Correspondence

We try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

To the Editor: Panic disorder is a common malady causing great distress and impairment in our medical care setting. The recent article by Roy-Byrne and colleagues[1] makes a good case for recognition and outlines and approach to treatment. The authors, however, fail to stress one important aspect of treating panic disorder - its comorbidity with bipolar disorders. The section on the psychopharmacology of panic does address the use of valproate and benzodiazepines in such patients. (The use of gaba-pentin is advocated without supporting evidence.) In addition, the article does not adequately address the potential for misdiagnosis and subsequent mistreatment of patients suffering from bipolar illness who do not have a previous diagnosis of such, but who might have panic attacks. Such attacks regularly prompt the patient to seek medical care.

If the clinician successfully diagnoses the panic attack, but fails to look further, the patient might be subjected to antidepressant therapy without the concomitant use of thymoleptic medications and, therefore, be placed at risk for exacerbations of hypomania, mania, rapid cycling, and refractory status. Sadly, our experience in the Mood Disorder Clinics at the University of Tennessee, Memphis, Department of Family Medicine, suggests that this scenario is common. Panic attacks are easier to see than hypomanic episodes.

The world psychiatric literature increasingly recognizes the comorbidity of mood and anxiety disorders. The Epidemiologic Catchment Area Survey estimated that the lifetime prevalence of panic disorder among patients with bipolar disorder was 20.8 percent.[2] Other clinical studies suggest a similar connection.[3,4] Twenty-three percent of panic disorder patients in a panic disorder program were classified as suffering from bipolar or cyclothymic mood disorder.[5] There is some evidence that panic disorder is a marker of genetic heterogeneity in bipolar disorders.[6,7]

A recent longitudinal clinical investigation suggests that bipolar disorders, particularly those resembling bipolar II disorder, are much more common in family practice settings than are documented in previously published cross-sectional (nonclinician) studies.[8] In this cohort 26 percent of bipolar patients suffered from panic attacks, a number similar to that in other citations. That observation is again bolstered by our Mood Disorder Clinic experience.

There is a very real potential to do harm to a patient with bipolar illness and panic attacks if the bipolarity is unrecognized and antidepressants are used alone in treatment. Additionally, panic disorder patients who have problematic responses to antidepressant drugs (unexpectedly rapid, exaggerated, erratic, inconsistent) or who are intolerant to multiple antidepressant trials should be questioned carefully for evidence of hypomania, premorbid affective temperament, and bipolar pedigree. It is worth informing family physicians who are using the proposed guidelines to consider these issues. Perhaps the section on making the diagnosis could be revised to include this information.

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The above letter was referred to the authors of the article in question, who offer the following reply.

To the Editor: We agree that recognition of bipolar disorder in panic disorder is important and might influence the choice of treatment. We did not discuss the issue of diagnosing bipolar disorder in the interest of both brevity and simplicity. A major unacknowledged problem is that hypomania is extremely difficult to diagnose with accuracy, as suggested by recent evidence that the bipolar diagnosis had poor reliability in the more streamlined, lay-interviewer DICI.[1] While more exten-

sively trained clinicians and specialists can recognize hypomania with some accuracy, and the authors' group, having the benefit of association with a world expert (Dr. Akiskal) might also be quite adept at diagnosing hypomania, we were reluctant to discuss this diagnosis in detail without also providing a simple diagnostic algorithm for hypomania, analogous to the one provided for panic. We don't think a simple algorithm exists. We believe there is a simple take-home message from the authors' letter: if your panic patient experiences either anxiety or agitation or a cyclic pattern of symptomatic remission and relapse in response to antidepressants, consider the possibility of an underlying bipolar disorder. Indeed, such conditions might be initially missed, even when carefully inquired about, because of the diagnostic problems noted above.

We also believe that the high rate of bipolar illness noted in the authors' cited study remains controversial and depends in part of the interpretation of subtle forms of mood instability and lability as bipolar. Furthermore, some bipolar patients with very brief and subtle hypomanias might be safely and effectively maintained on selective serotonin reuptake inhibitor antidepressants, which appear to produce a lower switch rate (ie, provocation of mania) than tricyclic antidepressants,[2,3] although this remains controversial. Thus, we hope this letter does not discourage clinicians form the use of selective serotonin reuptake inhibitor antidepressants in patients with panic disorder.

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Primary Care Physicians and Complementary-Alternative Medicine

To the Editor: The article by Berman and colleagues[1] makes some assumptions in its analysis of a survey sent out to physicians that might not be warranted. I am very busy, as are most physicians, and do not respond to most of the surveys I receive. If the survey is related to an area in which I have a special interest, however, then I do take the time to fill it out and return it. Likewise, I would expect that those physicians who have an interest in complementary and alternative medicine would be far more likely to respond to a survey on alternative medicine than the average physician. This effect would bias the results toward a higher percentage of physicians appearing to embrace these practices than actually do. Because the percentage of surveys returned was so low (10.6 percent from family physicians and general practitioners, 13.7 percent from internists, and 31.7 percent from pediatricians after three mailings), this response bias could have a large effect on the reported results.

One article used to justify their generalizations[2] was based on a survey of physicians regarding "issues of everyday concern to physicians in the practice of medicine" and had an overall response rate of 64 percent after three mailings. For this type of survey, one might be justified in regarding physicians as a homogenous group. For a survey on alternative medicine, however, a highly controversial topic, physicians opinions are far from homogeneous.

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References

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