

Benzodiazepines

Information for GPs

This information is designed to assist doctors in the management of patients ceasing benzodiazepine use, and is to be read in conjunction with the patient resource called 'Benzodiazepines: Reasons to stop and stopping use'.

This material was written as a result of our experience in the treatment of people with problems of benzodiazepine dependence and our interactions with doctors involved in the 'front line' of dealing with these patients.

We have attempted to distil information from the research literature on benzodiazepine withdrawal and, in particular, ways in which withdrawal can be minimised.

The patient resource, 'Benzodiazepines: Reasons to Stop and Stopping Use', has two broad functions:

1. The 'Reasons to stop' section assists patients to decide whether they should, with your assistance, cease their prescribed benzodiazepines.
2. The 'Stopping use' section provides the patient with assistance and strategies during the process of drug cessation.

We recommend the resource be available in your surgery and it should be provided to patients during the consultation when planned drug withdrawal is discussed.

Contents

Who needs help to stop?	2
Management of withdrawal	3
Therapeutic relationship	3
Withdrawal regimens	3
Alternative pharmacotherapy	4
Withdrawal symptoms	4
Referral	5
Prevention of dependence	5

Who needs help to stop?

Ceasing benzodiazepine use can be relatively easy for many people, but very difficult for others. Various estimates suggest that 30% to 40% of those people who take prescribed quantities for longer than one month will experience significant withdrawal symptoms upon abrupt cessation.

Common symptoms associated with benzodiazepine withdrawal are listed below. These symptoms do not necessarily occur in all people. Nor will they occur at the same time. Typically, symptoms are constant in the early stages, and then become intermittent. The general time period for withdrawal is six to eight weeks, but some patients will experience symptoms for less than two weeks. A minority of patients will experience symptoms intermittently for months.

General

These symptoms tend to occur with the withdrawal of any central nervous system depressant-type drug (including alcohol).

- > anxiety, panic attacks, depression and agoraphobia
- > sleep disturbances
- > irritability, difficulty in concentrating and remembering
- > tremor and general shakiness
- > sweating
- > nausea, loss of appetite, loss of weight
- > seizures (if taking greater than 50mg equivalent diazepam per day).

Specific to benzodiazepine withdrawal

- > metallic taste
- > distorted hearing – sounds appear unduly loud or strange
- > feelings of depersonalisation and unreality
- > distorted vision – patient may feel they are seeing things through a veil
- > sense of smell and touch heightened and distorted
- > pain, stiffness and muscular spasms, particularly in the face and scalp, which can result in headaches and muscle twitching
- > paranoid thoughts and feelings.

Benzodiazepine use can be a problem in four main groups of patients:

Firstly, some people find they are unable to stop taking their medication as a result of their inability to cope with the withdrawal symptoms.

Secondly, some individuals experience tolerance to the pharmacological effects. This may manifest itself through either breakthrough withdrawal symptoms or the patient self-reporting a need to increase the dosage to maintain control. You will need to discuss the implications of this with your patient as any increase in dose and/or duration of use may enhance dependence. It is now generally agreed that to minimise the likelihood of withdrawal symptoms, patients should not be prescribed benzodiazepines for periods longer than two to four weeks and even these patients should reduce the dose of medication gradually.

Thirdly, side effects of prolonged benzodiazepine use may prove to be debilitating in particular 'at risk' populations. Common problems to emerge are depression and impairments of psychomotor, cognitive and memory functions. These may manifest in the elderly as pseudodementia or trauma due to falls.

Mention should be made of the group that take large doses of benzodiazepines, well in excess of the prescribed quantities, to achieve an intoxicated effect. These people are typically in their late teens to early twenties and often are misusing other drugs. People in this group generally do better if referred to a specialist drug and alcohol agency.

Recently alprazolam has been rescheduled to S8, due to concerns about its abuse potential and toxicity. Advice on managing people being prescribed alprazolam can be accessed from the SA website at:

<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/medicines/alprazolam>

This web page can be accessed by browsing 'SA Health' and 'alprazolam'.

Management of withdrawal

Therapeutic relationship

Patients seeking repeat prescriptions or those for whom you feel benzodiazepines are no longer appropriate may be offered the factsheet **BENZODIAZEPINES: Reasons to Stop and Stopping Use**. Part one of this factsheet will assist them in making an informed decision as to continued use. When the patient has made the decision to stop or reduce their medication, part two of the factsheet will help to reinforce your advice and instruction.

When the patient seeks assistance in withdrawing from benzodiazepines, you should assist them in estimating the risk/benefit ratio. There is evidence that those who have a clear commitment and support from significant others have a better prognosis and are less likely to relapse. Providing open and honest information and continuing support are important elements of a successful withdrawal program.

Sometimes enlisting the help of the patient's pharmacist, to dispense the medication at regular intervals can be effective.

Most patients are best managed in the community setting at a time when there are no unusual stressors in their life. It is important to emphasise to your patient that withdrawal is not a race and you are more concerned with long-term outcomes. Having weekly meetings to discuss the prior week's symptoms and reach a joint decision about further reduction is ideal. The opportunity can also be taken to talk through the strategies set out in the factsheet **BENZODIAZEPINES: Reasons to Stop and Stopping Use**.

Withdrawal regimens

Most patients who have been on benzodiazepines for two months or longer can be weaned off over a period of four to six weeks. However, the rate of withdrawal should be titrated against the severity of withdrawal symptoms. For those requiring slower reductions, weekly reductions of 5-10% of the previous week's dose are usually appropriate. When withdrawal is severe, you may need to hold the patient at a particular dose level until withdrawal symptoms subside. For patients who have been prescribed multiple daily doses, the daily benzodiazepine dose should now be taken in four divided doses at fixed times. Removing the night time component last helps reduce the severity of rebound insomnia.

