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Helping patients withdraw¹

A number of patients who have been taking benzodiazepines for long periods of time may be reluctant to consider coming off their drugs or even resistant to the idea. This poses a problem for the GP.

Explanation of the drug's effects and limitations and encouragement of the patient's ability to cope without them will often be sufficient to enable the patient to give it a try. Extra resources may be useful, eg counselling, stress management, support groups.

The patient should not feel pressured but rather supported and encouraged.²

When a patient has decided to withdraw, frequent monitoring, reassurance, provision of information and a suitable environment are important to reduce the severity of withdrawal symptoms. Advice and written information should be provided about:

- ▲ management of acute stress-related anxiety
- ▲ management of insomnia
- ▲ structured problem solving
- ▲ diet
- ▲ dealing with cravings
- ▲ relapse prevention.

Managing withdrawal at home¹

Onset, duration and severity of benzodiazepine withdrawal symptoms are highly variable and depend on factors such as dose, half-life of the benzodiazepine taken and whether the patient is elderly.

Most patients experiencing uncomplicated withdrawal can be effectively managed by their GP in an outpatient setting.

Criteria for home detoxification are as follows:

- ▲ a patient currently using benzodiazepines who wishes to or agrees to withdraw from them
- ▲ patient is expected to experience only mild to moderate withdrawal symptoms
- ▲ a GP is available to provide regular monitoring of the patient's progress
- ▲ home supervision (eg a reliable relative or friend) should be available for patients withdrawing from high doses (>dose equivalent of 60mg diazepam).

Withdrawing from a low night-time dose

Withdrawing from a single low dose benzodiazepine at night-time can be difficult to achieve, especially if the patient has been taking this dosage for many years.

The need to withdraw depends on whether there have been adverse effects in addition to dependence, eg falls or incontinence.

Encourage patients who decide to withdraw to do so gradually. Tablets can be halved/quartered/taken on alternate nights/taken intermittently to minimise withdrawal effects. If temazepam capsules are being used, change to scored tablets or diazepam elixir.

Provide patients with specific information about the health benefits they may expect from ceasing the medication, eg feeling more alert in the morning. Reassure them that the medication is probably no longer helping them sleep and that any sleep disorder they may now experience is associated with withdrawal, not a recurrence of the original problem.



Prescribing pointers

Tolerance and withdrawal symptoms can occur in people who have been taking therapeutic or higher doses of benzodiazepines on a regular basis for two or more weeks.

It is estimated that tolerance and withdrawal symptoms are experienced in up to 45% of patients discontinuing low therapeutic doses of benzodiazepines, and up to 100% of patients for high doses. There is a significant risk of withdrawal if benzodiazepines are discontinued abruptly, particularly in the sick and the elderly.

Onset and duration of withdrawal symptoms

Withdrawal symptoms from short half-life benzodiazepines generally occur earlier than from long half-life benzodiazepines. Withdrawal symptoms commence within 1-2 days after reduction in dose of a short half-life benzodiazepine, and between 1-5 days for a long half-life benzodiazepine.

Short half-life benzodiazepines may be associated with more acute and intense withdrawal symptoms upon cessation.¹

The duration of withdrawal is highly variable. Withdrawal symptoms may persist for 6-8 weeks after cessation of benzodiazepines with a peak in intensity in the second and third weeks.

Withdrawal plan for patients using more than a typical dose for night-time sedation*

- ▲ Estimate the average daily intake of benzodiazepines.
- ▲ Calculate an equivalent dose of diazepam (see table on page 4) and substitute diazepam (it has a long half-life) for the benzodiazepines.
- ▲ Give diazepam in 3-4 divided doses per day at fixed times.
- ▲ Reduce dose by between 10-20% at weekly intervals. Reduction may need to be slower when the dose is down to 15 mg daily.
- ▲ Regularly review and titrate dose to the severity of withdrawal symptoms. In general practice a reducing regime will generally take 6-8 weeks, but may take 3-4 months or even a year.
- ▲ Sometimes, even when the dose is reduced by only a small amount, withdrawal symptoms re-emerge. In this case, the dose may be held at a plateau for 1-2 weeks or even increased for a few days before the reduction regime is resumed.

* Substitution with diazepam may not be suitable for the elderly because of the risk of drug accumulation

Information on withdrawal was reproduced with permission from *GP Drug & Alcohol Supplement* No. 9, February 1998², produced by the Central Coast Health Drug and Alcohol Services in NSW. Dr Tony Gill and his team have been operating this specialist service since 1994 to assist GPs in treating patients with alcohol and other drug problems.

A Complementary Update



Valerian, passion flower, hops, chamomile and catnip are herbs reputed to have sedative properties. They do not appear to carry the same risks of habituation or addiction that many pharmaceutical sedatives do but seem to have much less activity.

