NICE National Institute for Health and Care Excellence

NICE Pathways

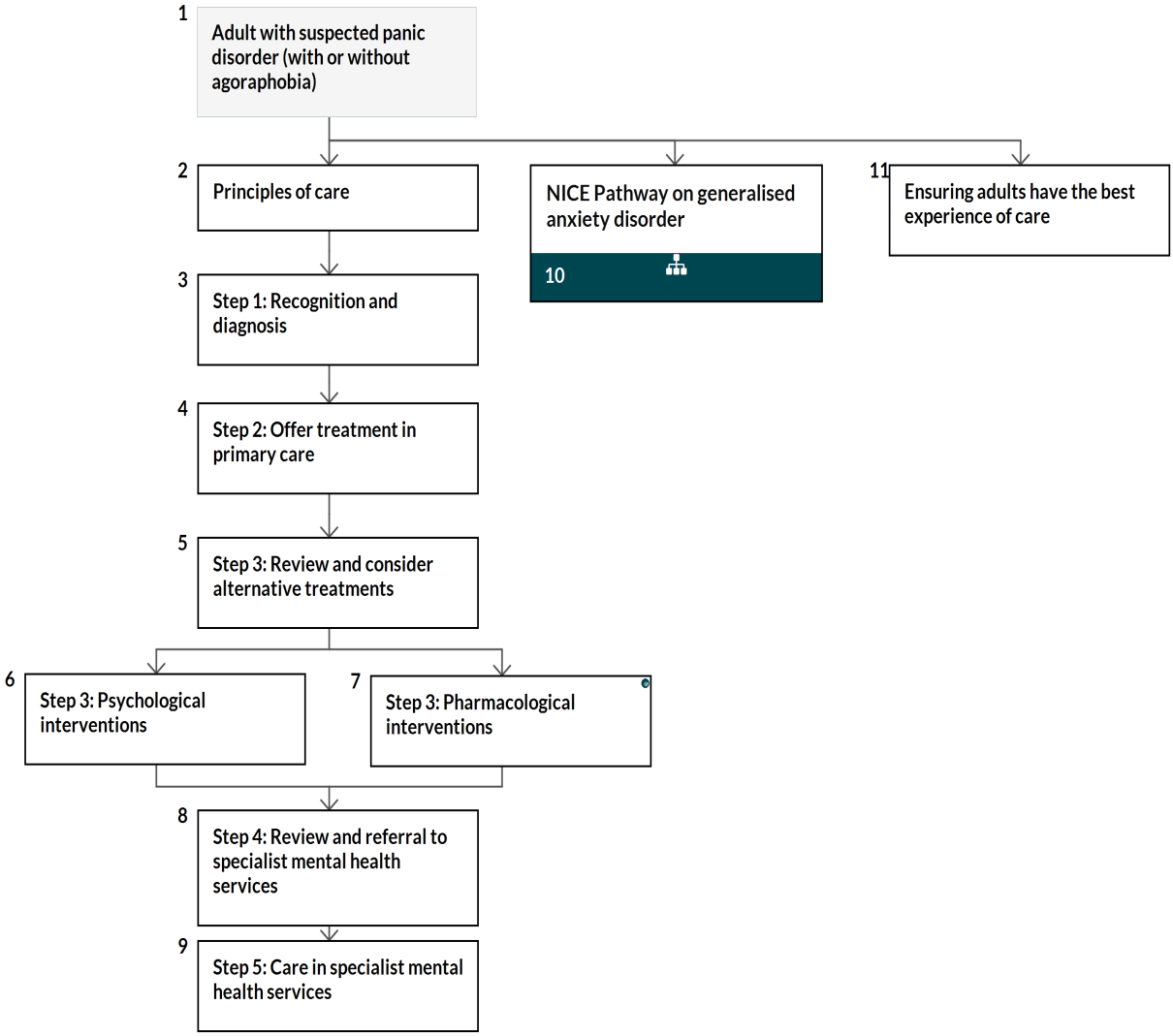
# Panic disorder overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/panic-disorder
NICE Pathway last updated: 04 November 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



## 1 Adult with suspected panic disorder (with or without agoraphobia)

No additional information

## 2 Principles of care

**Shared decision-making and information provision**

Shared decision-making should take place as it improves concordance and clinical outcomes.

Shared decision-making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care.

People with panic disorder and, when appropriate, families and carers should be provided with information on the nature, course and treatment of panic disorder, including information on the use and likely side-effect profile of medication.

To facilitate shared decision-making, evidence-based information about treatments should be available and discussion of the possible options should take place.

People's preference and the experience and outcome of previous treatment(s) should be considered in determining the choice of treatment.

Common concerns about taking medication, such as fears of addiction, should be addressed.

In addition to being provided with high-quality information, people with panic disorder and their families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate.

**Language**

When talking to people with panic disorder and their families and carers, healthcare professionals should use everyday, jargon-free language. If technical terms are used they should be explained to the person.

Where appropriate, all services should provide written material in the language of the person, and appropriate interpreters should be sought for people whose preferred language is not English.

Where available, consideration should be given to providing psychotherapies in the person's own language if this is not English.

