Panic Disorder in Thailand : A Report on the Secondary Data Analysis

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Abstract

Panic disorder (PD) is one of the most common psychiatric illnesses in Thailand but the picture of PD in Thailand is not clear. Therefore, the objective of this research was to review, summarize, and analyse data from research reports concerning the clinical aspects of PD in Thailand.

Relevant papers were searched comprehensively. Four groups of data including prevalence and incidence rates, sex differences, clinical symptoms during panic attacks, and scores of the Hamilton anxiety scale (HAM-A) were extracted where available. Data thus obtained were then grouped and compared.

It was found that 2.1 per cent to 12.4 per cent of patients who visited the psychiatric outpatient clinic for the first time were diagnosed as having PD. Males were affected at a similar rate to females with a ranging ratio of female : male from 1.3 : 1 to 0.67 : 1. The most common symptoms during panic attacks were palpitations, chest pain or discomfort, and dizziness or vertigo, similar to South American studies. Regarding scores of original HAM-A, mean somatic anxiety scores of PD patients who attended the cardiology clinic were significantly higher than generalized anxiety disorder patients (15.0 *vs* 9.8, $p < 0.05$). PD patients who attended the psychiatric clinic had higher mean scores of HAM-A when compared to PD patients who visited the cardiology clinic, but it was not statistically significant (27.7 *vs* 26.6, $p > 0.05$). However, the fear item of PD patients at the psychiatric clinic had significantly higher scores (2.1) than the other one (0.7).

The difference between these findings and those of Western studies may be caused by cultural factors. Thai men tend to react more promptly to panic attacks and seek medical attention while women mostly attributed their symptoms to "Air Disease". However, incidence rates from other rural areas are lacking. Before conclusions can be drawn, research on epidemiologic data in the community should be further investigated.

Key words : Panic Disorder, Panic Attack, Incidence Rate, Hamilton Anxiety Scale

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Anxiety disorders have been recognized by psychiatrists and other physicians in Thailand for many years and have been given a wide variety of names such as anxiety neuroses, neurocirculatory asthenia (NCA), anxiety states, cardiac neurosis, etc[1,2]. For some time the concept of anxiety states was considered by most Thai psychiatrists to arise from conflicts between drives and ego defenses or other psychological factors. In 1980, when the American Psychiatric Association (APA) introduced the term "panic disorder" (PD) in DSM-III,[3] Thai psychiatrists turned their interest to the importance of biological aspects of panic attacks and the separation of specific anxiety states according to their differential response to drug treatments. However, at the beginning Thai psychiatrists were reluctant to identify PD in their patients because they were not quite sure if these patients fitted the APA's diagnostic criteria of DSM-III.

In the same year that the term PD was officially accepted as a disease entity in DSM-III, Dr. Boonnum Wongchaowart, a Thai psychiatrist with a diploma from the American Board of Psychiatry and Neurology, returned to Thailand bringing with him many new American concepts including the concept of PD. Later, Dr.Waran Tanchaiswad, and Professor Tada Yipintsoi, a cardiologist, began a study of anxiety and depressive neuroses in cardiac patients[4]. It was not until 1985 that a case of PD was first reported by Dr.Pichet Udomratn in the Songklanagarind Medical Journal[5]. One year later a group of psychiatrists at Prince of Songkla University, headed by Dr.Surachai Kuasirikul and Dr.Pichet Udomratn, won a research support grant from the National Research Council of Thailand (NRCT) and The Psychiatric Association of Thailand for two research projects on PD. Since then, the number of research and review papers on this topic has gradually increased[6-21].

Although at least 15 academic articles written by Thai psychiatrists have been published in both national or international journals, the picture of PD in Thailand is not clear. The objective of this report was therefore to review, summarize, and analyse data of research papers concerning the clinical aspects of PD in Thailand.

MATERIAL AND METHOD

All articles related to panic disorder or anxiety neurosis written by Thai authors were searched through the internet at the website of the Khon Kaen Psychiatric Hospital (http//www.jrkk.go.th/library/library.html) where there is a Thai database of research and academic papers on the topics of mental health and psychiatry. If any paper was not in the list, then the researcher in this field was contacted directly. Four groups of data including prevalence and incidence rates, sex differences, clinical symptoms during panic attacks and scores of the Hamilton anxiety scale (HAM-A) were extracted where available. Data obtained were then grouped and compared. The student *t*-test or Kruskal-Wallis test for group differences were used for statistical analysis when it was appropriate.

