신체장애와 공존하는 불안장애의 감별과 치료

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내 용

- 신체장애 또는 타과진료 에서 불안장애의 중요성
- 신체장애에서 불안 및 불안장애의 원인
- 신체장애에서 불안 및 불안장애의 치료

Prevalence of AD in General Population and Primary Care

- General population
  - 15% lifetime prevalence (ECA)
  - 17% in past year (NCS)
- Medical Setting
  - any current anxiety disorder : 15%
  - 33% of primary care patients showed heightened anxiety symptoms or disorders

Arch Gen Psychiatry 1994;51:8-19, Gen Hosp Psychiatry 1998;20:21-28
Arch Gen Psychiatry 1994;51:740-750, J Gen Intern Med 2002;17:165-172

AD is Misdiagnosed in Primary Care

- 1/5 to ½ of psychiatric problem are not recognized or are misdiagnosed in the primary care setting
- The majority of PD cases remain undiagnosed, in part, because many patients present with somatic, not psychological symptoms
- 94% of patients are correctly diagnosed if the presenting complaint is anxiety and depression

Br J Gen Pract 1994;44:352-356,
Gen Hosp Psychiatry 2005;25:74-82

Patients with Anxiety do not present to Mental Health Providers

- 48% of all anxiety disorders to primary care physician
- High prevalence of AD in chronic physical illness (arrythmia, heart disease, diabetes, hypertension)
- Do not receive appropriate care for anxiety in primary care setting
- lack of skill or time to treat anxiety
- Reluctant to consider either psychosocial or pharmacological treatment in primary care patients

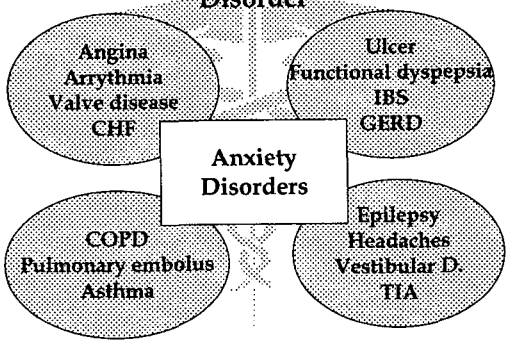
J Gen Intern Med 2002;17:165-172, Arch Gen Psychiatry 2001;58:55-61
Gen Hosp Psychiatry 2002;24:316-321

Delayed Diagnosis of AD and High Utilization of Health Care Resources

- PD patients have 3 times the number of visits of average medical patients
- PD patients are often evaluated by 10 physician before the diagnosis is made
- Often 10 years elapse before PD is diagnosed
- Significant symptom overlap

Am J Psychiatry 1991;148:1494-1500,
Br J Gen Pract 1994;44:352-356

Overlap between AD and Physical Disorder



If not treat Anxiety in the Medical Setting ?

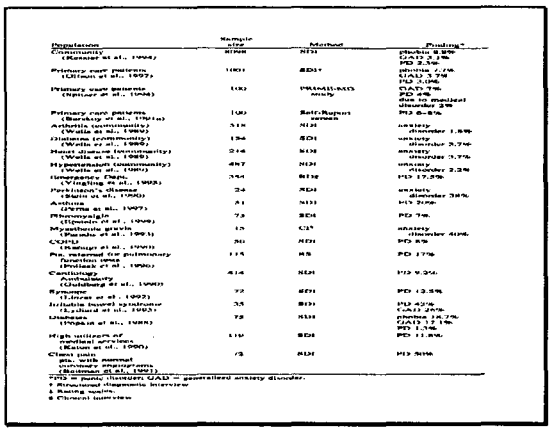
- Impair functioning and well-being
- Risk factor for the development of medical illness and may exacerbate some conditions
  - phobic anxiety -> fatal CAD, HET
- Poor adherence to medical treatment
- Refuse diagnostic procedures or surgery
- Out of the hospital against medical advice

Arch Intern Med 2000;160:2101-2107
Psychosom Med 2001;63:221-230

Normal Anxiety VS Pathologic Anxiety ?

