dyspnea	18	60.0
Sweating	17	56.6
Fatigue	16	53.3
Abdominal pains	14	46.6
Impotence	13	43.3
Difficult swallowing	13	43.3
Urinary symptoms	10	33.3

Table (5): Frequency of psychological symptoms in PD patients group. (n = 30)

	No	%
Fear of death	30	100.0
fear of going crazy	1	3.3
Fear of loss of control	3	10.0
Depersonalization	10	33.3
Derealization	12	40.0
Agitation	16	53.3
Depressed mood	18	60.0
Anticipatory anxiety	30	100.0
Suicidal thoughts	5	16.6
Obsessions	2	6.6

Table (6) : Types of trials of management prior to psychiatric treatment.

	No	%
General practitioners	28	93.3
Internal medicine physicians	25	83.3
Cardiologists	20	66.6
Chest specialists	8	26.6
Neurologists	20	66.6
Neurosurgeons	5	16.6
Endocrinologists	5	16.6
Audiologists	10	33.3
Traditional healers	22	73.4

Table (7) :Medical services delivered to the panic disordered patients. (n = 30)

	No	%
Cardiac investigations :		
a) ECGs	28	93.3
b) Echo cardiography	5	16.6
c) Catheterization	4	13.3
Neurological investigations :		
EEG	15	50.0
CT brain	10	33.3
MRI brain	6	20.0
Hormonal assays :		
Thyroid hormones	5	16.6
Others	2	6.6
Inpatient admissions	8	26.6
ICU admissions	4	13.3
Emergency room visits	22	73.3

Discussion

This study has dealt with some clinically important aspects of panic disordered patients in the private Egyptian sector. These are the mode of presentation, how they are referred to psychiatric consultation and the help-seeking behavior of the patients.

As regards presentation the present study has shown that chief presentations and symptoms are the physical symptoms especially the cardio-pulmonary, autonomic, and the vague somatic symptoms. The psychological symptoms are also present in 100 % of the patients but they are ignored by the physicians and most probably are attributed as secondary to the physical symptoms. Our findings are in agreement with the clinical studies of panic disorder in Western countries. ***(Ottaviani and Beck 1987, Othmer, and Othmer 1987, and Uhde ,and Nemiah 1989).***

The presentation of panic disorder makes the patients logically consult their GPs and IM physicians at first who either treat them or refer them. In our study their GPs referred only 10 % of patients while 80 % were referred by other specialties. This means that GPs and IM physicians direct most of the panic disordered patients to neurology and, cardiology, clinics most probably because they do not recognize the psychiatric background of this disorder. This failure of referral may reflect the lack of psychiatric education to the GPs and non-psychiatric physicians. Our results of failure of recognition in primary care settings are in agreement with ***(Van Korff et al 1989)*** and ***(Kermayer et al 1993)*** who reported the same rates of failure for depression, anxiety disorders and Somatization disorder in primary care settings.

The failure of recognition in primary care settings and other non-psychiatric settings lead to a series of expensive and unnecessary investigations. This is clear in our study. As shown in the results

cardiological investigations especially repeated ECGs were done for the majority of patients, followed by neurological investigations. These investigations are expensive especially for patients in a developing country like Egypt. Also these unnecessary investigations add to the anxiety of the patients who do not exactly know the nature of their illness and finally the patients themselves feel that they are abused by the physicians who do a lot of investigations and do not reach a diagnosis.

As regards utilization of hospital admissions and visits, our study showed clearly that panic-disordered patients utilize the hospital too much because of failure of their recognition by their GPs and ER physicians and even ICU physicians. Again this is a burden on the general hospital services and can be solved by improving the early diagnosis of panic disorder. This finding is in agreement with the study of ***(Shaw and Creed 1990)*** about the costs of somatic presentations of mental disorder in general.

An important finding in our study was that 73.4 % of the sample had visited traditional healers and used non-medical materials for treatment. However this was not the first step along the trip of treatment. It occurred after the step of non-psychiatric physicians and most probably it resulted from the state of frustration from failure of treatment and the condition of uncertainty of the diagnosis transmitted from the doctors to their patients. Our finding was in agreement with a very early study of ***(Okasha 1966)*** who studied the cultural impact on help seeking behavior of mental patients including cases of acute anxiety states (probably panic attacks). He reported that these patients are found among El Zar (pseudo-religious cermony) clients for management of their illness.

Finally, our study had reached some important conclusions about the profile of help seeking behavior of panic-disordered patients and their recognition in non-psychiatric settings. Presentations in general practice appears to be like its presentations in western countries as reported in the literature. Help seeking behavior is colored by cultural beliefs after frustration from the failure of treatment in medical settings and nearly three-quarters of the patients ask for treatment in traditional healing settings.

Panic disordered patients constitute a great burden on general hospitals because of the lot of unnecessary investigations and the utilization of inpatient beds and ICU in our limited hospitals.

Our study has some limitations because of being retrospective and the small sample size and dependence on the information from the patients and their families and the previous charts and notes and available investigations' reports. We recommend to do more research in this significant area, using bigger patient sample, comparison groups of other psychiatric disorders and follow up studies to know the impact of proper psychiatric diagnosis on the costs of panic disorder on the general hospital services.

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الانتفاع بالخدمات الطبية غير النفسيه

فى عينه من مرضى اضطراب الهلع المصريين

ينتشر اضطراب الهلع بين الناس بصوره عاليه حيث تبلغ نسبتة على مدار العمر بين واحد ونصف فى المائه وخمسه فى المائه. ولهذا يشكل هذا المرض مشكله صحيه عامه نظرا لإنتشاره من جهه ولفشل الأطباء الغير نفسانيين فى تشخيصه والتعامل معه من جهه اخرى.

يهدف هذا البحث الى دراسة الخصائص الاكلينيكيه لهذا المرض وكذلك الى دراسة الاستفاده من الخدمات الطبيه المختلفه قبل بداية التشخيص والتحويل الى العيادات النفسيه.

اعتمد البحث على فحص عينه من المرضى تتكون من ثلاثين مريضا متتاليا محولين الى إحدى العيادات النفسيه فى القاهرة خلال فترة عام واحد. تم تشخيص الحالات طبقا لكل من التقسيم العالمى العاشر للأمراض النفسيه وكذلك الدليل الامريكى الرابع للأمراض النفسيه. تم فحص جميع الاستشارات والزيارات الطبيه السابقه ، وكذلك الفحوصات السابقه على التحويل ، وكذلك تم فحص الحاله الجسمانيه والنفسانيه الحاليه وتم عمل اختبار هاملتون للقلق النفسى.

أوضحت النتائج النسب العاليه لتواتر الاعراض الجسمانيه للمرضى ، وكذلك السلسله الطويله من الفحوصات والاستشارات الطبيه المتكرره ، وكذلك توجه غالبية المرضى للمداواه بالطرق الشعبيه. تم مناقشة هذه النتائج فى ضوء وضع الطب النفسى فى مصر وما يشكله هذا الاضطراب من عبء على كاهل اقتصاديات الخدمات الصحيه فى مصر.