Chest pain—consider panic disorder

In the important article by Flook et al[1] on managing undiagnosed chest pain, the authors appropriately stressed the importance of considering gastroesophageal reflux disease (GERD) as one of the most likely diagnoses once potentially life-threatening causes have been excluded. The authors conclude, however, that after a "careful search for symptomatic cardiovascular disease, a clinical assessment for atypical GERD will provide a solid foundation for managing patients with undiagnosed chest pain."[1]

We believe that such an approach will lead to many diagnoses of "atypical GERD" in patients with chest pain actually resulting from psychological factors, which can frequently be diagnosed with reasonable certainty by clinical history and "examination of the patient's emotional system."[2] There are now direct methods to detect the emotional factors that cause symptoms; these factors need not and should not be "diagnosed by exclusion."[2]

Delaying appropriate psychological treatment can also be very costly to patients and the system. Several of the causes of chest pain listed in Table 2 of the article by Flook et al,[1] such as nutcracker esophagus, diffuse esophageal spasm, nonspecific motility disorder, panic attacks, and depression, can be treated with emotion-focused psychotherapy, such as short-term dynamic psychotherapy.[3] In settings other than the inpatient settings in the studies noted by the authors, these other causes are likely to be more common than GERD. In this letter, we focus on one of these problems: panic disorder (PD).

Before consulting their family doctors, many patients with chest pain have already presented "in crisis" to emergency departments (EDs), where, according to common ED practice, life-threatening causes of the pain have been "ruled out," diagnoses of "chest pain NYD" (not yet diagnosed) have been made,[4] and patients have been referred back to their FPs for further investigation. Fleet et al reported that 25% of patients presenting to the ED met the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition, (*DSM-IV*) criteria for PD, and that the diagnosis in that setting is missed 98% of the time.[5] By the time patients see their FPs, they might, in the security of the consultation room, have less severe symptoms, be less likely in retrospect to associate the pain with symptoms of anxiety, and thus be easier to misdiagnose.

Although some emergency physicians have acknowledged this deficiency in the service they offer,[6,7] counter-arguments have included the observation that primary care doctors who know their patients well are in a better position to make the diagnosis than an ED doctor who sees them at one point in time.[8] In any case, the reality of the situation is that patients with undiagnosed chest pain who have presented in crisis at EDs usually end up in their FPs' offices.

Panic disorder causes great distress for patients and has the potential to seriously impede psychosocial and occupational functioning. When identified and treated early, however, the outlook is favourable, with 50% to 70% becoming symptom free in acute treatment.[9] Undiagnosed and untreated PD can progress to a chronic disabling disease.[10] It is vital that FPs screen for and diagnose this condition and explain to patients the biopsychological nature of the disease. Johnson et al found that 84% of primary care patients who met *DSM-IV* criteria for PD expressed willingness to seek psychiatric care and 95% would have accepted psychological interventions,[11] suggesting that physicians need not fear that the diagnosis will offend their patients.

Treatment of PD is often within the realm of family practice. Studies have shown that combination treatments or brief psychotherapy alone might preclude the need for long-term medication use and have lower relapse rates than medications alone.[3,9] Misdiagnosis of PD as GERD might sentence a substantial group of patients to prolonged periods of suffering and the health care system to considerable avoidable resource consumption.[12]

—Sam G. Campbell MB BCH CCFP(EM)
—Allan A. Abbass MD FRCPC
Halifax, NS
by e-mail

References

1. Flook N, Unge P, Agréus L, Karlson BW, Nilsson S. Approach to managing undiagnosed chest pain. Could gastroesophageal reflux disease be the cause? *Can Fam Physician* 2007;53:261-6.

Make your views known!

Contact us by e-mail at **letters.editor@cfpc.ca**,
on the College's website at **www.cfpc.ca**,
by fax to the Editor at 905 629-0893, or by mail.
Canadian Family Physician
College of Family Physicians of Canada
2630 Skymark Ave, Mississauga, ON L4W 5A4

...

Faites-vous entendre!

Communiquez avec nous par courriel :
letters.editor@cfpc.ca, au site web du Collège :
www.cfpc.ca, par télécopieur au Rédactrice
905 629-0893, ou par la poste.
Le Médecin de famille canadien
Collège des médecins de famille du Canada
2630 avenue Skymark, Mississauga, ON L4W 5A4

2. Abbass A. Somatization: diagnosing it sooner through emotion-focused interviewing. *J Fam Pract* 2005;54(3):231-9, 243.
3. Abbass AA, Hancock JT, Henderson J, Kisely S. Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database Syst Rev* 2006;(4):CD004687.
4. Campbell SG. Advances in emergency medicine: a 10-year perspective. *Can J Diag* 2003;20(10):115-8.
5. Fleet RP, Dupuis G, Marchand A, Burelle D, Arsenault A, Beitman BD. Panic disorder in emergency department chest pain patients: prevalence, comorbidity, suicidal ideation, and physician recognition. *Am J Med* 1996;101(4):371-80.
6. Pollard CA, Lewis LM. Managing panic attacks in emergency patients. *J Emerg Med* 1989;7(5):547-52.
7. Lee J, Dade LA. The buck stops where? What is the role of the emergency physician in managing panic disorder in chest pain patients? *Can J Emerg Med* 2003;5(4):237-8.
8. Epstein NL. Chest pain and panic disorder in the ED? *Can J Emerg Med* 2003;5(5):308.
9. Furukawa TA, Watanabe N, Churchill R. Combined psychotherapy plus antidepressants for panic disorder with or without agoraphobia. *Cochrane Database Syst Rev* 2007;(1):CD004364.
10. Fleet RP, Lavoie KL, Martel JP, Dupuis G, Marchand A, Beitman BD. Two-year follow-up status of emergency department patients with chest pain: was it panic disorder? *Can J Emerg Med* 2003;5(4):247-54.
11. Johnson MR, Gold PB, Siemion L, Magruder KM, Frueh BC, Santos AB. Panic disorder in primary care: patients' attributions of illness causes and willingness to accept psychiatric treatment. *Int J Psychiatry Med* 2000;30(4):367-84.
12. Barsky AJ, Ettner SL, Horsky J, Bates DW. Resource utilization of patients with hypochondriacal health anxiety and somatization. *Med Care* 2001;39(7):705–15.