- Normal anxiety : transient response to stress, necessary cue for adaptation and coping
- Pathologic anxiety
  - autonomy
  - intensity
  - duration
  - behavior

  " impair coping, normal function is disrupted, avoidance or withdrawal "



Paradigms of Interactions between Physical Illness and Anxiety Disorder

- Physical Illness → Anxiety (transient)
- Physical Illness → Anxiety Disorders
- Anxiety Disorders → Physical Illness
- Physical Illness ↔ Anxiety Disorders

Anxiety or AD as a Psychological Reaction to the Experience of Illness

- Uncertainty regarding medical diagnosis
- Uncertainty regarding medical prognosis
- Anxiety about one's body
- Fear of death
- Anxiety about the impact of illness on identity and livelihood
- Anxiety regarding strangers and being alone in the hospital
- Anxiety regarding negative reactions from physicians

Anxiety Resulting from Traumatic Procedures

- Serious medical illness and invasive procedure producing marked anxiety reaction
- Association with PTSD
  - myocardial infarction and coronary artery bypass graft
  - treatment of breast cancer
  - * 5-10% → 30-40% hospitalized after traumatic physical injuries
  - * traumatic event ; uncontrollable and life-threatening

J Consult Clin Psychol 1995;63:981-986
Am J Psychiatry 2002;159:941-946

Anxiety Interfering with Evaluation and Treatment

- Refusal of work-up or treatment
  - Fear of pain or discomfort
  - Catastrophic interpretation of physical symptoms or of the planned work-up (they're looking for cancer)
  - Need to minimize or deny a potentially serious condition

Chronic Physically Ill and Anxiety Sensitivity

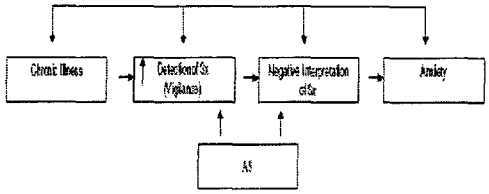


TABLE 1. Prevalence of chronic illnesses and elevated AS

Chronic illness[a]	Prevalence in sample	Overall model	P	ASI physical Wald statistic*	ASI physical Odds ratio	95% Confidence Interval
Hypertension	33.2% (n = 121)	$\chi^2(6)=37.9$, $R^2=.22$	<.0001	14.37*	2.71	1.61–4.54
Heart Disease	11.2% (n = 31)	$\chi^2(6)=78.32$, $R^2=.38$	<.0001	7.56*	2.58	1.31–5.09
Cholesterol	31.2% (n = 86)	$\chi^2(6)=50.18$, $R^2=.26$	<.0001	7.46*	1.98	1.21–3.22
Kidney Disease	2.2% (n = 6)	$\chi^2(6)=4.62$, $R^2=.10$	.57	1.87	2.34	.52–9.95
Cancer	4.7% (n = 13)	$\chi^2(6)=19.86$, $R^2=.23$	.261	.93	.57	.19–1.73
Lung Disease	11.2% (n = 31)	$\chi^2(6)=9.48$, $R^2=.09$	.21	.76	.75	.40–1.42
Arthritis	19.6% (n = 54)	$\chi^2(6)=36.60$, $R^2=.21$	<.0001	.55	1.26	.63–1.77
Diabetes	9.1% (n = 25)	$\chi^2(6)=10.72$, $R^2=.09$	.12	1.53	1.47	.78–2.66

[a]Coded as 1 for illness present and 0 for no illness. Total N greater than total number of sample because some participants had more than one chronic illness. AS = anxiety sensitivity.
*P < .00625.

TABLE 4. Vitality in relation to physical and total anxiety sensitivity (AS) in the chronically ill

Group/Variable	Adjusted R^2	F	b	t	P
Hypertension	.21	6.57***			
Physical AS			-.20	-1.27	.08
Age			.05	.56	.59
Gender			.06	.86	.37
Neuroticism			-.35	-2.94	.003
Hypertension	.24	7.53***			
Total AS			-.28	-2.37	.02
Age			-.01	.15	.89
Gender			-.07	.90	.36
Neuroticism			.30	-2.48	.01
High Cholesterol	.42	14.19***			
Physical AS			-.18	-1.85	.06
Age			-.17	-1.88	.06
Gender			.04	.40	.65
Neuroticism			-.46	-5.13	.00
High Cholesterol	.44	15.19***			
Total AS			-.26	-2.34	.02
Age			-.17	-1.74	.08
Gender			.03	.37	.70
Neuroticism			-.56	-5.11	.00

***P < .0001.

Medical Illness Mimicking Anxiety Disorder

- Medical Illness cause anxiety symptoms
  - 25% neurological problem
  - 25% endocrinologic cause
  - 12% circulatory, rheumatoid-collagen vascular disorder and chronic infection
  - 14% miscellaneous
- Directly producing anxiety – temporal lobe tumor and hyperthyroidism
- Other medical condition – autonomic arousal and interpret as a psychological state

Psychosom med 1979;41:331-40

Medical Anxiety VS PrimaryAnxiety ?

