Duloxetine in the treatment of panic disorder

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An extensive list of medications for the treatment of panic disorder (PD) was made available in recent years, including the selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and benzodiazepines. However, both SSRIs and tricyclics have an initial activation and a long latency period of response, while benzodiazepines may induce abusive utilization or sedation. Duloxetine is a new drug with selective serotonin and norepinephrine reuptake inhibitor (SSNRI) antidepressant profile. The efficacy of this agent in the treatment of a broad spectrum of symptoms associated with depression, including anxiety and physical symptoms (Dunner et al., 2003) suggests that this compound may be effective in the treatment of PD. We report for the first time, to our knowledge, a case of a patient with PD successfully treated with duloxetine as evaluated by standardized clinical rating scales.

Ms. A., a 26-yr-old woman presented to the psychiatry outpatient unit with a history of 3 months of panic attacks with agoraphobia. The attacks were unexpected and were characterized by palpitations, dypnea, shaking, chest pain, fears of losing control and dying. The episodes had a duration of 15–20 min and occurred 3 to 4 times daily, and agoraphobia prevented her from going to public places alone. The patient met DSM-IV criteria for PD with agoraphobia, as assessed by the Portuguese version (Del-Ben et al., 2001) of the SCID-CV (First et al., 1997). She had no other comorbid condition. Ms. A. received various medications, including fluoxetine, paroxetine, sertraline, citalopram, clomipramine and bromazepan. During the treatment with these medications she presented either cholinergic symptoms (clomipramine), sedation (bromazepan), or paradoxical dysphoria (SSRIs), which precluded adequate drug trials. Escitalopram (30 mg/d for 2 months) had no effect on the symptoms. Duloxetine (60 mg/d) was then introduced, leading to a total disappearance of panic attacks within 1 wk. Panic and Agoraphobia Scale (PAS; Bandelow, 1995) baseline score decreased from 33 to 11 and 2 after 1 wk and 1 month respectively. Clinical Global Impression scale (CGI; Guy, 1976) scores confirmed the above outcome (from 6 to 3 and 1 respectively). A 3-month follow-up showed no relapse of the symptoms, although 0.5 mg/d of clonazepam needed to be introduced due to insomnia (probably a side-effect of duloxetine).

The observation that both serotonergic and noradrenergic activity is important in the pathophysiology of PD raises the issue of the possible efficacy of SSNRIs, as they affect both systems. Former studies showed that venlafaxine, another representative of SSNRIs, could be an option for PD even for refractory patients (Geraciotti, 1995) and at relatively low doses (Papp et al., 1998; Pollack et al., 1996). Our case thus confirms a potential usefulness of SSNRIs, and suggests that duloxetine may also be effective for the treatment of PD. Moreover, the rapid disappearance of panic attacks raises the possibility that this antidepressant may have an unusually fast onset of action. However, duloxetine might currently be considered a second-line treatment for PD cases like this that fail to respond to or tolerate other better-documented treatment options, since controlled studies would be necessary to further confirm these observations.

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Statement of Interest
J.A.S.C. has undertaken paid advisory and lecture work for Janssen, Wyeth, Eli Lilly, and Lundbeck.

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