

## Behavior

Bruce Bower reports from New York City at the annual meeting of the American Psychiatric Association

### The global heart of panic

An international study shows that panic disorder — in essence, recurring panic attacks — occurs throughout the world and involves several universal symptoms. “The heart is at the core of panic disorder across cultures,” says Heinz Katschnig of the University of Vienna, Austria, who directed the collaborative effort. Commonly observed panic symptoms are heart palpitations, dizziness and faintness.

Katschnig bases his claim in part on interviews with 1,168 panic disorder patients from 14 countries: Austria, Belgium, Brazil, Canada, Colombia, Denmark, England, France, Italy, Mexico, the United States, Spain, Sweden and West Germany. All were diagnosed according to current U.S. guidelines.

Although panic disorder crosses many time zones, cultural influences create some differences in its expression, Katschnig notes. Symptoms such as choking or smothering sensations, numbness, tingling, and fear of dying occurred more frequently in Latin America and southern Europe. Fear and avoidance of public places was more common in northern Europe and North America. Patients reported a fear of going crazy and altered perceptions of themselves more often in the Americas than in Europe. Differences in climate, language and access to mental health care may shape cultural variations in panic disorder, Katschnig maintains.

The disorder also reaches beyond Western industrialized countries, says Michaela Amering of the University of Vienna. Two examples are “kayak-angst” among Greenland’s Eskimos and “koro” in Southeast Asia, she asserts. Eskimo men may experience kayak-angst — a sudden anxiety, dizziness and fear of dying — while fishing placid ocean waters in cramped, one-person kayaks. Koro, described for more than 2,000 years, is a sudden fear that the genitals are retracting into one’s body and will cause death. Both panic conditions are short-lived and subside with reassurance from others, Amering says.

“The data now available show more similarities than differences in panic disorder across cultures,” observes Myrna M. Weissman of Columbia University in New York City. The main point of contention, she holds, is whether panic disorder occurs alone or as part of broader conditions, such as generalized anxiety and post-traumatic stress.

### Price battle over schizophrenia drug

A drug long available in Europe and approved for U.S. use last February may substantially help many schizophrenics who fail to respond to other drugs (SN: 5/23/87, p.324). But psychiatrists from around the United States claim the medication is financially out of reach for many of the patients who need it most, particularly people with chronic schizophrenia who have little money or health insurance.

The drug, known as clozapine, is marketed by Sandoz Pharmaceuticals Corp. in East Hanover, N.J. Because about 1 percent of clozapine patients experience a potentially fatal drop in white blood cells, anyone taking the drug must participate in a weekly blood-monitoring program run by a private laboratory chosen by Sandoz. The total yearly cost is nearly \$9,000 per patient, mostly for the monitoring program.

Many psychiatrists contend that private clinicians and state and Veterans Administration hospitals could do the blood monitoring just as well and at less expense. Some states, including Oregon, say they may file antitrust suits against Sandoz.

Gilbert Honigfeld of Sandoz argues that without the national testing program, careless monitoring — and thus some clozapine-induced deaths — appear likely. Even a few deaths will result in a U.S. ban on clozapine, he says. In the long run, the current program saves money by keeping patients out of hospitals and nursing homes, Honigfeld maintains.

## Biomedicine

### Obesity: Waist not, but okay behind

A big belly may be more hazardous to your heart than a fat butt. That’s the warning from a team of researchers who find that the distribution of body fat is just as important as a person’s overall weight when it comes to risky blood levels of cholesterol and fatty acids.

Scientists first reported in 1956 that women whose fat concentrates around the waist — an apple-shaped distribution of fat usually seen in men — are more likely to suffer diabetes and atherosclerosis than women with the more common pear-shaped, or lower-body, fat distribution. In the early 1980s, researchers linked upper-body obesity to diabetes and heart disease in both men and women (SN: 1/26/85, p.57).

In the latest study, detailed in the May CIRCULATION, David S. Freedman of the Centers for Disease Control in Atlanta and his colleagues at the Medical College of Wisconsin in Milwaukee measured the levels of blood fats in 1,124 healthy men and women. They found the men more likely to show several risk factors for heart disease: significantly elevated levels of total cholesterol and triglycerides; higher concentrations of low-density lipoprotein (the “bad” cholesterol carrier); and substantially lower levels of high-density lipoprotein (the “good” cholesterol carrier).

These gender differences persisted even when the researchers adjusted for such factors as the men’s greater alcohol consumption and higher rate of obesity. But when the team took into account that the men’s body fat generally concentrated in a “spare tire” around the waist, while most women concentrated their fat in the buttocks and thighs, the differences in the blood tests made sense.

“What makes our study unique is that it is the first to examine whether the male/female differences in body-fat distribution could account for the differences in blood fats,” Freedman says. In an editorial accompanying the research report, Deborah L. Wingard of the University of California, San Diego, asserts that if the upper-body obesity noted in Freedman’s study is similarly linked to risk factors for other diseases, pear-shaped individuals who are only 10 to 20 pounds overweight may not have to worry about the health consequences of their weight as much as apple-shaped people. “Perhaps we should be counting ‘apples’ and ‘pears,’ not men and women,” Wingard writes. “By understanding these gender differences in coronary heart disease risk, we may be better able to counsel all individuals on how to reduce their risk.”

### Strengthening bones without hormones

A nonhormonal drug increased bone mass and reduced fracture incidence in 66 postmenopausal women suffering from osteoporosis, report U.S. and Danish researchers in the May 3 NEW ENGLAND JOURNAL OF MEDICINE.

The disease, which occurs most often in women over the age of 50 and has been linked to low levels of the sex hormone estrogen, develops when bone loss exceeds buildup in the constant bone-remodeling process spearheaded by two classes of cells — osteoclasts, which break down bone, and osteoblasts, which rebuild it. In their three-year study, the scientists found that low doses of etidronate disodium — a drug known to inhibit osteoclast activity in patients with Paget’s disease, another bone disorder — showed similar effectiveness in osteoporotic women without suppressing bone mineralization as higher doses had done in previous studies. Compared with study participants who received calcium supplements only, women who received calcium and the drug had an average 8 percent greater bone mass and only 11 percent as many bone fractures, report researchers at Sundby Hospital in Copenhagen, the University Institute of Pathology in Aarhus and the University of California, San Francisco.