RESULTS

1. Prevalence and incidence rates.

Epidemiologic data on panic and related disorders are important for understanding the full clinical picture of these disorders, i.e. who is at risk of becoming ill, and who may need treatment[22]. However, the available data in Thailand is based mostly on clinical sources. Though inferences about these disorders are based on limited samples of those who come to outpatient clinics in hospitals, they can give us a current picture and understanding of the epidemiology of these disorders.

Before the introduction of DSM-III, there was a study of clinical manifestations of anxiety neurosis in patients who attended the psychiatric outpatient clinic of Siriraj Hospital which is one of the biggest hospitals in Bangkok. It was found that 40 per cent (180 out of 450) of all first time patients in one year were diagnosed with anxiety neurosis according to Fieghner's research diagnostic criteria[23].

In 1983 a preliminary report on an epidemiological survey of psychiatric disorders in a Southern Thai village was published. From this report, 13.3 per cent (12 out of 90) of the village population had anxiety neurosis based on data from the Present State Examination (PSE) done by a senior psychiatrist and a psychologist. At the same time, the above sample was seen independently by another psychiatrist and it was found that 25.9 per cent (7 out of 27) suffered from anxiety neurosis according to ICD-9 classification[24].

Another report dealt with the psychiatric evaluation of patients who were regular attenders of a cardiac clinic in a municipal hospital in Southern Thailand. From this study,[4] Present State Examination (PSE) type of structured interviews were

conducted on 243 patients. Among these, there were also 60 patients who had a clinical interview performed by the psychiatrist. It was found that the incidence of both anxiety and depressive neuroses as defined by the structured interview was 19 per cent (45 out of 243), while this incidence increased to 27 per cent (16 out of 60) when evaluated by the psychiatrist who used the criteria of ICD-9[4].

After the introduction of DSM-III and when Thai psychiatrists had become familiar with this classification, data concerning specific anxiety states, especially panic and related disorders, were available.

In 1988 a one-year study of patients who attended the psychiatric outpatient clinic of Ramathibodi Hospital for the first time found that 4.1 per cent (26 out of 665) were diagnosed as having PD[25]. Later a retrospective study in newly attending patients who visited that clinic from 1986-1990 was analysed. Though the clinical sample size was extended to 5,608 patients during the 5 year period, only 120 of them, or 2.1 per cent, suffered from PD[16].

The data from our psychiatric clinic at Songklanagarind Hospital, from mid March 1990 to mid March 1991, were also analysed, and it was found that 12.4 per cent (80 out of 644) and 8.7 per cent (56 out of 644) were diagnosed as having PD and generalized anxiety disorder (GAD), respectively[15]. Table 1 shows the summary of the above findings.

2. Sex differences

As far as sex differences are concerned, both similarity and variability in rates of diagnosis are of interest. Table 2 shows a summary of data for both male and female PD patients extracted from references number 10, 15, 16, 20, and 25. The ratio of female to male was also calculated.

3. Symptoms during panic attacks

From our study at Songklanagarind Hospital,[9] the most common symptoms in 30 patients suffering from PD during panic attacks were palpitations (96.7%), chest pain or discomfort (86.7%) and dizziness or vertigo (86.7%). Most patients had

Table 1. Summary of epidemiologic data on anxiety neurosis and panic disorder.

Author	Year	Diagnosis	Rates %		Method used
Ruangtrakul S, et al.	1979	Anxiety neurosis	40	(180/450)	Feighner's RDC
Wongchaowart B and	1983	Anxiety neurosis	13.3	(12/90)	PSE
Tanchaiswad W			25.9	(7/27)	clinical interview (ICD-9)
Tanchaiswad W and	1987	Anxiety and	19	(45/243)	structured interview
Yipintsoi T		depressive neuroses	27	(16/60)	clinical interview (ICD-9)
Nilchaikovit T	1988	PD	4.1	(26/665)	clinical interview (DSM-III)
Silpakit C and	1986-1990	PD	2.1	(120/5608)	clinical interview (DSM-III)
Sukanich P					
Udomratn P	1991	PD	12.4	(80/644)	
		GAD	8.7	(56/644)	clinical interview (DSM-III-R)

RDC = Research Diagnostic Criteria, PSE = Present State Examination, GAD = Generalized Anxiety Disorder

Table 2. Number of panic disorder patients both male and female and ratio of female to male.