Valerian (*Valeriana officinalis*) is the best studied natural sedative but the identity of the active sedative constituents remains unclear. Hence, difficulty arises when standardising plant material or assessing studies testing a variety of preparations. Also much of the research is published in German making ready assessment of the evidence difficult.

A sedative action has been documented in clinical studies and side effects have not been reported. However, changes

were generally found in subjective (sleep latency, night-time motor activity, quality of sleep) not objective (EEG) measures and study quality is suboptimal. Nevertheless, the German Commission E (government expert committee) still approved valerian as a sleep-promoting agent and calmative. Roots and rhizome are used to make a tea, tincture, extract, capsules or tablets which are administered several times a day. It is unclear whether valerian would potentiate existing sedative therapy.^{1,2,3}

Oxazepam: poor choice for night-time sedation

Although the short half-life (5-15 hours) of oxazepam may make it seem desirable, it has a slow onset of action (2-3 hours to reach peak plasma concentration). Consider non-drug options but, if a benzodiazepine is indicated, use 10-20 mg of temazepam at bed-time. It has a similar half-life but a more rapid onset of action reaching peak plasma concentration in 1/2-1 hour for capsules and 1/2-2 hours for tablets.



GP Exchange *a column in which GPs share their prescribing experiences*

How to say “No” to prescribing

In his practice in Melbourne’s St Kilda, one of the 10 areas where the most scripts are dispensed for doctor shoppers, GP Nick Carr has developed what he calls a “whole practice approach” to saying “No” to first time doctor shoppers.

While there is no ‘right’ approach, he says, “these pointers have assisted us to minimise the difficulties associated with saying ‘No’ to doctor shoppers.”

Prior to the consultation

We respectfully tell people up front that we have made a decision not to prescribe. A sign on the surgery door states our practice policy, that we prefer not to prescribe drugs of dependence.

Our receptionists are trained to respond in an honest, clear and respectful manner when a patient asks a question or makes a statement that indicates he or she may be a doctor shopper. For example, if asked, “Will the doctor give me some Valium?” the receptionist can answer, “Probably not” or similar.

Most first time doctor shoppers arrive without an appointment. If there is a possibility the person is a doctor shopper, our receptionist knows not to keep him or her waiting. It is our policy to see the person straightaway. It is disrespectful to keep people waiting for 45 minutes when you know you’re not going to give them what they want.

During the consultation

As soon as you have any suspicion that the person is a doctor shopper, establish whether or not the visit is to request a drug. You could ask something like, “What do you think I can do to help?” We do not take histories in detail because we have found that after you have listened to a long story it is almost impossible to say “no”. We go straight to the point of the consultation, which is the request for a prescription.

We refuse requests for prescriptions in simple but polite terminology, eg “I don’t prescribe drugs like this.” We let patients know respectfully that it is our decision not to prescribe and we don’t defer responsibility for this decision to the government, the HIC or anyone else.

In many consultations where I have taken this approach, the patient has said something to the effect of “Thanks, Doc” or “That’s good.” Some patients may argue but usually not very much, and only occasionally some get angry.

Dealing with aggression

If patients do get angry, the most effective approach we have found is to depersonalise the communication. The exact words are important: “It is nothing to do with you personally. This is the way I work. I don’t prescribe these for anyone.” I have found in the more than ten years of using this approach that this is also the best method of avoiding violence.

If despite this someone gets aggressive we say, “This consultation is over. Now please leave.” If they refuse, we call the police.

Offer alternative help

A person who is simply there to get a prescription will seem to accept whatever you offer as long as it is accompanied by a prescription. This is not helping, neither is it building rapport; it simply continues drug use.

Paradoxically the best rapport is established by not writing a prescription. Patients who see you as being ethical will respect you enough to come back. A patient who returns will often say, “I remember you wouldn’t prescribe. Now I need some help.”

“Sign here before you go”

In my experience, most patients expect to sign the Medicare slip before they go. If a patient won’t sign I make a note in the ‘Doctor’s comments’ box before sending the unsigned document to Medicare.

For a very brief consultation, I let the patient see me tear up the Medicare document and throw it in the bin. This shows the patient you are a reasonable, ethical person.

For a more detailed description and script of the approach used by Dr Carr, see *Australian Family Physician* Vol. 27, No. 9, September 1998, pp817-821.



NPS, making it easier for you to make the best decisions for your patients

What's new at NPS

GP Divisions adopt NPS programs

Divisions of General Practice around Australia are joining with NPS to provide support and resources to assist GPs keep up-to-date with developments in therapeutics.

Thirteen divisions have completed agreements to run NPS programs and have been funded to appoint a facilitator to work within each division. Another 24 divisions are currently negotiating with NPS, and still more have expressed interest in participating.

