Unusual presentation of more common disease/injury

Challenges in management of complex panic disorder in a palliative care setting

Itoro Udo,¹ Amanda Gash²¹Liaison Psychiatry, Roseberry Park Hospital, Tees, Esk, Wear Valleys NHS Foundation Middlesbrough Trust, UK²Liaison Psychiatry, Thatchell Center, University Hospital of North Tees, Tees, Esk, Wear Valleys NHS Foundation Trust, UK

Correspondence to Dr Itoro Udo; dr_itoro@yahoo.com

Summary

This is a complex case of post-traumatic stress disorder (PTSD) with comorbid panic disorder occurring in a woman in her mid-60s, with a family history of neurotic illness. PTSD arose in the context of treatment for terminal lung cancer. This patient who had been close to her father watched him die of cancer, when he was about her age. Her diagnosis and treatment prompted traumatic recollections of her father's illness and death that resulted in her voluntary withdrawal from cancer treatment. The goals of treatment were to promptly reduce anxiety, minimise use of sedating pharmacotherapy, promote lucidity and prolong anxiety-free state thereby allowing time for important family interactions. Prompt, sustained relief of severe anxiety was necessary to achieve comfort at the end of life. Skilled additions of psychological therapies (eye movement desensitisation reprocessing, clinical hypnosis and breathing exercises) with combined pharmacotherapy (mirtazepine and quetiapine) led to control of anxiety and reduction of post-traumatic stress.

BACKGROUND

Anxiety disorders are often underestimated by healthcare professionals. They can impact negatively on the quality of life of persons with long-term physical health conditions and their carers. Lack of proper, timely treatment can result in withdrawal or non-engagement with physical health treatments. Owing to delays in recognition and referral, patients may experience physical and psychological distress.

CASE PRESENTATION

A married lady in her mid-60s was referred to liaison psychiatry from a palliative care team based in a hospice in North East England for 'panic attacks'. She was anxious about 'everything' and repeatedly stated 'I need help'. She felt that she was 'losing control' but could not elaborate on this. It was reported that since she started attending the day care centre a few days previously, she was not joining in with groups, repeatedly stating that she did not want to talk about the topics that were being discussed.

She was diagnosed with metastatic lung cancer 4 months earlier. She had undergone chemotherapy, later radiotherapy and voluntarily decided to stop treatment because she found it emotionally traumatic. She had been previously had an orthopaedic surgery on her foot, the experience of which she said was 'okay' and had occasional migraines. She had no previous history of treatment for mental health problems.

Her mother was described as having been a 'nervous' person who died of natural causes in her 80s. Her father with whom she had a close relationship was described as having experienced 'nervousness and panic attacks'. He received electroconvulsive treatment for presumed depression and died at the age of 65 of bowel cancer. The patient was in a supportive marriage for 45 years. She had

a daughter who lived close by and three grandchildren whom she was proud of. Her family was the centre of her world.

Her daughter described her as somebody who 'normally copes very well with stress'. She usually managed her household affairs. Her husband described her as an 'out-going person who used to take the grandchildren all over the place. She was always going somewhere'.

On initial mental state examination, she was a healthy looking casually dressed lady who was lying on a bed, being reassured repeatedly by a nurse. A rotating fan was in use and a window was opened at her request to let in air. She was hyperventilating, sipping small quantities of water and complaining of tingling sensations on her fingers. She reported difficulty in seeing clearly. She needed readjustment of her pillow position repeatedly. Her speech was fast, of low volume and tone. Her mood was objectively and subjectively very anxious. She thought she was losing control. She did not appear to be experiencing delusions or hallucinations. She was fully oriented in time, place and person. She had no thoughts, plans or intent to harm herself or others. She agreed that she was very anxious and wanted help.

On physical examination, her pulse was 82 beats/min, her blood pressure was 140/80 mm Hg and her respiratory rate was difficult to obtain as she could not stay still.

INVESTIGATIONS

Hospital anxiety and depression scale as and where appropriate.