Site of study	Year	Female (n)	Male (n)	Ratio of female : male
Ramathibodi Hospital[25]	1988	14	21	0.67:1
Ramathibodi Hospital[16]	1986-1990	67	53	1.26:1
Songklanagarind Hospital[10]	1986-1987	17	13	1.31:1
Songklanagarind Hospital[15]	1990-1991	40	40	1:1
Saraburee Hospital[20]	1997-1998	9	12	0.75:1

9 out of 12 symptoms during panic attacks which was much more than 4 symptoms as defined in the criteria. The frequencies of the DSM-III panic attack symptoms in this clinical population are shown in Table 3.

4. Hamilton anxiety scale (HAM-A) in panic disorder patients

There are only two papers studying HAM-A in Thai PD patients[9,10]. The first paper is a retrospective analysis of HAM-A scores of 34 cardiac patients with anxiety states. From this group of patients, 10 met the DSM-III criteria for PD and 24 for GAD. It was found that the psychic anxiety in the PD group was higher than the GAD group but was not statistically significant. The GAD group had equal mean scores of both psychic and somatic anxiety, while the PD group had very high mean scores of somatic anxiety. The mean somatic anxiety scores of the PD group were significantly higher than the GAD group, especially in items of somatic-muscular, somatic-sensory, cardiovascular and respiratory symptoms. (Table 4)

Comparing the mean scores of each item on the HAM-A between PD patients who attended the cardiology clinic and those who came to the psychiatric clinic, revealed that the mean scores of both groups were quite similar, except for the fears item where PD patients who attended the psychiatric clinic had significantly higher scores than the other group. (Table 5)

DISCUSSION

Research data in Thailand shows that PD does occur in Thailand as well as other countries, with the Thai incidence ranging between 2.1 per cent - 12.4 per cent. The reason why the incidence of PD at Songklanagarind Hospital is 3 to 6 times higher than the incidence rate at Ramathibodi Hospital in Bangkok is unclear.

Psychiatrists at Songklanagarind Hospital may over-diagnose PD or, vice versa, psychiatrists in Bangkok may under-diagnose this problem. Moreover, people who live in the South may have some biological or psychological factors which are vulnerable to PD.

In terms of female to male ratio, studies in other countries, except in some Spanish-speaking populations, show that females have consistently higher rates than males[26]. However, the data in Thailand (Table 2) are not consistent with those reports.

The reasons why the number of female patients was not as high as in other countries, especially in the West, may be explained by the following possibilities[15].

1) In Thai culture, symptoms of "panic attack" which occur in women are ordinarily viewed by local people as the "Air Disease" of women. This belief is based on the idea that a human being is composed of four elements i.e.

Table 3. Percentage of patients with symptoms during panic attack, comparing Thai patients and those in other countries

Symptoms	Thailand * (% of pts.)	Other countries ** (% of pts.)
Dyspnea or shortness of breath	76.7	75.2
Palpitations	96.7	87.6
Chest pain or discomfort	86.7	60.6
Choking or smothering sensation	83.3	64.2
Dizziness	86.7	89.0
Faintness	56.7	89.0
Paresthesias	66.7	53.7
Hot or cold flashes	83.3	80.2
Sweating	83.3	75.4
Feeling of unreality	23.3	49.8
Trembling	63.3	75.8
Fear of dying	83.3	63.9
Fear of going crazy	46.7	56.6
Fear of losing control	56.7	-

* data from Udomratn P, et al. (reference number 10)

** data from Katschnig M and Amering M (reference number 26)

earth, water, air, and fire. Others believe that women will be sick if there are disturbances in "blood and air". The word "air" in Thai is "Lom", while the word "fainting" or "faintness" in Thai also have the same sound "Pen Lom". Most Thai women who have infrequent panic attacks do not go to a hospital. They and their relatives view the women as suffering from "Air Disease" and use herbal medicine called "anti-air drug" ("Ya Lom") or a decongestant inhalant. They visit doctors only if their panic attacks appear frequently or their symptoms cannot be alleviated by traditional medicine.

