



HKCPMA Newsletter

Official newsletter of the Hong Kong Community Psychological Medicine Association



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Message from the Chairman



Dr Lee Fook Kay, Aaron

At the time of writing, we are already under the shadow of the H1N1 influenza pandemic. During this period, the WHO considers the overall severity of the influenza pandemic to be moderate. This assessment is based on scientific evidence available to WHO, as well as input from its member states on the pandemic's impact on their health systems, and their social and economic functioning.

From the Hong Kong Special Administrative Region Government's perspective, there is most concern about serious cases and flu-related deaths occurring in young people, including in the previously healthy, those with pre-existing medical conditions and pregnant women.

According to clinical psychologists, the general public reaction to a pandemic is a mixture of uncertainty and anxiety about the future. Thus, for the next few weeks to several months, we must expect that many people will be worried – about themselves and their families getting infected, about the possible worsening of the economy and loss of jobs – and feeling helpless about their future. This might be particularly true among high-risk groups like healthcare workers and flight attendants.

How should we prepare psychologically for a pandemic?

Here are the "3Rs" for you and your patients:

1. Be **Realistic** – Maintain a realistic perception about the situation. Refer to reliable, mainstream news sources or medical advice from our government rather than the popular mass media. But, be realistic, not overly optimistic!
2. Be **Reasonable** – Engage in reasonable precaution. Be vigilant (but not over-vigilant) of personal, home and environmental hygiene. Continue with your daily operations as normal.

3. Be **Reassuring** – Let your patients express their concern. Clarify their queries. Equip them with proper knowledge.

What if the situation worsens?

Here are the "4As" for you and your patients:

1. **Attend**... the latest pandemic information; the various ways of protecting ourselves and others; and personal stress reactions.
2. **Adjust**... habits/lifestyle in relation to the latest pandemic condition; perception of vulnerability; and stress relief tactics.
3. **Avoid**... both physical and mental exhaustion; over-correction of personal lifestyle or habits; overwhelming yourself and your patients with excessive information.
4. **Assist**... patients who are easily anxious; your colleagues and accept help from each other; **YOURSELF** and take care of your own health!

I wish to share with you news about recent HKCPMA small-group discussions that were held on 26 May 2009, sponsored by Wyeth. In the Tsim Sha Tsui session, a full table of enthusiastic family doctors discussed their cases on managing patients with psychological problems in the community. There were numerous interesting questions for Dr Lee Tak Shing, our honorary psychiatrist consultant tutor for the Tsim Sha Tsui tutorial group, who facilitated the session. At the same time, two similar sessions were led by Dr Lo Chun Wai in Central and Dr Chiu Siu Ning in Kowloon. Hopefully, our HKCPMA members enjoy these invaluable opportunities to discuss challenging clinical cases face-to-face with devoted community psychiatric tutors, within an effective support-group format, and will continue to participate in the future. I must take this opportunity to thank Dr Peter Ng Chin Wang for being the adviser to the three groups he supervises continuously.

Another HKCPMA continuous medical education (CME) activity will be held on 25 September 2009. The topic will be "Achieving Remission in the Treatment of Major Depressive Disorder" (please see *Upcoming Events*, overleaf). It will be an honour to have Professor

Siegfried Kasper (Professor and Chairman of the Department of Psychiatry, Medical University of Vienna, Austria) as our speaker. Professor Kasper is a frequent national and international speaker, and is actively involved in research programmes studying psychopharmacology in depression, anxiety, psychosis and dementia.

Now to this issue of the HKCPMA newsletter, which focuses on anxiety disorders. We have an excellent interview with Dr Ronald Chen Yuk Lun, an experienced psychiatric tutor for the Postgraduate

Diploma course in Community Psychological Medicine (since 2003), in which he provides insight into the topic of anxiety disorders, and shares a case on treating panic disorder that I hope you will find useful.

Enjoy this issue and I look forward to seeing you during forthcoming CME meetings in mid 2009. Remember to protect yourselves and your patients from panic in a pandemic!