In addition:

- > Keep track of when the prescription should be used up and be aware if a patient is returning for prescriptions ahead of schedule.
- > If this is occurring, then limited dispensing duration is recommended (eg patient picks up medications weekly, twice weekly or even daily).

Short half-life benzodiazepines appear to be associated with more intense withdrawal symptoms due to their rapid elimination (see following table).

In patients who have previously had severe withdrawal, it may be necessary to substitute a long-acting benzodiazepine such as diazepam. The following table gives approximate equivalent doses of diazepam. Note that due to differences in metabolism the exact equivalent will vary from patient to patient.

The figures in the table should be treated as a general guide only. **In those patients whom conversion is made, the patient should be stable on the equivalent dose of diazepam prior to recommencing any further reduction.*

Benzodiazepine equivalents

Name	Duration of Action [#]	Approx dose equiv to 5mg diazepam	Trade names	Tablet strengths	Schedule
Alprazolam	Short	0.5 - 1mg	Alprax, Kalma, Xanax, Ralozam	0.25mg, 0.5mg, 1mg, 2mg	Schedule 8 Controlled Drug. Drugs of Dependence Unit (DDU)
Bromazepam	Intermediate	3 - 6mg	Lexotan	3mg, 6mg	S4
Clobazam	Long	10 - 15mg	Frisium	10mg	S4
Clonazepam	Long	0.25 - 0.5mg	Rivotril, Paxam	0.5mg, 2mg	S4
Diazepam	Long	5 mg	Antenex, Ducene, Ranzepam, Valium, Valpam	2mg, 5mg	S4
Flunitrazepam	Long	1 - 2mg	Hypnodorm	1mg	Schedule 8 Controlled Drug. Drugs of Dependence Unit (DDU)
Lorazepam	Intermediate	0.5 - 1 mg	Ativan	1mg, 2.5mg	S4
Nitrazepam	Long	5 mg	Alodorm, Mogadon	5mg	S4
Oxazepam	Short	30 mg	Alepam, Murelax, Serepax	15mg, 30mg	S4
Temazepam	Short	10 - 20mg	Normison, Temaze, Temtabs	10mg	S4
Triazolam	Very short	0.25 mg	Halcion	0.125mg	S4
Zolpidem	Very short	10 mg	Dormizol, Somidem, Stildem, Stilnox, Zolpibell	10mg (6.25mg & 12.5mg modified release)	S4
Zopiclone	Very short	7.5 mg	Imovane, Imrest	7.5mg	S4

[#] Approximate duration of action:

Very short	< 6hours
Short	6-12 hours
Intermediate	12-24 hours
Long	> 24 hours

Different sources quote varying equivalents. Figures in **BOLD** are recommended as safest and most consistent with references and clinical experience.

Alternative pharmacotherapy

There is often a temptation to manage withdrawal symptoms pharmacologically. This has not proven to be particularly rewarding. β blockers and α_2 agonists have been tried for somatic symptoms without much effect.

Antidepressants and major tranquillisers have been used for night time sedation. Both agents have potential risks: cardiotoxicity as a result of an overdose from antidepressants and tardive dyskinesia following prolonged use of major tranquillisers. Recent concerns over the safety of tryptophan have reduced enthusiasm to use it as a hypnotic.

Withdrawal symptoms

These usually commence one to two days after reduction in dose of a short-acting benzodiazepine or five to seven days for a long-acting benzodiazepine. The severity and duration is variable as is the constellation of symptoms. Typically the symptoms will resolve four to six weeks after completing the detoxification program.

However, symptoms may persist for up to 12 months. For patients on low doses of benzodiazepines, the duration and intensity of withdrawal symptoms is not clearly related to the prescribed dose.

Individuals who take more than the equivalent of 50mg diazepam per day are at risk of withdrawal seizures and/or hallucinations.

Referral

In addition to patients who use high doses of benzodiazepines, you may also seek to refer patients who are unable to negotiate withdrawal under your direction. Inpatient detoxification is best undertaken by a specialist unit. Patients who have one or more of the following characteristics should be referred for inpatient detoxification.

Patients best suited for inpatient detoxification:

- > benzodiazepine daily dose greater than the equivalent of 50mg diazepam per day
- > antisocial personality disorder
- > past history of withdrawal seizures
- > failed previous outpatient detoxification
- > strong patient preference following informed consent
- > patients with a current alcohol or other drug dependence.

Assistance and advice can be given by Drug and Alcohol Services South Australia through the Alcohol and Drug Information Service (ADIS), telephone 1300 13 1340.

Prevention of dependence

Problems of dependence will be minimised if the following guidelines are followed.

Guidelines for prescribing benzodiazepines

- > Where possible use non-pharmacological alternatives (eg counselling).
- > Use only for appropriate indications.
- > Explain the use of the medication and the context of its use.
- > Use lowest dose necessary.
- > Assess efficacy at one week.
- > One benzodiazepine if possible.
- > Regular review.
- > Taper gradually.
- > Limit prescription to two to four weeks.
- > Warn of possibility of dependence when use is prolonged (informed consent).
- > Contraindicated in patients known to be substance abusers.
- > In chronic conditions, intermittent brief use may be appropriate.

For more information

Alcohol and Drug Information Service (ADIS) Phone: 1300 13 1340

Confidential telephone counselling and information (8.30am to 10pm every day).

Drug and Alcohol Services South Australia
75 Magill Road, Stepney SA 5069
Phone: (08) 7425 5000
www.sahealth.sa.gov.au/dassa



www.ausgoal.gov.au/creative-commons



Government
of South Australia

SA Health