Table 4. Mean score of Hamilton anxiety scale in panic disorder and generalized anxiety disorder in patients attending the cardiology clinic.

No	Item	PD (N=10)	GAD (N=24)	p value
1.	Anxious mood	2.4	2.3	0.3669
2.	Tension	2.4	2.2	0.3957
3.	Fears	0.7	0.3	0.1872
4.	Insomnia	1.4	1.6	0.3812
5.	Intellectual	1.5	1.0	0.0961
6.	Depressed mood	1.2	0.8	0.0868
7.	Somatic (muscular)	2.4	1.4	0.0034*
8.	Somatic (sensory)	2.0	1.4	0.0363*
9.	Cardiovascular Symptoms	3.0	2.2	0.0294*
10.	Respiratory Symptoms	2.9	1.2	0.0001**
11.	Gastrointestinal Symptoms	1.7	1.2	0.1537
12.	Genitourinary Symptoms	1.1	0.8	0.1207
13.	Autonomic Symptoms	1.9	1.5	0.1872
14.	Behavior at interview	2.0	1.6	0.0606
	Psychic anxiety	11.6 (7-17)	9.8 (4-17)	
	Somatic anxiety	15.0* (11-18)	9.8 (0-20)	
	Total morbidity	26.6* (18-34)	19.6 (5-30)	

* $p < 0.05$
** $p < 0.001$

Table 5. Mean score of Hamilton anxiety scale in panic disorder patients who attended cardiology clinic and psychiatric clinic.

No	Item	PD at cardiology clinic (N=10)	PD at psychiatric clinic (N=30)	
1.	Anxious mood	2.4	2.3	
2.	Tension	2.4	2.4	
3.	Fears	0.7	2.1*	
4.	Insomnia	1.4	1.7	
5.	Intellectual	1.5	1.3	
6.	Depressed mood	1.2	1.2	
7.	Somatic (muscular)	2.4	2.1	
8.	Somatic (sensory)	2.0	1.8	
9.	Cardiovascular Symptoms	3.0	3.0	
10.	Respiratory Symptoms	2.9	2.5	
11.	Gastrointestinal Symptoms	1.7	1.9	
12.	Genitourinary Symptoms	1.1	1.1	
13.	Autonomic Symptoms	1.9	2.3	
14.	Behavior at interview	2.0	2.0	
	Psychic anxiety	11.6	13.0	(p = 0.6526)
	Somatic anxiety	15.0	14.7	(p = 1.0000)
	Total morbidity	26.6	27.7	(p = 0.7470)

2) An additional cultural factor may be that women suffer from many symptoms which are normally related to menstruation, menopause, or child birth so that it may take longer or be more difficult for them to identify symptoms of PD or related conditions. Additionally, PD may occur more readily at these times reinforcing the belief that they are simply "women's problems" which do not require medical treatment.

3) In Thai society, the traditional role of women is to be good housewives working only in the house, cooking food, raising their children and taking care of their husbands when they return home. If a woman suffers from either mild or severe agoraphobia it does not affect her daily life so much and, thus, does not draw attention to the need for medical help.

4) If symptoms of panic attack appear in men they tend to react more promptly and seek medical attention. As the head of the family, they are financially independent, and in a better position to seek medical advice which must be paid for.

As yet we do not have comparative studies from other rural areas of Thailand to show whether the incidence of PD in men and women is different in rural areas where the traditional life-style persists from that of urban areas, such as Bangkok, where traditional values have been undermined by a more modern life-style.

Referring to symptoms during panic attacks, it was found that palpitations was the most striking similarity when comparing our data with the data from a large international multicenter study in the "Cross- National Collaborative Panic Study Second Phase" in four different cultural groups (26,27). It seems that palpitations, the "core" symptom of PD is, in fact, universal.