Dr Aaron Lee Fook Kay
Chairman, HKCPMA

HKCPMA Events

Friday, 26 June 2009

Time: 09:00–16:30

Topic: Seminar on Psychotherapy for People with Personality Disorders

Speakers: Professor Mak Ki-Yan; Dr Wilson Tsui; Dr Frenzi Li

Venue: Room 302, The Salvation Army Education & Development Center, No 6, Salvation Army Street, Wanchai, Hong Kong

Registration fee: HK\$700 (HKCPMA members); HK\$900 (non-members)

Organized by: The International Society of Chinese Applied Psychology, Hong Kong, Macau and Taiwan Branch Society

Co-organized by: The Hong Kong Medical Association; The Hong Kong Community Psychological Medicine Association; The Mental Health Association of Hong Kong; The Hong Kong College of Mental Health Nursing

Poster of seminar available at: www.hk-iscap.net/Seminar.html

Wednesday, 26 August 2009

Time: 13:00–15:30

Topic: New Treatment Options for Depression from the GP Perspective

Speaker: Dr Mak DP Arthur

Moderator: Dr Sammy Tsoi Lai To

Venue: 6th Floor, Function Room, Hong Kong Jockey Club, Shatin Club House

Friday, 25 September 2009

Time: 13:00–15:30

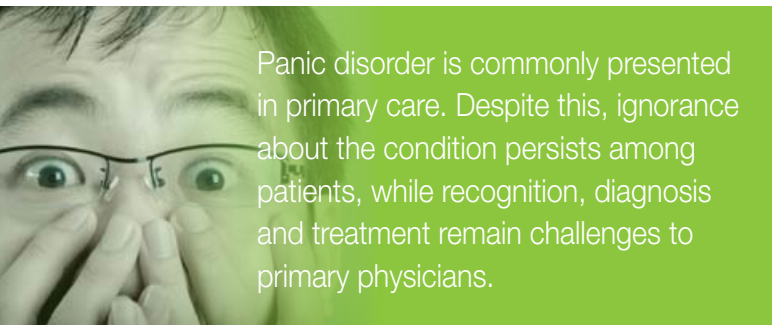
Topic: HKCPMA CME Lecture on “Achieving Remission in the Treatment of Major Depressive Disorder”

Speaker: Professor Siegfried Kasper

Chairman: Dr Aaron Lee Fook Kay

Sponsored by: Eli Lilly

Panic in the Community



Panic disorder is commonly presented in primary care. Despite this, ignorance about the condition persists among patients, while recognition, diagnosis and treatment remain challenges to primary physicians.

Panic disorder – frequent in primary care, often misunderstood

Panic disorder is an anxiety disorder with a significant healthcare burden that frequently presents in general practice.¹ Yet, it largely remains under-recognized and under-treated.^{1–3} The onset of panic disorder has two peaks: one in late adolescence and one in the mid thirties of life.⁴ The condition runs in families and affects twice as many women as men.⁴ Most patients follow a pattern of remission–relapse, although up to 20% will have a chronic course of illness.⁴

In the USA, the 12-month and lifetime prevalence of panic disorder were reported to be 2.1% and 5.1%, respectively,⁵ while in Europe, the 12-month prevalence of panic disorder with agoraphobia was 1.8%.⁶ A similar prevalence in Hong Kong was determined from a 2005 telephone survey of 10,302 households, which had a 29.1% response rate.⁷ This study reported that 3.89% of participants had panic disorder in the last 6 months, while 14.9% had subthreshold panic disorder.⁷

Of the Hong Kong subjects with panic disorder who sought medical treatment, the majority (44.4%) first consulted a general practitioner (GP).⁷ Almost one fifth (18.8%) had previously visited an emergency room for their symptoms.⁷ However, of those who received any medical attention, an overwhelming 92.9% were not given a physical cause for their symptoms, and 81.8% continued to worry about their health after seeing the doctor.⁷ This finding underscores the unmet need in panic disorder management within the Hong Kong community.

