The buck stops where? What is the role of the emergency physician in managing panic disorder in chest pain patients?

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In this issue of the *Canadian Journal of Emergency Medicine*, Fleet and colleagues[1] report that up to 25% of emergency department (ED) patients with chest pain meet diagnostic criteria for panic disorder (PD), and that this high prevalence did not decline at follow-up, an average of 2 years later (see page 247). Of note, cardiologists in a specialized chest-pain unit diagnosed PD in only 2% of patients who met *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), 3rd ed, revised (DSM-III-R) criteria for the disorder.[1] This high "miss rate" was replicated by a group of specialty-trained emergency physicians.[2]

When PD is identified and treated early, the outlook is favourable: up to 15% of patients experience complete remission and 85% become relatively symptom free.[3] But, left untreated, PD can progress to a chronic disabling disease with hypochondriasis, phobic avoidance and full-blown agoraphobia.[4–6] Patients with uncontrolled PD are frequent users of ED and health care resources. In a multicentre, population-based study, Klerman and coworkers[7] reported that PD patients were 28 times more likely to use the ED than persons with no psychiatric disorder, while Fleet and colleagues[1] reported a 4-fold increase in ED visits for chest pain.

But is it the emergency physician's job to diagnose PD? From the first day of our residency, we are taught to assume the worst and rule it out. The thought of calling a pulmonary embolism "panic disorder" scares most of us,[8] and emergency physicians often feel their responsibility is limited to "ruling-out" life-threatening disease. At the other end of the spectrum, a recent study demonstrated the feasibility of a protocol in which emergency physicians used a brief screening tool to identify PD patients, then prescribed a month of paroxetine therapy.[2] There are problems with each extreme. Simply reassuring patients that "it's not a heart attack" is ineffective.[9] This approach is associated with a high rate of repeat ED visits. Worse, without treatment, patients may become increasingly disabled and their disposition more complicated with each visit. The "treat and street" strategy (or in this case, the "street — don't treat" strategy) is a convenient approach for emergency physicians, but it may in the long run aggravate ED overcrowding. On the other hand, relatively few emergency physicians feel comfortable prescribing serotonin reuptake inhibitors for patients with chest pain, and admitting patients with "rule-out PD" to inpatient psychiatry services would quickly overwhelm their capacity to deal with more urgent psychiatric conditions. So what are we to do?

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First, we must acknowledge that we have a problem. Erring on the side of caution is prudent, but failing to di-

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agnose 98% of patients with PD is dismal, and we can surely do better. Alerting emergency physicians to the consequences of missing this diagnosis is a crucial first step in improving our sensitivity. Wuslin and cohorts[2] have shown that a brief clinical screening tool enabled emergency physicians to accurately recognize PD among chest pain patients and, in this issue of *CJEM*, Fleet and colleagues summarized the diagnostic criteria for PD and panic attacks.[1]

Second, we need to develop effective ways to communicate the diagnosis of PD. Emergency physicians are often reluctant to suggest that chest pain may be a psychiatric symptom; however, when a cardiac cause is excluded and PD is apparent, such reluctance speaks to the ongoing stigma associated with psychiatric conditions. A cross-sectional survey of primary care patients who met DSM-IV criteria for PD revealed that 84% were willing to seek psychiatric care and that 95% would have accepted psychological interventions.[10] This suggests that the failure to identify and treat this disabling condition may be more related to physician discomfort than patient concerns. The survey authors[10] recommended that "primary care clinicians should more assertively inform their patients of PD diagnoses and recommend psychiatric treatments with less fear about stigmatizing and alienating them." Anecdotally, I have found that characterizing panic attacks in medical terms, and describing them as a "fight or flight" catecholamine responses, leads to greater patient acceptance of the diagnosis and treatment options. We, as emergency physicians, should study methods for effectively communicating this diagnosis to our patients — or at least take a lesson from our psychiatric colleagues. Our reticence is hurting our patients.

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Third, we should avoid having to invent the process of arranging psychiatric follow-up in the middle of a busy shift. As one of my mentors repeatedly told me: "Never think on the job!" Rather, department heads need to network with mental health or primary care specialists and establish referral pathways and protocols appropriate to local resources. Given the high prevalence of non-cardiac chest pain and PD, recognized diagnostic criteria and an established referral protocol will improve patient care and reduce emergency recidivism in a cost-effective manner. Future research should study the effectiveness of programs to identify patients with PD in reducing ED usage, and preventing complications of PD.

Finally, if PD patients are presenting to EDs because there are no better alternatives, we should advocate for improved access to mental health care access. It is the least we can do — for our patients' benefit if not for our own. Psychiatrists, like all specialists, often have waiting lists that preclude them from seeing such referrals in a timely manner, and primary care physicians willing to treat PD may be in short supply. Few provinces cover psychological services, yet cognitive-behavioural therapy has been shown cost effective in the treatment of PD.[11]

Why should emergency physicians get involved? Because it is not psychiatrists, nor cardiologists, who are there in the middle of the night when patients awaken sweaty and terrified, convinced they are dying. Like it or not, with PD (and many other conditions), the buck stops in the ED.

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