DIFFERENTIAL DIAGNOSIS

A primary diagnosis of post-traumatic stress disorder (PTSD) with superimposing panic disorder.

The following differential diagnoses were considered: mixed anxiety and depression (ICD 10: F42.2), generalised

anxiety disorder (ICD 10:F41.1), social phobia (ICD 10:F40.1), specific phobia (ICD 10:F40.2), obsessive compulsive disorder, predominantly obsessional thoughts or ruminations (ICD 10:F42.1).

TREATMENT

At initial assessment she was being prescribed oral morphine sulphate 160 mg two times a day, oral amitriptyline 20 mg two times a day, oral diazepam 5 mg three times a day and 5 mg prn, oral lorazepam 0.5 mg prn four times a day, oral mirtazepine 30 mg nocte. With the combination of increase in mirtazepine to 45 mg nocte, subsequent addition of quetiapine 50 mg two times a day¹ with breathing exercises, eye movement desensitisation and reprocessing (EMDR) and clinical hypnosis; regular lorazepam was tapered down and stopped.

OUTCOME AND FOLLOW-UP

On the day of referral, breathing exercises were done for about 15 min with symptoms of panic attack subsiding, but she was left too exhausted to give more history. Lorazepam was increased from 0.5 mg three times a day and once a day prn to 1 mg four times a day, for panic attacks. Mirtazepine was increased from 30 to 45 mg nocte. Collateral history was sought from her family. An inpatient hospice admission for symptom control was agreed with referrers.

It was confirmed that 'she had not always been an anxious person. At first diagnosis she seemed to be coping well and then she slipped into anxiety' during cancer treatment. This led to a discontinuation of cancer therapy. Apart from her husband, she had not told family members at the time that she was discontinuing treatment. She was generally unwilling to try cognitive behaviour therapy (CBT) because she did not want to talk about 'death and all that'. Over the next 3 weeks, her levels of anxiety generally subsided, her husband helping her with breathing exercises.

She was reviewed 20 days postreferral, at home. She was in panic and easily startled. It was reported that she had been well all day till they returned from hospital where she had gone for some investigations. She was very distressed. She could barely sit still. She kept sipping water, removing and replacing her glasses. On exploring, she dreaded being left to die alone and in pain. Quetiapine 50 mg two times a day was started as off-licence adjunct medication to control her anxiety.¹ EMDR was given as treatment for trauma presenting with PTSD.²

On the 23rd day postreferral, she was seen at home. At which time, she was busy sorting her utility bills. She appeared more settled in behaviour than on previous visits. Her husband reported satisfaction with her progress but her legs were swollen. Her thoughts were on how she could continue to remain well. The second session of EMDR was held. We agreed to start reducing her benzodiazepines. Her husband was to continue assisting her with breathing exercises. She was subsequently diagnosed as developing cellulitis over the swollen legs (from deep venous thrombosis) and antibiotic was started by her general practitioner.

On the 39th day postreferral, she reported doing generally better at home. Her right leg was more swollen. She had fallen out of bed some days before. On mental state

examination, she was sitting on a sofa, fully aware of her surroundings but she appeared confused from time to time, euthymic, with reduced reactivity of affect. It was assessed that she would have struggled to process with EMDR so anxiety was managed with clinical hypnosis³ on that occasion. She worked well with it. Measuring anxiety subscale of the hospital anxiety and depression scale, reduced to five (normal) for the first time. Lorazepam was reduced to 1 mg nocte and breathing exercises were to be continued.

She later went into planned respite at a local care home. On review there on the 46th day postreferral, she was 'not too good today'. Her family had visited her that day. On mental state examination, she was mildly anxious in mood and affect. She was well oriented and not drowsy. Fifth session of EMDR was held with good effect. This was followed by hypnotic relaxation exercise which was also well received. Regular lorazepam was stopped, prn indication was retained.³ She passed on peacefully, in dignity, 2 days later.