Diagnose panic disorder based on positive identification

The diagnosis of panic attacks and panic disorder in primary care should depend on a positive identification of symptoms and impact on functioning, and not only on elimination of other conditions.³ Specific diagnostic criteria are outlined in the Table.^{3,4,8}

The presentation of symptoms are often cardiac or respiratory in nature, and cause serious concern for both patients and GPs alike – it is not uncommon for patients to mistake their symptoms for a heart attack.^{3,4} In the Hong Kong prevalence study, panic disorder sufferers had a similar symptom profile to that reported in Western counterparts, with palpitations and chest discomfort being among the most commonly reported.⁷

Conditions that can mimic or cause panic attacks, such as hyper- and hypothyroidism, temporal lobe epilepsy, asthma, cardiac arrhythmias and pheochromocytoma, should be excluded.⁴ Likewise, excessive caffeine (or other stimulant) intake, alcohol withdrawal and high-dose corticosteroid treatment should be ruled out as causes of panic attacks.⁴

Table. Diagnostic criteria for panic attack and panic disorder, with or without agoraphobia^{3,4,8}

Panic attack	<p>A discrete period of intense fear or discomfort in which 4 or more of the following symptoms developed abruptly and reached a peak within 10 minutes:</p> <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> • Chest pain or discomfort • Shortness of breath or smothering • Palpitations, pounding heart or accelerated heart rate <p><u>Neurological</u></p> <ul style="list-style-type: none"> • Trembling or shaking • Parasthesias (numbness or tingling) • Feeling dizzy, unsteady, light-headed or faint <p><u>Autonomic</u></p> <ul style="list-style-type: none"> • Sweating • Chills or hot flushes <p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> • Choking feeling • Nausea or abdominal distress <p><u>Psychiatric</u></p> <ul style="list-style-type: none"> • Derealization (feeling of unreality) or depersonalization (being detached from oneself) • Fear of losing control or going crazy • Fear of dying
Panic disorder	<p>Recurrent, unexpected panic attacks, followed by 1 or more of the following for at least 1 month:</p> <ul style="list-style-type: none"> • Persistent concern about having additional attacks • A significant change in behaviour related to the attacks <p><i>Panic attacks not due to physiological effects of a substance or medical condition, and are not better accounted for by another mental disorder</i></p>
Panic disorder with agoraphobia	<p>Panic disorder accompanied by agoraphobia or anxiety about being in situations in which escape might be difficult (or embarrassing) or in which help might not be available in the event of having a panic attack</p>

Who is the panic disorder patient?

People with panic disorder are high utilizers of medical services.² In the Hong Kong study, respondents with panic disorder spent an average of US\$1,189 on medical consultation and physical check-ups in the last 6 months, and 3% spent more than US\$10,000.⁷ Also, patient populations with chronic respiratory disorders, cardiac problems or gastrointestinal conditions are often associated with a higher frequency of panic disorder.^{2,4} While screening of panic disorder is not generally recommended, the exception may apply for higher risk groups.⁴ Importantly, most panic disorder patients will experience another psychiatric illness in their lifetime. For community patients, depression, generalized anxiety disorder and agoraphobia are among the most common psychiatric comorbidities, while many may also abuse alcohol.⁴

Pharmacotherapy is the cornerstone of treatment in primary care

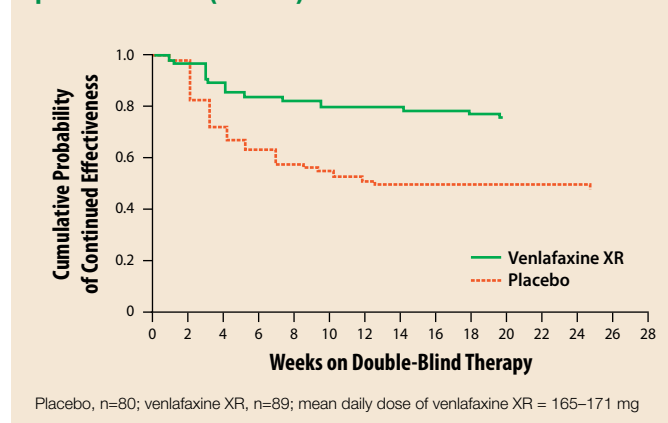
In general practice, pharmacological intervention remains the cornerstone of treatment.³ Psychotherapy, specifically cognitive behavioural therapy, alone or in combination with pharmacological approaches, also plays an effective role in panic disorder treatment.^{9,10}