GP and Vice-President of the Melbourne Division of General Practice, Zoltan Vilagosh, said that by joining with NPS the division is able to provide prescribing programs that focus on the needs of local doctors.

According to Dr Vilagosh, "GPs are looking for well-researched, independent information on therapeutics that can be applied in a practical way in day to day practice. The goal of NPS and the division is to work with GPs to provide them with the information they need to make the best decisions for their patients."

Lynn Weekes, NPS Chief Executive Officer, said that NPS programs focus on quality prescribing rather than just cost-containment, are based on the most current evidence and address the relative merits of different medicines and other (non-drug) therapies.

"Divisions are able to negotiate which programs would be most relevant in their area," she said.

"Programs being run through divisions include making practice visits to GPs, conducting workshops, assisting GPs attain continuing education and quality assurance points and Practice Incentives Program payments by completing NPS clinical audits and case studies, and working with GPs to adapt prescribing guidelines to local situations."

Newly appointed divisional facilitators from around Australia recently attended the first of a series of training workshops run by NPS to equip them to develop and run local prescribing programs.

NPS programs will also provide independent information to other health professionals, pharmacists and consumers.

For more information, call NPS on 02 9332 3944.

NPS funds research

NPS has allocated its first round of research funds to projects aimed at improving the quality of prescribing in the community.

The NPS Research Grant Program encourages and fosters research in wise use of medicines. Each year the grant program will target areas of identified need, and award one-year grants of up to \$50,000.

Awards made for 1999

Community acquired pneumonia: improving the quality of prescription of antimicrobial agents: Dr James McCarthy, University Dept of Medicine, Fremantle Hospital, WA.

Use of therapeutic flags to highlight potentially inappropriate prescribing in the elderly: Prof Susan Tett, School of Pharmacy, University of Queensland.

Changing benzodiazepine prescribing for anxiety and depression in general practice: Mr Tony Wade, Australia's Health Pty Ltd, Queensland.

The effect of single patient trials on changing GPs' attitudes to research: Ms Deborah Askew, School of Social and Preventative Medicine at the University of Queensland.

"Unprescription" pad

NPS has produced a symptomatic management pad to be used for the patient with a respiratory tract illness where antibiotics will have little or no benefit. The pad includes patient information and a "script" form for non-antibiotic treatments. A poster promoting "No antibiotics" for colds, most coughs and sore throats is also available for the doctor's waiting room. For your free copy, please fill in the coupon and return or fax to NPS.

Please send me NPS Symptomatic Management Pad and poster.

Name: _____

Address: _____

Tel: _____

Profession: _____

Benzodiazepine dose equivalents^{1,2}

Approximate equivalent dose* to diazepam 5 mg and duration of action			
Alprazolam:	Kalma [®] , Ralozam [®] , Xanax [®]	0.5 – 1 mg	Short – Intermediate
Bromazepam:	Lexotan [®]	3 – 6 mg	Short – Intermediate
Clobazam:	Frisium [®]	10 mg	Intermediate
Clonazepam:	Rivotril [®] , Paxam [®]	0.5 mg	Intermediate
Diazepam:	Antenex [®] , Ducene [®] , Valium [®]	5 mg	Long
Diazepam Elixir 1 mg/ml:	Manufactured by Orion Laboratories (not on PBS)	5 mg	Long
Flunitrazepam:	Hypnodorm [®] , Rohypnol [®]	1 – 2 mg	Intermediate
Lorazepam**:	Ativan [®]	1 mg	Short – Intermediate
Nitrazepam:	Alodorm [®] , Mogadon [®]	5 – 10 mg	Intermediate
Oxazepam:	Alepam [®] , Murelax [®] , Serepax [®]	15 – 30 mg	Short
Temazepam:	Euhypnos [®] , Nocturne [®] , Nomapam [®] , Normison [®] , Temaze [®] , Temtabs [®]	10 – 20 mg	Short
Triazolam:	Halcion [®]	0.25 mg	Short

* The widely varying half-lives and receptor binding characteristics of these agents make exact dose equivalents difficult to establish.

** Lorazepam may be relatively more potent at higher doses.

Clarification

NPS News 2 carried an article titled: “Managing gastrointestinal risk: Is misoprostol (Cytotec[®]) helpful?” In the statement, “An economic analysis of the study however did not justify the cost in the majority of cases (>\$250,000 per complication prevented)”, the amount is in US dollars.

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National Prescribing Service Limited

Our goal To improve health outcomes for Australians through prescribing that is: ▲ safe ▲ effective ▲ cost-effective.

Our programs To enable prescribers to make the best prescribing decisions for their patients, the NPS provides:
▲ information ▲ education ▲ support and other resources.

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