DISCUSSION

She described her illness, with an affect-laden term as being a 'horror'. It was of a catastrophic nature to her; her experience of severe anxiety arose within context of her physical illness and within 6 months of cancer diagnosis. Her treatment triggered traumatic memories of her father's illness at about her age and her experience of it. Her refusal to continue cancer therapy, join in groups or engage in CBT was interpreted as avoidance of recollection of previous and current trauma. On clinical observation, she appeared to be hyper vigilant, on occasions easily startled by movements around her and had a history of poor sleep patterns. These may have led to the falls from bed at night. Hence a primary diagnosis of PTSD was made. With PTSD, 'rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it.'⁴

As she experienced recurrent panic attacks, to varying degrees, for at least a month, even with various treatments; occurring on occasions when she was not in observable danger as at home, with periods of freedom from symptoms allowing her to sort out her bills, a secondary diagnosis of panic disorder was made.⁴

In summary, primary diagnosis of PTSD with comorbid panic disorder were made. The latter was the more significant source of distress. Her physical health problems of metastatic lung cancer with deep venous thrombosis and superimposing cellulitis were noted.

Our patient did not engage with CBT to manage anxiety and PTSD.^{2 5 6} We are increasingly seeing patients who do not consent to CBT for various reasons. One of the commoner reasons is that the morbidity associated with physical illness/treatment leaves them without the energy needed to engage with CBT. EMDR was acceptable to her, is recommended for the primary diagnosis and hence its use.² Its benefits in resolving her stress symptoms resulted in a reduction in panic as well. When she became medically unwell, it had to be suspended and clinical hypnosis resorted to. Hence, specialised applications of behavioural (breathing exercises), trauma reduction (EMDR) and anxiolytic (clinical hypnosis) methods were

employed to gain results. It could also be argued that CBT would have taken a longer time to deliver results.⁷ In this case, time was of the essence. A typical course of CBT would have lasted 12–20 sessions while EMDR and hypnosis with medications took six sessions.

EMDR is a psychological therapy that utilises rhythmic eye movements together with patient's recall of a traumatic memory to reduce symptoms associated with distressing experiences. It is recommended by NICE and American Psychiatric Association for PTSD.^{2, 8} Its effectiveness in reducing hypervigilance, re-experiencing and consequent avoidance associated with response to trauma has been demonstrated by meta-analyses.^{9, 10}

EMDR works on the psychological theory that overwhelming trauma causes physiological responses which interfere with information processing such that components of the traumatic event are stored as fragments of memory. These fragments of memory become frozen and are not integrated into the rest of the body's psychological adaptive response to trauma. These fragments (behaviour, emotions, sensation or thoughts) could be reactivated by reminders leading to re-experiencing of distress which may be of similar magnitude as those caused by the original traumatic event.¹¹ The eye movements elicited during EMDR is thought to be linked to the same processes that occur during rapid eye movement sleep.¹²

This therapy is usually not carried out in circumstances where because of physical ill-health a patient cannot withstand the rigour of therapy; in circumstances of severe substance misuse, severe self-harming behaviours and florid psychosis. Eye problems need to be evaluated before the start of therapy. Benzodiazepine use may interfere with access to memories and so its use needs to be evaluated. Pregnancy may not be a good time to tackle trauma. In cases of existing seizure disorder, another modality apart from eye movements may be used such as tapping. In patients with a history of serious assaultive behaviour, past and current acts, urges and current coping strategies need to be carefully assessed before commencement of therapy.¹³

Now recognised by NICE as a psychological therapy, Clinical Hypnosis involves the induction of an altered state of consciousness during which suggestions that enhance self-efficacy and reduce suffering may be presented, bypassing the critical function of the left hemisphere.¹⁴ Some patients describe it as a state of focused attention in which they feel very calm and relaxed.¹⁵ Its primary clinical use is to induce a state of relaxation in anticipatory anxiety such as prior to venepuncture,¹⁶ dental procedures,¹⁷ burns management,¹⁸ surgery¹⁹ or childbirth.²⁰ It has applications in anxiety-related illnesses like tension headache, migraines²¹ and in stress-related illnesses like psoriasis,²² asthma.²³ It is of use in the management of chronic pain associated with chronic illness like cancer²⁴ and in primary care for the management of phobias²⁵ and habits like smoking.²⁶ NICE recommends it for treatment of refractory Irritable Bowel syndrome.²⁷