In Hong Kong, selective serotonin reuptake inhibitors (SSRIs; escitalopram, paroxetine, sertraline) and the selective serotonin noradrenaline reuptake inhibitor (SNRI) venlafaxine XR are approved as first-line therapies for panic disorder.¹¹ A meta-analysis of trials involving SSRIs in panic disorder showed that these agents were significantly effective in improving symptoms of global anxiety and depression versus placebo.¹²

Of the SNRI antidepressants, only venlafaxine XR is approved for panic disorder in Hong Kong. A large, placebo-controlled trial of venlafaxine XR (75–225 mg daily) in patients with panic disorder showed

that active treatment led to significantly greater improvement in global severity of panic, anticipatory anxiety, and fear and avoidance of social activities than placebo.¹³ Furthermore, another study showed that venlafaxine XR was safe, well tolerated and significantly more effective than placebo in preventing relapse ($p < 0.001$) (Figure).¹⁴ Secondary measures of treatment efficacy, quality of life and disability were also significantly improved with venlafaxine XR versus placebo ($p \leq 0.005$).¹⁴

Figure. Kaplan-Meier survival analysis of time to relapse in ITT population during double-blind phase of trial (N=169)¹⁴



Optimizing management in primary care

As a means to improving treatment adherence, GPs may find it useful to provide the following five messages to their patients when they first prescribe medication³:

1. Take the medication every day
2. Allow 2–4 weeks for results to appear
3. Continue taking the medication even if improvement occurs
4. Do not discontinue treatment without contacting the doctor
5. Call the doctor with any treatment-related problems

Beyond this, two factors – patient engagement and a collaborative approach to the process of care – may be crucial for ensuring optimal outcomes in the management of panic disorder in primary care.²

Conclusions

As Lee, et al, of the Hong Kong study concluded in 2005, “Because panic disorder is common, impairing yet highly treatable, our findings call for immediate public health intervention in Hong Kong.”⁷ Being the doctors to whom sufferers most commonly first present, GPs undoubtedly have a window of opportunity for more effective management of panic disorder in the community. This should comprise heightened awareness of typical patient and symptom profiles, accurate diagnosis and appropriate treatment strategies for this debilitating mental condition.

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Managing Anxiety in Hong Kong

An interview with Dr Ronald Chen



Dr Chen is a Specialist in Psychiatry and Honorary Clinical Assistant Professor in the Department of Psychiatry, Faculty of Medicine, University of Hong Kong.

Anxiety disorders, which include generalized anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder, posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD), comprise some of the psychiatric illnesses most frequently encountered in general practice.

Despite this, many Hong Kong patients continue to 'suffer in silence' or seek medical help only for physical symptoms. As Dr Ronald Chen explained, this is largely due to "Chinese people being unwilling to talk about their emotions and feelings. They talk to doctors about physical symptoms, but they might not be able to disclose their psychological trauma."

Physical discomfort and excessive worrying or anxiety are the major signs and symptoms of anxiety disorders. As Dr Chen described, anxiety disorders can mimic various kinds of disease and involve various body systems. Gastrointestinal symptoms include diarrhoea, epigastric discomfort, abdominal pain and nausea; cardiovascular symptoms include increased pulse and blood pressure, and chest tightening; and respiratory symptoms include breathing difficulties. Hand tremor, muscle tightness and headache are also common.

Anxiety symptoms can be considered to lie on a spectrum of increasing severity. Obviously, perfectly healthy people can also experience anxiety and stress occasionally without having a psychiatric condition. The difference is that, in patients with overt disease, relief from excessive worry or anxiety is near-impossible without medical intervention.

