

Editorials

Panic Disorder: The Decision To Seek Health Care

Panic disorder can be present in as many as 6.5 percent of primary care patients¹ and is associated with high medical utilization,² the tendency to report multiple medically unexplained symptoms (chest pain, headache),³ and high medical costs.⁴ Panic disorder is also associated with considerable vocational and social disability⁵ and a high risk of suicide.⁶ Unfortunately, only 1 in 3 persons in the community with this psychiatric disorder is receiving known effective treatment.

Because of high medical utilization for unexplained physical complaints in patients with panic disorder, primary care physicians are in an advantageous position to provide early diagnosis and treatment. Increasing knowledge about the mode of presentation of patients with panic disorder has suggested that there is a high rate of panic disorder among patients seeking help for cardiologic complaints, such as chest pain and tachycardia; neurologic complaints, such as headache, dizziness, and syncope or near-syncope; and gastrointestinal complaints, such as abdominal pain, often associated with alternating constipation and diarrhea.⁷

The important study reported in the current issue of *JABFP* entitled "Factors Affecting the Threshold for Seeking Care: The Panic Attack Care-Seeking Threshold (PACT) Study"⁸ emphasizes the high rate of panic attacks in the community (9.4 percent), with close to one-half of the respondents (43 percent) meeting *Diagnostic and Statistical Manual of Mental Disorders*, ed 3, *Revised* (DSM-III-R) criteria for panic disorder. Realini and Katerndahl's study examined the factors associated with seeking medical care among persons with panic attacks. Using multivariate analysis, the factors most associated with medical care seeking are having to get someone

to drive, inability to work because of panic symptoms, and a treatment experience score based on three questions regarding the frequency of treatment and variety of providers seen. The first two factors emphasize that symptoms causing a large amount of social and vocational disability are most likely to be associated with health care use. The authors suggest that the last factor could reflect repeatedly seeking care for panic attacks. This phenomenon of patients with panic disorder seeking repeated care has been noted in the Epidemiology Catchment Area Study⁴ in which community respondents with panic disorder had the highest medical utilization when compared with persons with other psychiatric disorders.

The authors emphasize that many studies of symptoms and disorders in primary and specialty care fail to account for persons in the community who often have similar symptoms for which they do not seek care. Moreover, there could be important biopsychosocial differences between those who seek care for medical symptoms or disorders and those who do not, as well as between patients with similar disorders in primary and tertiary care populations.

Goldberg and Huxley⁹ have emphasized that there is a series of filters determining whether patients in the community visit primary care physicians with their symptoms, and whether they make it through the filter of primary care to referral to specialists. In studies using daily health care diaries,¹⁰ respondents in the community have had a new symptom every 5 to 7 days, 95 percent of which are not brought to the attention of a physician. These include such common symptoms as respiratory tract infections, abdominal pain, and headache. Most of these symptoms are self-limited and handled within the family system with rest, over-the-counter medications, and advice from friends and family. Perhaps 5 percent of these symptoms make it through the first filter and are brought to the attention of a physician, either because of their more severe nature (i.e., abdominal pain from

Submitted 2 February 1993.

From the Consultation-Liaison Division, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle. Address reprint requests to Wayne Katon, MD, Consultation-Liaison Division, Department of Psychiatry and Behavioral Sciences, RP-10, University of Washington, Seattle, WA 98195.

appendicitis) or, just as commonly, because of associated psychological distress.

Among people with mental illness who visit primary care physicians, Goldberg and Huxley⁹ have labeled those patients accurately recognized by physicians as having conspicuous psychiatric morbidity. A subset of these patients will make it through the second filter and be referred to a mental health specialist. Factors associated with referral to the specialist include severity of the disorder and the primary care physician's treatment skills. Goldberg and Huxley, however, have also found that a substantial subset of patients have hidden psychiatric illness whose conditions are not accurately diagnosed. These patients are likely either to stay in the primary care system or, because of the frequent association of mental illness with unexplained medical symptoms such as pain or fatigue, to be referred to a medical specialist. Among the subset of patients with conspicuous psychiatric morbidity who are referred to a mental health specialist, a small subset will pass through the next filter to an inpatient psychiatric unit. Many specialist studies describing the characteristics of medical or mental disorders rely on these inpatient samples, which could have limited generalizability to community or primary care patients with similar disorders.

These differences in characteristics among community, primary care, and tertiary care samples are readily seen in persons with common physical symptoms. Many common symptoms, such as fatigue, irritable bowel syndrome, or headache, occur frequently in the community. Psychological distress associated with these common symptoms can be associated with medical care seeking.¹¹⁻¹³ Thus, if patients with these symptoms are studied in primary care, there could be a higher rate of psychological distress and psychiatric disorders associated with these symptoms than if patients with these symptoms were studied in the community. Moreover, patients who are referred to tertiary care with common symptoms (or self-refer to tertiary care) could even have a higher rate of comorbid psychiatric illness associated with their health care utilization. Thus, a recent report found that patients with fatigue who were in the community had a 1.2 to 1.9 percent rate of affective illness compared with 7.2 percent in primary

care patients with fatigue and 15 to 64 percent in tertiary care patients with fatigue.¹⁴

A classic example from the medical literature also illustrates the importance of differences between patients in tertiary care and primary care. Results from initial studies of children with febrile seizures referred to neurologists, which showed an increased risk of subsequent seizures, were not able to be replicated when primary care population-based samples of children with febrile seizures were studied.¹⁵ The primary care or denominator population of patients was most likely a different subset of patients than the relatively small group of selected patients who made it through the filter of primary care to specialist.

More research such as undertaken in the Realini and Katerndahl study needs to be completed so we can better understand the decision to seek health care in patients with common symptoms and disorders, as well as understand epidemiologic differences among community, primary care, and tertiary care populations.