It is not recommended for psychosis, obsessive compulsive disorder or severe alcohol misuse. It should be used with caution in situations with comorbid addictions, clinical depression, dementia, severe-profound learning disability, severe head injury and deafness.¹⁴ It has potential for creation of false memories.¹⁴

Training in England is limited to healthcare personnel with professional qualification and practice is regulated by the British Society of Clinical and Academic Hypnosis.²⁸

On reflection, without recourse to the specialised applications of psychological therapies, this patient's course could have been that of progressive increase in dosage of sedating medications that may have disrupted her final experience of care from her family and her utilisation of confiding relationships to self-soothe at the end of life. Development of rapport with the patient and her family was key. With rapport came trust, within which otherwise personally held information was freely given that allowed for case formulation and personalised management of severe anxiety. What remains unknown is whether this lady's decision to withdraw from treatment was influenced by her previous traumatic experiences.

Learning points

- ▶ Anxiety disorders can result in discontinuation of cancer treatments.
- ▶ Various phases of cancer management: diagnosis, treatment and discontinuation can cause psychological distress.
- ▶ Prevalence of anxiety disorders ranges from 12% to 28% in different studies. It is thought to be twice as common among cancer patients.²⁹
- ▶ Anxiety can be likened to a mask behind which are fears or negative thoughts that need to be explored.
- ▶ Pharmacological and psychological treatments are available and effective.
- ▶ Trauma-focused cognitive behaviour therapy and eye movement desensitisation and reprocessing (EMDR) are recommended psychological treatments for post-traumatic stress disorder.²
- ▶ EMDR is valuable in circumstances where patients who do not desire an exploration of the personal meanings of their traumatic experiences and for those in whom quick resolution of symptoms is important for optimal biopsychosocial functioning such as return to work.⁷

Competing interests None.

Patient consent Obtained.

REFERENCES

1. **Tees, Esk, Wear Valleys NHS Foundation Trust.** *Guidelines for unlicensed and off-label use of medicines.* Tees, Esk, Wear Valleys NHS Foundation Trust. PHARM 0003/V3. Issue No 3. 2011.
2. **National Institute for Clinical Excellence.** *Post-traumatic stress disorder (PTSD).* London: National Institute for Clinical Excellence, 2005.
3. **British Society of Clinical and Academic Hypnosis.** *Clinical hypnosis module 1.* Birmingham: British Society of Clinical and Academic Hypnosis, 2011.
4. **World Health Organisation.** *The ICD-10 classification of mental and behavioural disorders.* Geneva: World Health Organisation, 1992.
5. **National Institute for Health and Clinical Excellence.** *Generalised anxiety disorder and panic disorder (with or without Agoraphobia) in adults.* London: National Institute for Health and Clinical Excellence, 2011.
6. **Baldwin DS, Anderson IM, Nutt DJ, et al.** Evidence-based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol* 2005; **19**(6):567–96.