In Dr Chen's view, "GPs are very important gatekeepers. They see patients in the community on a daily basis so are better placed to recognize early anxiety symptoms, especially in people with subclinical symptoms (as opposed to frank disease)." He continued, "If we can dig out and help this population, we can perhaps prevent them from going into a clinical condition."

Dr Chen believes that greater communication between specialists and family doctors, as well as with patients, is the key to better management of anxiety disorders. Patients presenting with minor, uncomplicated anxiety symptoms can be effectively managed by GPs, while severe or complicated illness, or cases of unclear diagnosis, would be better to refer to psychiatrists. Meanwhile, ongoing discussions and opportunities for case sharing between specialists and GPs are invaluable. "More communication, more discussions and mutual referrals would be better [for optimal management]," said Dr Chen.

Nowadays, due to advances in pharmacology and neuroscience, there are effective pharmacological treatments for anxiety disorders. Both selective serotonin reuptake inhibitors, and the serotonin and nor-adrenaline reuptake inhibitors rank among the first-line agents for treating many anxiety disorders, and they typically have favourable side effect profiles. Older drugs, like the tricyclic antidepressants, are seldom used nowadays.

However, as Dr Chen highlighted, "Drugs alone may not completely help to control anxiety disorders and prevent further relapse because

patients may have underlying personality or lifestyle problems that make coping with stress difficult." Thus, some psychological treatment, specifically cognitive behavioural therapy, is needed to help patients have a healthier, more positive mindset. Beyond this, patients should be encouraged to increase their social network and after-work activities, so they learn to relax and enjoy life more. On the upside, when patients receive appropriate treatment, most do overcome their anxiety disorder with time.

According to Dr Chen, an ongoing challenge for Hong Kong is how to increase recognition of anxiety disorders as a common community health problem. How to overcome this? "Education, better communication between family doctors and their patients, and better specialist and family doctor interaction and networking will help society, as a whole, have greater awareness," he concluded.

Case study on panic disorder involving effective treatment with an SNRI

A 45-year-old accountant presented with sudden chest discomfort at home after dinner. He was fearful and worried that he might be having a heart attack. He felt palpitation and had difficulty breathing. The severity of his physical discomfort and anxiety increased rapidly. He had to lie in bed and called an ambulance. On arrival at the Accident and Emergency Department, he gradually felt better and was less anxious. Physical examination and initial investigation, including blood tests and electrocardiogram, did not reveal any obvious abnormality. He was much relieved and was discharged home.

On the next day, he was still worried that he had an underlying heart disease that was not diagnosed at the busy public hospital. Thus, he consulted a private cardiologist. After thorough investigation, no abnormality was found. However, a week later, he had another similar "attack" when he was working at the office. He was scared and immediately went to the outpatient department of a private hospital. The doctor did not find any physical abnormalities and opined that he might have an anxiety disorder, advising him to consult a psychiatrist. However, he did not consider himself "mad" and continued to believe that he had some hidden physical conditions, yet to be identified. In the following weeks, he had several more similar "attacks". He continued to consult various doctors, including traditional Chinese herbalists. No specific physical illness could be found and he felt increasingly frustrated and demoralized. He was reluctant to leave home and avoided social activities. He had poor concentration and memory. As a result, his work efficiency was significantly reduced.

In view of his poor condition, his wife strongly encouraged him to see a psychiatrist. In the psychiatric interview, he had the chance to express his work stress and financial difficulties that he dared not share with others, including his wife. He was diagnosed to have panic disorder. He was prescribed Efexor XR 37.5 mg daily, which was increased to 75 mg daily, a week later. He tolerated the drug well without any significant side effects. Moreover, he was educated on the bodily symptoms of the stress response, relaxation exercise and stress management. He was encouraged to expose himself to places where panic attacks were associated. He had good compliance and response to treatment. He has been free from panic attacks for 6 months and has resumed normal daily activities.