Wayne Katon, MD
Seattle, WA

References

1. Katon W, Vitaliano PP, Russo J, Cormier L, Anderson K, Jones M. Panic disorder: epidemiology in primary care. *J Fam Pract* 1986; 23:233-9.
2. Katon W, Von Korff M, Lin E. Panic disorder: relationship to high medical utilization. *Am J Med* 1992; 92(Suppl 1A):7S-11S.
3. Simon G, Von Korff M. Somatization and psychiatric disorder in the NIMH Epidemiologic Catchment Area Study. *Am J Psychiatry* 1991; 148: 1494-500.
4. Simon GE. Psychiatric disorder and functional somatic symptoms as predictors of health care use. *Psychiatr Med* 1992; 10:49-59.
5. Markowitz JS, Weissman MM, Ouellette R, Lish JD, Klerman GL. Quality of life in panic disorder. *Arch Gen Psychiatry* 1989;46:984-92.
6. Weissman MM, Klerman GL, Markowitz JS, Ouellette R. Suicidal ideation and suicide attempts in panic disorder and attacks. *N Engl J Med* 1989; 321:1209-14.
7. Katon WJ. Panic disorder in the medical setting. Washington, DC: American Psychiatric Association Press, Inc., 1991.
8. Realini JP, Katerndahl DA. Factors affecting the threshold for seeking care: The Panic Attack Care-Seeking Threshold (PACT) study. *J Am Board Fam Pract* 1993; 6:215-23.
9. Goldberg D, Huxley P. Mental illness in the community: the pathway to psychiatric care. London: Tavistock, 1980.

10. Demers RY, Altamore R, Mustin H, Kleinman A, Leonardi D. An exploration of the dimensions of illness behavior. *J Fam Pract* 1980; 11:1085-92.
11. Walker EA, Katon WJ, Jemelka RP. Psychiatric disorders and medical care utilization among people who report fatigue in the general population. *J Gen Intern Med*. In press.
12. Drossman DA, Sandler RS, McKee DC, Lovitz AJ. Bowel patterns among subjects not seeking health care. Use of a questionnaire to identify a population with bowel dysfunction. *Gastroenterology* 1982; 83: 529-34.
13. Stewart WF, Schechter A, Liberman J. Physician consultation for headache pain and history of panic: results from a population-based study. *Am J Med* 1992; 92(Suppl A):35S-40S.
14. Katon W, Walker EA. The relationship of chronic fatigue to psychiatric illness in community, primary care and tertiary care samples. In: Bock GR, Whelan J. Chronic fatigue syndrome. Chichester, NY: CIBA Foundation symposium; v 173, Wiley, 1993.
15. Ellenberg JH, Nelson KB. Sample selection and the natural history of disease. *Studies of febrile seizures*. *JAMA* 1980; 243:1337-40.

Nondiagnostic And Inconsistent Results From Colposcopy

"Frequency of Nondiagnostic Findings on Colposcopy: Implication for Management" by Nuovo and Kreiter in this issue of *JABFP* presents the histologic findings of a series of patients (nonpregnant, not exposed to diethylstilbestrol) who underwent colposcopic-directed biopsies. The primary indication for the colposcopic procedure included two sequential Papanicolaou smears indicating atypical cellular changes or one Papanicolaou smear with evidence of dysplasia. Their data suggest that clinicians can be faced with nondiagnostic histology reports in nearly one-third (29.7 percent) of patients undergoing colposcopic examination for these indications. Much of this dilemma stems from inconsistent terminology and confusion re-

garding the meaning of nondiagnostic reporting. Reconsideration of some of the data in light of problems with terminology and careful review of the basic tenants of colposcopic examination will help address this dilemma and in most cases will guide therapy towards desirable outcomes.

First, it is the clinician who must ultimately decide how to care for a patient whose Papanicolaou smear is interpreted as abnormal.¹ Few argue that dysplasia of any grade on a screening Papanicolaou smear report warrants colposcopic evaluation, and in most cases ectocervical biopsy and endocervical curettage (ECC). Furthermore, a Papanicolaou smear report of persistent cellular atypia prompts many clinicians to evaluate these women's cervixes with colposcopy and biopsy as well. Both the Papanicolaou smear and the colposcopic appearance of the cervix share one feature in common, however; *neither* procedure is diagnostic. Only the histologic interpretation of the colposcopic-directed biopsy provides an opportunity to diagnose or explain the abnormal smear and guide appropriate intervention (i.e., expectant management, cryotherapy, electrosurgery, laser surgery, cone biopsy). When such biopsies appear to explain or to correlate inadequately with the Papanicolaou smear findings and colposcopic impression, the clinician is compelled to make management decisions that are not as clearly defined. Clinicians are routinely presented with ambiguous, nondiagnostic, or nonconfirmatory test results during the work-up of many medical conditions. Nondiagnostic results as defined by Nuovo and Kreiter are those negative for dysplasia, but showing atypia, inflammation, hyperkeratosis, and parakeratosis. As defined, histologic examination would find nondiagnostic results by failing to explain the cause for abnormal findings on screening cell studies.

This notion of nondiagnosis can be misleading, however. At a minimum, what the nondiagnostic biopsy findings actually show is atypia, inflammation, hyperkeratosis, or parakeratosis of squamous tissue *without* dysplasia. The results can be nondiagnostic in the sense that they fail to explain the abnormal cytologic findings; nonetheless, they also do not show dysplasia. The ultimate purpose of the colposcopic-directed biopsy is to rule out invasive (or microinvasive) cervical cancer and to guide

Submitted, revised, 8 March 1993.

From Family Medicine Spokane, Spokane, WA. Address reprint requests to Gary R. Newkirk, MD, 510 South Cowley, Spokane, WA 99202.