NICE has written information for the public on treating generalised anxiety disorder and panic disorder in adults.

## 3 Step 1: Recognition and diagnosis

### Consultation skills

All healthcare professionals involved in diagnosis and management should have a demonstrably high standard of consultation skills so that a structured approach can be taken to the diagnosis and subsequent management plan for panic disorder. The standards required for Membership of the Royal College of General Practitioners are a good example of standards for consulting skills.

### Diagnosis

The diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care.

There is insufficient evidence on which to recommend a well-validated, self-reporting screening instrument to use in the diagnostic process, and so consultation skills should be relied upon to elicit all necessary information.

### Comorbidities

The clinician should be alert to the common clinical situation of comorbidity, in particular, panic disorder with depression and panic disorder with substance misuse.

Be aware when prescribing SSRIs of the need to ask about cocaine use when considering drug–drug interactions, and the need to avoid concurrent use of multiple serotonergic drugs. Follow the MHRA safety advice on citalopram.

The main problem(s) to be treated should be identified through a process of discussion with the person. In determining the priorities of the comorbidities, the sequencing of the problems should be clarified. This can be helped by drawing up a timeline to identify when the various problems developed. By understanding when the symptoms developed, a better understanding of the

relative priorities of the comorbidities can be achieved, and there is a better opportunity of developing an effective intervention that fits the needs of the individual.

**Presentation at A&E or other setting**

If a person presents in A&E, or other settings, with a panic attack, they should:

- be asked if they are already receiving treatment for panic disorder
- undergo the minimum investigations necessary to exclude acute physical problems
- not usually be admitted to a medical or psychiatric bed
- be referred to primary care for subsequent care, even if assessment has been undertaken in A&E
- be given appropriate written information about panic attacks and why they are being referred to primary care
- be offered appropriate written information about sources of support, including local and national voluntary and self-help groups.

## 4 Step 2: Offer treatment in primary care

Refer to general principles in the NICE Pathway on common mental health problems for guidance on identifying the correct treatment options.

The treatment option of choice should be available promptly.

There are positive advantages of services based in primary care (for example, lower rates of people who do not attend) and these services are often preferred by people.

For people with mild to moderate panic disorder, offer or refer for one of the following low-intensity interventions:

- individual non-facilitated self-help
- individual facilitated self-help.

Information about support groups, where they are available, should be offered. (Support groups may provide face-to-face meetings, telephone conference support groups [which can be based on CBT principles], or additional information on all aspects of anxiety disorders plus other sources of help.)

The benefits of exercise as part of good general health should be discussed with all people with panic disorder as appropriate.

**Monitoring and follow-up**

Individuals receiving self-help interventions should be offered contact with primary healthcare professionals, so that progress can be monitored and alternative interventions considered if appropriate. The frequency of such contact should be determined on a case-by-case basis, but is likely to be between every 4 and 8 weeks.

Short, self-completed questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible.

## 5 Step 3: Review and consideration of alternative treatments

For people with moderate to severe panic disorder (with or without agoraphobia), consider referral for:

- CBT or
- an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological intervention.

## 6 Step 3: Psychological interventions

CBT should be used.

CBT should be delivered only by suitably trained and supervised people who can demonstrate that they adhere closely to empirically grounded treatment protocols.

CBT in the optimal range of duration (7–14 hours in total) should be offered.

For most people, CBT should take the form of weekly sessions of 1–2 hours and should be completed within a maximum of 4 months of commencement.

Briefer CBT should be supplemented with appropriate focused information and tasks.

Where briefer CBT is used, it should be around 7 hours and designed to integrate with structured self-help materials.

For a few people, more intensive CBT over a very short period of time might be appropriate.

### Monitoring and follow-up

There should be a process within each practice to assess the progress of a person undergoing CBT. The nature of that process should be determined on a case-by-case basis.

Short, self-completed questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible.

## 7 Step 3: Pharmacological interventions

See the NICE Pathway on medicines optimisation.

### Antidepressant medication

Antidepressants should be the only pharmacological intervention used in the longer-term management of panic disorder. The classes of antidepressants that have an evidence base for effectiveness are the SSRIs, SNRIs and TCAs. At the time of this amendment (June 2020) escitalopram, sertraline, citalopram, paroxetine and venlafaxine are licensed for the treatment of panic disorder.

The following must be taken into account when deciding which medication to offer:

- the age of the person
- previous treatment response
- risks
    - the likelihood of accidental overdose by the person being treated and by other family members if appropriate
    - the likelihood of deliberate self-harm, by overdose or otherwise (the highest risk is with tricyclic antidepressants)
- tolerability
- the possibility of interactions with concomitant medication (consult the interactions section of the British National Formulary)
- the preference of the person being treated
- cost, where equal effectiveness is demonstrated.

All people who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects (including transient increase in anxiety at the start of treatment)

and of the risk of discontinuation/withdrawal symptoms if the treatment is stopped abruptly or in some instances if a dose is missed or, occasionally, on reducing the dose of the drug.