- Medical cause anxiety
  - lack of personal or family history, lack of psychosocial stressors, later age onset
  - disproportionate physical symptoms(marked dyspnea, tachycardia or tremor)
  - atypical physical symptoms(syncope, confusion, focal neurological symptoms)
- Primary anxiety
  - emotional trauma related to the onset of anxiety
  - daily symptoms
  - neurotic feature
  - gradual resolution of symptoms after an attack

Compr Psychiatry 1962;3:129-151

Medical Condition associated with Anxiety Symptoms

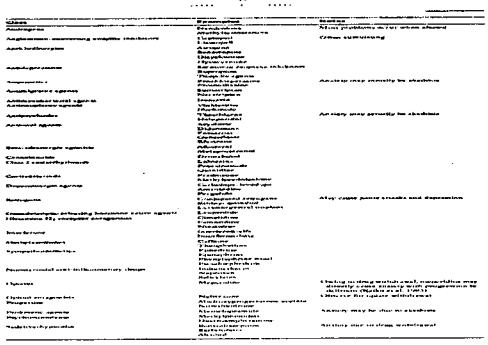
CARDIOVASCULAR CONDITIONS	NEUROLOGIC CONDITIONS
Angina pectoris	Akathisia
Arrhythmias	Encephalopathy
Congestive heart failure	Mass lesion
Hypovolemia	Postconcussion syndrome
Myocardial infarction	Seizure disorder
Valvular disease	Vertigo
ENDOCRINE CONDITIONS	PEPTIC ULCER DISEASE
Carcinoid syndrome	RESPIRATORY CONDITIONS
Hyperadrenalism	Asthma
Hypercalcemia	Chronic obstructive pulmonary disease
Hyperthyroidism	
Hypocalcemia	Pneumothorax
Hypothyroidism	Pulmonary edema
Pheochromocytoma	Pulmonary embolism
METABOLIC CONDITIONS	IMMUNOLOGIC CONDITIONS
Hyperkalemia	Anaphylaxis
Hyperthermia	Systemic lupus erythematosus
Hypoglycemia	
Hyponatremia	
Hypoxia	
Porphyria	

*Partial listing.

Substance Induced Anxiety

- Medication or medication withdrawal
- Caffeine
  coffee 150mg, tea 50-100mg, cola 40-50 mg/12oz]
  chocolate bar 12-25mg
  OTC medication(Excedrin)
- OTC sympathomimetics(for example, pseudoephedrine) nasal spray, herbal preparation ephedra

Substance that may cause Anxiety



Treatment Anxiety in the Medically Ill

- **Psychotherapy**
  - supportive therapy
  - cognitive-behavioral therapy
  - psychodynamic therapy
- **Pharmacotherapy**
  - benzodiazepines
  - antidepressants
  - antipsychotics
  - buspirone
  - beta-blocker
  - antihistamine
  - anticonvulsants

Medication	Route	Dosage	Elimination half-life	Comments
Alprazolam	Oral	0.25–1.0 mg tid	9–20 hours	Rapid onset. Interdose withdrawal a problem, but new extended-release form is available.
Chlordiazepoxide	Oral, intramuscular	5–25 mg qid	28–100 hours (including metabolites)	Useful for alcohol withdrawal.
Clonazepam	Oral	0.25–1 mg bid–tid	19–60 hours	Also used for absence seizures, periodic leg movements, and neuropathic pain.
Diazepam	Oral, intravenous	2–10 mg qid	30–200 hours (including metabolites)	Also used as an anticonvulsant and muscle relaxant.
Lorazepam	Oral, intramuscular, intravenous	0.5–2.0 mg up to qid	8–24 hours	Intravenous availability is an advantage. Metabolized by conjugation. Also approved for chemotherapy-related nausea and vomiting.
Midazolam	Intramuscular, intravenous	Intramuscular: 5 mg single dose Intravenous: 0.02–0.10 mg/kg per hour	1–20 hours (including metabolites)	Used for preoperative sedation and intravenous induction.
Oxazepam	Oral	10–30 mg qid	3–25 hours	Metabolized by conjugation. May also be useful for alcohol withdrawal.

Source. Adapted from *Physician's Desk Reference* 2003; Berchtlbuyk-Butler and Jeffries 2002.

Self-Regulation Methods

- Muscle relaxation
- Electromyographic biofeedback
- Meditation and the relaxation

결 론

- 신체 질환과 불안은 밀접한 연관이 있으나, 임상 특히 타과에서 불안이 잘 인식되지 못하고 있고 치료 역시 부적절하게 받고 있다.
- 불안을 유발하는 신체 질환 및 약물에 대한 이해가 필요하고, 신체 질환에 대한 심리적 반응을 이해하는 것이 불안을 치료하는데 필요하다.
- 정신약물치료와 정신사회적 치료는 신체 질환 환자에서 나타나는 불안을 경감시키고, 이는 신체 질환의 예후에 매우 중요하다.
- 신체질환에서 불안에 대한 주의 깊은 평가와 치료가 중요하다.