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FAST FACTS AND CONCEPTS #145

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Background Anxiety and fear occur commonly in the dying patient. However, disabling anxiety and/or panic is not a normal aspect of the dying process. Separating "normal" death-related anxiety from pathological panic is an important palliative care skill.

Definitions

- A panic attack is defined in the DSM-IV as "a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms develop abruptly and reach a peak within 10 minutes: palpitations, pounding heart or accelerated heart rate, sweating, trembling or shaking, sensations of shortness of breath or smothering, feeling of choking, chest pain or discomfort, nausea or abdominal distress, feeling dizzy, unsteady, lightheaded or faint, derealization or depersonalization, fear of losing control or going crazy, fear of dying.
- Derealization describes a sensation of feeling estranged or detached from one's environment.
- Depersonalization is an altered and unreal perception of self, one's feelings and/or situation. Described by one patient as "feeling like you are on the outside looking in".

Diagnosis

- A combination of physical symptoms (feeling dizzy, weak, nauseous, unsteady, lightheaded, breathless) and affective symptoms (fear of loss of control) are used to diagnose a panic disorder.
- Terminally ill patients may often have many of the physical symptoms listed above as a part of their illness process. Thus the presence of derealization, depersonalization and fear of loss of control are more useful in making the diagnosis of panic disorder in the terminally ill.
- A contributing feature to the diagnosis of panic disorder is if a patient develops recurrent symptoms, worries about future 'attacks' and alters her/his behavior in anticipation of such attacks.
- Terminally ill patients with chronic dyspnea may often worry about "suffocating to death."

Management

- Educate patients about the diagnosis and reassure them that their symptoms can be greatly palliated with appropriate treatment.
- Optimize medical management of symptoms like pain, non-pain symptoms (especially dyspnea) and depression.
- Ideal therapy is a combination of medical therapy with psychological counseling.
- Add complementary/alternative treatments: music therapy, massage therapy, guided imagery, biofeedback.
- Medical management is influenced by anticipated lifespan and severity of panic symptoms.
- Selective serotonin reuptake inhibitor (SSRI) monotherapy or SSRI therapy augmented with low dose benzodiazepines for a period of 3 to 4 weeks followed by SSRI monotherapy (taper off benzodiazepines after 3 weeks) is indicated in patients with an anticipated lifespan of at least several weeks.
- SSRIs can exacerbate anxiety in some patients during the first few days of therapy. Consider adding benzodiazepines as needed for the first few weeks in such cases.
- Benzodiazepine monotherapy should be considered in patients with anticipated lifespan of days to weeks. Consider low dose long acting benzodiazepine therapy on schedule (e.g. diazepam 1 mg every 12 hours)

with short acting benzodiazepines (e.g. lorazepam 0.5 mg every 4 to 6 hours as needed) for acute breakthrough symptoms.

- Many terminally ill patients need maintenance therapy for the rest of their life span, as relapse rates are high on treatment discontinuation. In cases where treatment termination is attempted, it is recommended that the medications be tapered gradually over a several week period to allow early detection of a relapse.
- Abrupt termination of benzodiazepine therapy often may result in intense rebound anxiety. This may happen when the patient is actively dying and unable to take oral medications. In such cases, use alternate routes of drug administration (diazepam gel, diazepam rectal suppository or diazepam or midazolam infusions).

References

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Version History: This Fast Fact was originally edited by David E Weissman MD and published in November 2005. Current version re-copy-edited in April 2009.

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ACGME Competencies: Medical Knowledge, Patient Care

Keyword(s): Non-Pain Symptoms and Syndromes

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