For people aged under 30 who are offered an SSRI or SNRI:

- warn them that these drugs are associated with an increased risk of suicidal thinking and self-harm in a minority of people under 30 **and**
- see them within 1 week of first prescribing **and**
- monitor the risk of suicidal thinking and self-harm weekly for the first month.

People started on antidepressants should be informed about the delay in onset of effect, the time course of treatment, the need to take medication as prescribed, and possible discontinuation/withdrawal symptoms. Written information appropriate to the person's needs should be made available.

Unless otherwise indicated, an SSRI licensed for panic disorder should be offered.

If an SSRI is not suitable or there is no improvement after a 12-week course and if a further medication is appropriate, imipramine or clomipramine may be considered.

Note that this is an off-label use for imipramine and clomipramine. See prescribing medicines at NICE website for more information.

When prescribing an antidepressant, the healthcare professional should consider the following.

- Side effects on the initiation of antidepressants may be minimised by starting at a low dose and increasing the dose slowly until a satisfactory therapeutic response is achieved.
- In some instances, doses at the upper end of the indicated dose range may be necessary and should be offered if needed.
- Long-term treatment may be necessary for some people and should be offered if needed.
- If the person is showing improvement on treatment with an antidepressant, the medication should be continued for at least 6 months after the optimal dose is reached, after which the dose can be tapered.

If there is no improvement after a 12-week course, an antidepressant from the alternative class (if another medication is appropriate) or another form of therapy should be offered.

**Discontinuation/withdrawal symptoms of antidepressant medication**

People should be advised to take their medication as prescribed. This may be particularly important with short half-life medication in order to avoid discontinuation/withdrawal symptoms.

Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms. To minimise the risk of discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period of time.

All people prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.

Healthcare professionals should inform people that the most commonly experienced discontinuation/withdrawal symptoms are dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances.

Healthcare professionals should inform people that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms.

If discontinuation/withdrawal symptoms are mild, the practitioner should reassure the person and monitor symptoms. If severe symptoms are experienced after discontinuing an antidepressant, the practitioner should consider reintroducing it (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms.

NICE is developing a guideline on medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management.

**Drugs not to be used**

Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder.

Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder.

**Monitoring anti-depressants and follow-up**

When a new medication is started, the efficacy and side-effects should be reviewed within 2 weeks of starting treatment and again at 4, 6 and 12 weeks. Follow the summary of product characteristics with respect to all other monitoring required.

At the end of 12 weeks, an assessment of the effectiveness of the treatment should be made, and a decision made as to whether to continue or consider an alternative intervention.

If medication is to be continued beyond 12 weeks, the individual should be reviewed at 8- to 12-week intervals, depending on clinical progress and individual circumstances.

Short, self-completed questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible.

## Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

**Anxiety disorders quality standard**

3. Pharmacological treatment

## 8 Step 4: Review and referral to specialist mental health services

In most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered.

## 9 Step 5: Care in specialist mental health services

Specialist mental health services should conduct a thorough, holistic reassessment of the individual, their environment and social circumstances. This reassessment should include evaluation of:

- previous treatments, including effectiveness and concordance
- any substance use, including nicotine, alcohol, caffeine and recreational drugs (see identification and assessment in the NICE Pathway on drug misuse management in over 16s and assessment for harmful drinking and alcohol dependence in the NICE Pathway on alcohol-use disorders)
- comorbidities
- day-to-day functioning
- social networks

- continuing chronic stressors
- the role of agoraphobic and other avoidant symptoms.

A comprehensive risk assessment should be undertaken and an appropriate risk management plan developed.

Be aware when prescribing SSRIs of the need to ask about cocaine use when considering drug–drug interactions, and the need to avoid concurrent use of multiple serotonergic drugs. Follow the MHRA safety advice on citalopram.

To undertake these evaluations, and to develop and share a full formulation, more than one session may be required and should be available.

Care and management should be based on the individual's circumstances and shared decisions made. Options include:

- treatment of co-morbid conditions
- CBT with an experienced therapist if not offered already, including home-based CBT if attendance at clinic is difficult
- full exploration of pharmaco-therapy
- day support to relieve carers and family members
- referral for advice, assessment or management to tertiary centres.

There should be accurate and effective communication between all healthcare professionals involved in the care of any person with panic disorder, and particularly between primary care clinicians (GP and teams) and secondary care clinicians (community mental health teams) if there are existing physical health conditions that also require active management.

See the NICE Pathway on transition between community or care home and inpatient mental health settings.

## 10 NICE Pathway on generalised anxiety disorder

See Generalised anxiety disorder

## 11 Experience of care

Use these recommendations together with the recommendations in the NICE Pathways on:

- patient experience in adult NHS services
- service user experience in adult mental health services.

## Glossary

### CBT

cognitive behavioural therapy

### SSRIs

selective serotonin reuptake inhibitors

### SNRIs

serotonin-noradrenaline reuptake inhibitors

### TCAs

tricyclic antidepressants

## Sources

Generalised anxiety disorder and panic disorder in adults: management (2011 updated 2020) NICE guideline CG113

## Your responsibility

### Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They

should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

### Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

### Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the

interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.