Other panic attack symptoms, especially "choking and smothering sensation" and "fear of dying", were also examined. These symptoms, have been found to show a marked north/south difference, which is especially pronounced in South America but less distinct in Europe(26). Our data shows a high percentage (83.3%) of patients with choking or smothering sensation and fear of dying during panic attacks which resembles the data from Colombia, Brazil, and Mexico(26). It may well be that we share something in common with these countries. For our patients at Songklanagarind Hospital, "fear of dying" was a strong push for them to seek medical treatment(10).

Although our study was completed before the publication of DSM-III-R,(28) we still found that 26.7 per cent of patients had nausea, abdominal distress, or "air in the stomach" during their panic attacks. This agreed with the revised edition of DSM-III which added nausea and abdominal distress as one of the symptoms during attacks(28).

In terms of HAM-A in Table 4, these scores may result from the population studied who were patients already attending a cardiology clinic. Patients in this clinic had prominent somatic symptoms, especially cardiorespiratory symptoms, and decided to consult a cardiologist or had been referred by another physician. The difference in scores of HAM-A in Table 5 may reflect that patients who had rather severe psychic symptoms (including fear) were referred to psychiatric clinics, whereas, patients who had mild psychic symptoms but rather severe physical symptoms were sent to a cardiology clinic. Beitman and his colleagues hypothesized that PD patients who come to a cardiology clinic should be subtyped. One subtype is called "nonfearful panic disorder" (NFPD)(29) and is defined as patients who fit the diagnosis of PD without being required to report the experience of subjective fear. This group would have some characteristics different from the other PD subjects who reported subjective fear. However, this hypothesis should be further studied.

Finally, our clinical data show that panic attacks and PD do occur in Thailand, suggesting that at least panic attacks are universal and not just an "American disease"(26,30).

Apart from the universal occurrence of panic attacks, the differences in their clinical presentation seem noteworthy. The meaning of these differences is difficult to interpret, but, as Katschnig and Amering concluded, "they should alert clinicians carrying out scientific projects on PD in different countries to the possibility that it might not be justified to simply pool results obtained in different countries"(26).

SUMMARY

Panic disorder is one of the most common psychiatric illnesses in Thailand with a greater incidence rate at Songklanagarind Hospital in the South than at Ramathibodi Hospital in Bangkok. Unlike other studies, males are affected at a similar rate to

females. The most common symptoms during panic attacks were palpitations, chest pain or discomfort, and dizziness or vertigo as elsewhere reported. Similar to South American Studies, a high percentage of Thai patients also experienced a choking or smothering sensation and fear of dying during attacks. Regarding scores of the original Hamilton anxiety scale, it was found that mean somatic anxiety scores of PD in patients who attended the cardiology clinic were significantly higher than GAD patients, especially in items of somatic-muscular, somatic-sensory, cardiovascular and respiratory symptoms.

The difference between these findings and those of Western studies may be caused by cultural factors. The author suggests that men tend to react more promptly and seek medical attention while women and their relatives mostly attribute their symptoms to "Air Disease". Before conclusions can be drawn, more research on PD in Thailand should be undertaken.