7. **Nijdam MJ**, Gersons BPR, Reitsma JB, *et al*. Brief eclectic psychotherapy v. Eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: randomised controlled trial. *Br J Psychiatry* 2012;**200**:224–31.
8. **American Psychiatric Association**. *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder: American Psychiatric Association Practice Guidelines*. Arlington, VA: American Psychiatric Association, 2004.
9. **Bisson J**, Ehlers A, Matthews R, *et al*. Psychological treatments for chronic post-traumatic stress disorder. Systematic review and meta-analysis. *B J Psychiatry* 2007;**190**:97–104.
10. **Rodenburg R**, Benjamin A, de Roos C, *et al*. Efficacy of EMDR in children: a meta-analysis. *Clin Psychol Rev* 2009;**29**:599–606.
11. **Solomon RM**, Shapiro F. EMDR and the adaptive information processing model: potential mechanisms of change. *J EMDR Practice Res* 2008;**2**:315–25.
12. **Stickgold R**. Sleep-dependent memory processing and EMDR action. *J EMDR Practice Res* 2008;**2**:289–99.
13. **Richman A**. Eye Movement Desensitization and Reprocessing Part 1 Training Manual. 2011.
14. **Brann L**, Owen J, Williamson A. eds *The handbook of contemporary hypnosis: theory and practice*. Chichester: Wiley-Blackwell, 2012:30–8.
15. **Kirsch I**. APA definition and description of hypnosis: defining hypnosis for the public. *Contemp Hypn* 1994;**11**:142–3.
16. **Kuttner L**. Pediatric hypnosis: pre-, peri-, and post-anesthesia. *Pediatr Anesth* 2012;**22**:573–7.
17. **Holden A**. The art of suggestion: the use of hypnosis in dentistry. *Br Dent J* 2012;**212**:549–51.
18. **Harandi AA**, Esfandani A, Shakibaei F. The effect of hypnotherapy on procedural pain and state anxiety related to physiotherapy in women hospitalized in a burn unit. *Contemp Hypn* 2004;**21**:28–34.
19. **Lang EV**, Benotsch EG, Fick LJ, *et al*. Adjunctive non-pharmacological analgesia for invasive medical procedures: a randomised trial. *Lancet* 2000;**355**:1486–90.
20. **Reinhard J**, Peiffer S, Sanger N, *et al*. The effects of clinical hypnosis versus Neurolinguistic Programming (NLP) before External Cephalic Version (ECV): a prospective off-centre randomised, double-blind, controlled trial. *Evid Based Complement Altern Med* 2012;**120**:1–6. doi:10.1155/2012/626740. (accessed 6 Aug 2012).
21. **Hammond DC**. Review of the efficacy of clinical hypnosis with headaches and migraines. *Int J Clin Exp Hypn*. 2007;**55**:207–12.
22. **Shenefelt PD**. Hypnosis in dermatology. *Arch Dermatol* 2000;**136**:393–9.
23. **Anbar RD**. *Functional respiratory disorders: when respiratory symptoms do not respond to pulmonary treatment*. New York: Humana Press, 2012.
24. **Montgomery GH**, DuHamel KN, Redd WH. A meta-analysis of hypnotically induced analgesia; how effective is hypnosis? *Int J Clin Exp Hypn* 2000;**46**:1380153.
25. **McGuinness TP**. Hypnosis in the treatment of phobias: a review of the literature. *Am J Clin Hypn* 1984;**26**:261–77.
26. **Carmody TP**, Duncan C, Simon JA, *et al*. Hypnosis for smoking cessation: a randomised trial. *Nicotine Tob Res* 2008;**10**:811–18.
27. **National Institute for Health and Clinical Excellence**. *Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care, CG 61*. London: National Institute for Health and Clinical Excellence, 2008.
28. **British Society of Clinical and Academic Hypnosis (BSCAH)**. *About BSCAH*. http://www.bscah.com/about_bscah/ (accessed 6 Aug 2012).
29. **Muszbek K**. Anxiety and Adjustment Disorders in Cancer Patients. Presented at International Psycho-Oncological Society Online Lectures. 2010–2012. http://www.ipos-society.org/education/core_curriculum/en/Muszbek_anx/player.html (accessed 9 May 2012).

This pdf has been created automatically from the final edited text and images.

Copyright 2012 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit <http://group.bmj.com/group/rights-licensing/permissions>.
BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Please cite this article as follows (you will need to access the article online to obtain the date of publication).

Udo I, Gash A. Challenges in management of complex panic disorder in a palliative care setting. *BMJ Case Reports* 2012;10.1136/bcr-2012-006800, Published XXX

Become a Fellow of BMJ Case Reports today and you can:

- Submit as many cases as you like
- Enjoy fast sympathetic peer review and rapid publication of accepted articles
- Access all the published articles
- Re-use any of the published material for personal use and teaching without further permission

For information on Institutional Fellowships contact consortiasales@bmjgroup.com

Visit casereports.bmj.com for more articles like this and to become a Fellow