Response

The letter from Drs Campbell and Abbass and our article[1] both serve as reminders to physicians to consider all of the important causes of chest pain, including GERD and psychiatric disease. We whole-heartedly agree with several important points in their letter. Anxiety disorders meeting *DSM-IV* criteria are common among patients visiting the emergency department for chest pain.[2] Optimal care would diagnose and manage anxiety at an early stage in order to reduce suffering and improve outcomes. We believe FPs have the expertise to provide a patient-centred approach to care that encompasses the range of physical and psychological issues involved in chest pain.

The complex interplay between the brain and the gut warrants additional emphasis. Studies show that people suffering with either chest pain or GERD will often have concomitant anxiety.[2,3] Furthermore, having an anxiety disorder does not immunize an individual against other causes of chest pain, including cardiac causes and GERD. In the same way that overemphasis on acid-related causes could distract our attention from the patients who have anxiety disorder, we must not overlook GERD or coronary artery disease in patients with panic disorder or other anxiety disorders. Comorbid conditions are common in patients with chest pain, and appropriate management is needed for both the psychological and physical components of their conditions.[2] The brain-to-gut and gut-to-brain connections are real and very important when assessing and managing GERD patients presenting with chest pain.[4,5]

If a patient's chest pain is caused by GERD, treatment with proton pump inhibitors can completely resolve symptoms and restore health.[6] It is not common to have this degree of success with treatments for the other causes of chest pain and comorbid conditions. Family physicians are well positioned by virtue of their skills and ongoing care to diagnose and manage both physical and psychological diseases associated with chest pain.[7] We are proud of the important role FPs play in the evidence-based management of chest pain, anxiety disorders, and depression.

—Nigel Flook MD CCFP FCFP, Edmonton, Alta
—Peter Unge MD PhD, Stockholm, Swed
—Lars Agréus MD PhD, Stockholm, Swed
—Björn W. Karlson MD PhD, Mölndal, Swed
—Staffan Nilsson MD, Norrköping, Swed
by e-mail

References

1. Flook N, Unge P, Agréus L, Karlson BW, Nilsson S. Approach to managing undiagnosed chest pain. Could gastroesophageal reflux disease be the cause? *Can Fam Physician* 2007;53:261-6.
2. Husser D, Bollmann A, Kuhne C, Molling J, Klein HU. Evaluation of noncardiac chest pain: diagnostic approach, coping strategies and quality of life. *Eur J Pain* 2006;10(1):51-5.
3. Wiklund I. Review of the quality of life and burden of illness in gastroesophageal reflux disease. *Dig Dis* 2004;22(2):108-14.
4. Kamolz T, Velanovich V. Psychological and emotional aspects of gastroesophageal reflux disease. *Dis Esophagus* 2002;15(3):199-203.
5. Wiklund I, Butler-Wheelhouse P. Psychosocial factors and their role in symptomatic gastroesophageal reflux disease and functional dyspepsia. *Scand J Gastroenterol Suppl* 1996;220:94-100.
6. Revicki DA, Crawley JA, Zodet MW, Levine DS, Joelsson BO. Complete resolution of heartburn symptoms and health-related quality of life in patients with gastro-oesophageal reflux disease. *Aliment Pharmacol Ther* 1999;13(12):1621-30.
7. Botoman VA. Noncardiac chest pain. *J Clin Gastroenterol* 2002;34(1):6-14.

Cause of confusion

I read with interest Dr Gillson's letter in the January 2007 issue (*Can Fam Physician* 2007;53:29-30) regarding the North American tendency to confuse progesterone and progestogen and found myself in such violent agreement that I needed to inform him that this is not purely a North American phenomenon. The same confusion and fuzzy terminology is widely encountered in Ireland and the United Kingdom. This is surely just one example of the insidious effects of pharmaceutical marketing on our thinking, despite the fact that there is widespread belief that medical professionals are somehow immune to subliminal advertising!

—Ailís ní Riain MB MICGP MBA
—Dublin, Ireland
by e-mail

When the law calls

I am writing in response to the article by Dr Dalby in the January 2007 edition of *Canadian Family Physician* entitled "On the witness stand. Learning the courtroom tango."[1] Much of Dr Dalby's article will be very helpful to family doctors who are asked or called to give testimony; however, some statements in the article might mislead family physicians in the following areas: the definition of an expert in the context of Canadian law, the responsibility