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REFERENCES

1. Udomratn P. Panic and generalized anxiety disorders. In : Pruksachatkunakorn P, ed. Psychiatry Vol.2, 2nd ed. Chiengmai : Tanabun Press, 1991: 529-617.
2. Udomratn P. Panic disorder. In : Tantiplacheewa K, ed. Textbook of Psychiatry. Bangkok : Thammasat University Press 1993:464-74.
3. American Psychiatric Association. Diagnosis and Statistical Manual of Mental Disorders. 3nd ed. Washington, DC : American Psychiatric Association, 1980:225-39.
4. Tanchaiswad W, Yipintsoi T. Anxiety and depressive neurosis in a cardiac outpatient of a general hospital. Thai J Intern Med 1987;2:14-8.
5. Udomratn P. Panic disorder.Songkla Med J 1985; 3:317-21.
6. Udomratn P. Panic disorder : historical review. Songkla Med J 1985;3:452-6.
7. Udomratn P. From panic to agoraphobia. Songkla Med J 1986;4:126-32.
8. Udomratn P. Diagnostic criteria for panic disorder : update 1987. Songkla Med J 1987;5:222-4.
9. Udomratn P, Tanchaiswad W. Hamilton anxiety scale in panic and generalized anxiety disorders. J Psychiatr Assoc Thailand 1988;33:17-23.
10. Udomratn P, Tanchaiswad W, Kuasirikul S. Panic disorder at Songklanagarind Hospital. J Psychiatr Assoc Thailand 1988;33:107-18.
11. Kuasirikul S, Tanchaiswad W. Effect of alprazolam and diazepam in panic disorder : A double blind study. J Psychiatr Assoc Thailand 1988;33: 193-204.
12. Udomratn P. Cafergot induced panic attack in a case of panic disorder with migraine headache. J Psychiatr Assoc Thailand 1990;35:105-14.
13. Udomratn P. Clinical features of panic disorder in Thailand. In : Panic disorders, the role of alprazolam. Hong Kong : Excerpta Medica Asia, 1991:13.
14. Udomratn P. Panic disorder in the menopause : a psychiatric illness that gynecologists should not overlooked. Abstract of the 2nd Pan-Pacific Congress of Psychosomatic Obstetrics and Gynecology. Korea : Pusan, 1991:60.
15. Udomratn P. Anxiety disorders at Songklanagarind Hospital from 1990-1991. data presented at an International Symposium on Panic disorder at Goodwood Park Hotel, Singapore. June 18, 1991.
16. Silpakit C, Sukanich P. Panic disorder : diagnosis and treatment by non-psychiatrist physician. J Psychiatr Assoc Thailand 1992;37:182-90.
17. Assanagkornchai S, Udomratn P. Knowledge, attitude and practice towards psychiatric illness in Thai panic disorder patients. ASEAN J Psychiatry 1993;3:11-9.
18. Udomratn P. Moclobemide treatment in a depressed patient with panic attacks and obsessional thoughts. ASEAN J Psychiatry 1994;4:29-35.
19. Udomratn P. Efficacy of SSRIs in panic disorder. Abstract of the 5th ASEAN Federation for Psychiatry and Mental Health Congress. Indonesia : Bandung, 1995:87.
20. Sukhawana S. Ethyl loflazepate in the treatment of panic disorder. J Psychiatr Assoc Thailand 1998;43:336-44.
21. Ekasawin S. Panic disorder in children and adolescents : a review and case report. J Psychiatr Assoc Thailand 1999;44:65-72.
22. Weissman MM. Epidemiology of panic disorder

and agoraphobia. In : Ballenger JC, ed. Clinical Aspects of Panic Disorder. New York : Wiley-Liss, 1990:57-65.
23. Ruangtrakul S, Srisangnam U, Tongtang O, et al. Anxiety neurosis : Clinical features in 180 patients. J Psychiatr Assoc Thailand 1979;24:283-90.
24. Wongchaowart B, Tanchaiswad W. Epidemiological survey of psychiatric disorder in a Southern Thai village : A preliminary report. J Psychiatr Assoc Thailand 1983;28:115-26.
25. Nilchaikovit T. Round table discussion on panic disorder. In : Symposium proceedings and panel discussion on "panic disorder : an update". Hong Kong : Excerpta Medica Asia, 1988:15-28.
26. Katschnig H, Amering M. Panic attacks and panic disorder in cross-cultural perspective. In : Ballenger JC, ed. Clinical Aspects of Panic Disorder. New York : Wiley-Liss, 1990:67-80.
27. Klerman GL. The Cross-National Collaborative Panic Study. Arch Gen Psychiatry 1988;45:407-12.
28. American Psychiatric Association. Diagnosis and Statistical Manual of Mental Disorders. 3rd ed., revised. Washington, DC : American Psychiatric Association, 1987:235-53.
29. Beitman BD, Mukerji V, Flaker G, Trombka LH, Basha IM. Panic disorder in cardiology patients with atypical chest pain. In : Ballenger JC, ed. Clinical Aspects of Panic Disorder. New York : Wiley-Liss, 1990:111-37.
30. Lepine JP, Pelissolo A. Epidemiology, comorbidity and genetics of panic disorder. In : Nutt DJ, Ballenger JC, Lepine JP, eds. Panic disorder : Clinical diagnosis, management and mechanisms. London : Martin Dunitz, 1999:9-23.

โรคแพนิคในประเทศไทย : รายงานการวิเคราะห์ข้อมูลทุติยภูมิ

*พิเชฐ อุดมรัตน์, พ.บ.**

วัตถุประสงค์ เพื่อทบทวน สรุป และวิเคราะห์ข้อมูลที่ได้จากงานวิจัยเกี่ยวกับโรคแพนิคในประเทศไทย ใน 4 หัวข้อคือ ความชุกและอุบัติการณ์, ความแตกต่างเรื่องเพศ, อาการที่เกิดขึ้นขณะมี panic attack และคะแนนของ Hamilton anxiety scale (HAM-A)

วิธีการ สืบค้นจากฐานข้อมูลที่มีอยู่ในประเทศไทย และสอบถามจากผู้นิพนธ์โดยตรง เพื่อหาบทความที่เกี่ยวข้องกับโรคแพนิค แล้วนำข้อมูลที่ได้ใน 4 หัวข้อมาจัดกลุ่มและเปรียบเทียบกับรายงานในต่างประเทศ สถิติที่ใช้คือร้อยละ และหากสามารถเปรียบเทียบข้อมูลระหว่างสองกลุ่มได้จะใช้ student *t*-test หรือ Kruskal – Wallis test

ผล พบอุบัติการณ์ของโรคแพนิคในคลินิกจิตเวชผู้ป่วยนอก เป็นจำนวนร้อยละ 2.1 ถึง 12.4 โดยพบพอ ๆ กันทั้งผู้หญิงและผู้ชาย อัตราส่วนระหว่างหญิงต่อชายอยู่ในช่วงตั้งแต่ 1.3:1 ถึง 0.67:1 โดยอาการที่พบมากที่สุดขณะเกิด panic attack คือใจสั่น, เจ็บหน้าอกหรือแน่นอึดอัด, มึนงงหรือวิงเวียน ส่วนคะแนนของ HAM-A นั้น พบว่าผู้ป่วยโรคแพนิคที่ไปตรวจที่คลินิกโรคหัวใจจะมีค่าเฉลี่ยของ somatic anxiety สูงกว่า ผู้ป่วยโรคกังวลทั่วไปอย่างมีนัยสำคัญทางสถิติ (15.0 *vs* 9.8, $p < 0.05$) แต่ผู้ป่วยโรคแพนิคที่ไปตรวจที่คลินิกโรคหัวใจนั้นจะมีคะแนนเฉลี่ยไม่ต่างจากผู้ป่วยโรคแพนิคที่มาตรวจที่คลินิกจิตเวช ยกเว้นในข้อ (item) ของความกลัว (fear) เท่านั้น ที่พบว่าผู้ป่วยโรคแพนิคที่มาคลินิกจิตเวชมีคะแนนสูงกว่ามาก (2.1 *vs* 0.7)

สรุป โรคแพนิคเป็นโรคจิตเวชที่พบได้บ่อยโรคหนึ่งในประเทศไทย ข้อมูลทางคลินิกหลายอย่างเหมือนกับที่มีรายงานในต่างประเทศ เช่น อาการใจสั่น ซึ่งเป็นอาการที่พบมากที่สุดขณะเกิด panic attack อย่างไรก็ตาม การที่ผู้ป่วยเพศชายมาพบแพทย์ได้มากพอ ๆ กับเพศหญิง ซึ่งแตกต่างจากที่มีรายงานในต่างประเทศนั้น อาจเป็นเพราะปัจจัยทางวัฒนธรรมหลายประการ เช่น อาการ panic attack นี้เมื่อเกิดในผู้หญิงมักถูกมองว่าเป็น "โรคลม" ในขณะที่ผู้ชายจะมาพบแพทย์ได้รวดเร็วกว่าเมื่อมีอาการดังกล่าว ผู้วิจัยได้เสนอให้ศึกษาเรื่องระบาดวิทยาของโรคแพนิคโดยเฉพาะในชุมชนและในชนบทเพิ่มเติมอีกต่อไป

คำสำคัญ : โรคแพนิค, Panic Attack, อุบัติการณ์, Hamilton Anxiety Scale

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