continued from page 9

The planned amount of poppy straw and seed was cut by half in 1986, but the sown areas were reduced by 30 per cent only. Two hundred and eighty-six collective and state farms in ten regions and territories, including densely populated ones, go on cultivating poppy. Calculations show, however, that a sufficient amount of poppy and hemp' can be grown in three or four regions with plantations properly guarded. There are several hemp varieties with low narcotic concentrations, but farms are not too eager to accept them.

Wild hemp thickets have to be destroyed. Meanwhile, experts are debating at length whether the quicksands of the Chu Valley will start moving once deprived of vegetation. They seem to have forgotten that hemp is not part of local flora: it has been introduced by man. The hemp-grown area grew 30 times in the Jambul Region alone in the last 35 years.

PRAVDA: If the authorities were punished more severely for inadequate protection of narcotic-bearing crops and raw substances, and when they are at fault for not destroying wild narcotic-bearing plants, the amount of black-market drugs would shrink dramatically, many readers think.
VLASOV: A timely proposal. The Ministry has elaborated appropriate decisions, and offered them for discussion. I think it is high time to introduce a state monopoly on oil-yielding poppy plantations. Research institutions are too slow in developing detection equipment.

A narcomaniac who refuses treatment can be forced into hospital . . . compulsory treatment has been introduced for drug addicts under age.

We largely count on parents' and teachers' help. It is high time that every family realises how serious the danger is. Attempts to conceal drug abuse bear sinister fruit. School medical check-ups are not efficient enough in detecting drug-abusing adolescents.

We must act in team with the Young Communist League (YCL). YCL branches, classmates and teachers are the first to spot addicts before the militia detects them. The law-enforcing agencies shall be promptly informed to make due steps. Drug abuse among young people can be drastically reduced if voluntary people's patrols and YCL squads in teacher-training, medical and other colleges get down to it.

Once again, I call your attention to the extreme danger of drug abuse. Success of the effort depends on efficient work by state, economic and public bodies. All republics, regions and territories have worked out comprehensive prevention plans by now with active Party and state bodies' participation. They are to be implemented without delay.

To finish with drug abuse is an urgent, responsible and humane task. Our country has every possibility to cope with it. ❞

DEPENDENCE

Some say it's worse than coming off heroin, others that it's nearly 'all in the mind' — an example of the myths and confusion surrounding withdrawal from benzodiazepine tranquillisers, the most widely prescribed drugs in the world. One of Britain's leading medical authorities on the subject reviews the evidence on withdrawal and its treatment: the conclusion is that the risks justify prescribing only for severe, otherwise unmanageable anxiety.

Malcolm Lader

ANXIETY IS ONE of the most ubiquitous of human emotions but only when it is severe, chronic, all-pervasive or intolerable does it require medical treatment. Lack of training in psychological problems, and failure to appreciate that non-drug alternatives exist and are usually effective, has led to the widespread use of tranquillisers by general practitioners for most of this century. We have witnessed the introduction of successive sedatives and tranquillisers each ushered in with claims that the drawbacks of their predecessors had been overcome. Most recently, the benzodiazepines ousted the barbiturates because they were perceived by doctors, and then by patients, as being more effective, less toxic and less liable to induce abuse and dependence. The last attribute is the most open to doubt.

Cases of physical and psychological dependence on the benzodiazepines have been reported in hundreds of scientific papers. However, until about six years ago, these reports involved patients who had escalated their doses to levels way above those prescribed therapeutically. For example, I treated one patient taking 200mg a day of diazepam (Valium), over 10 times the usual therapeutic dose, and another on 15mg a day of lorazepam (Ativan), five times the usual dose. But such cases are not common and are most often encountered in the context of the abuse of a range of drugs.

We now know from a series of clinical and laboratory studies that physical dependence can follow the use of even normal doses of a benzodiazepine tranquilliser or sleeping pill. On discontinuing such therapy, 15-35 per cent of long-term (over six months) users will have a characteristic withdrawal syndrome, similar to that following barbiturate use and reminiscent of mild delirium tremens — the state of agitated confusion sometimes seen in withdrawing alcoholics. After abrupt discontinuation, especially of doses at the upper end of the therapeutic range, a severe illness can come on, with fits or severe paranoid states with confusion. As with delirium tremens, the patient's life may be threatened. Consequently, abrupt withdrawal should *never* be attempted.

Professor Malcolm Lader is a psychopharmacologist at the Institute of Psychiatry, where for several years he has been researching benzodiazepine dependence. His works on the subject include co-authorship of the book Dependence on tranquillisers, *OUP 1984.*

Even after tapering off the dosage, a withdrawal syndrome may occur. In its mildest and most common form it represents a rebound syndrome, as seen with many drugs, not just psychotropic ones. For a day or two or sometimes longer the patient feels jumpy, tense, anxious and their sleep is poor and broken by nightmares. This syndrome merges into more definite withdrawal syndromes which are characterised by:

- ▶ Psychological symptoms of anxiety: apprehension, mental tension, distractibility, inattention, irritability and insomnia.
- ▶ Bodily symptoms of anxiety: palpitations, tremor, sweating, nausea, stomach cramps and loss of appetite and weight.
- ▶ Perceptual symptoms of heightened sensory awareness: sounds seem loud, lights bright; pains and muscle spasms may be widespread; the patient feels unsteady; there may be taste/smell abnormalities.

Other symptoms may occur, such as 'pseudowithdrawal' — in which the patient becomes anxious and apprehensive about the process of withdrawal even before any real reduction in dose has taken place — while after withdrawal, panics, phobias and depression may supervene, even though the patient has no previous history of these symptoms.

After stopping a benzodiazepine, even after tapering the dose over several weeks, there is usually some delay before rebound or withdrawal effects can be seen. The delay depends on the time taken before the drug is cleared from the body. Accordingly, after a short-acting compound such as triazolam (Halcion), withdrawal reactions may occur the next night with grossly disrupted sleep; after lorazepam, a medium-duration compound, withdrawal is usually seen in 48-72 hours; whereas after stopping diazepam or one of the other long-acting tranquillisers, withdrawal may be delayed for up to 10 days.

Puzzling exceptions do occur. Sometimes patients develop apparent withdrawal symptoms while still on medication and raising the dose may not always help. This has been attributed to the development of tolerance. Another unexplained observation is that one benzodiazepine may not suppress withdrawal from another. For example, it is often difficult to substitute

ON TRANQUILLISERS

diazepam for lorazepam.

The duration of the withdrawal syndrome is very variable and very difficult to predict in the individual case. Most syndromes last seven to 21 days, although residual anxiety may persist or depression become marked. However, in some unfortunate patients, the perceptual symptoms such as pain may persist for weeks, months or, rarely, a year or two. Furthermore, such symptoms are typically not helped by resuming benzodiazepine therapy. Although some of these prolonged reactions may be 'neurotic' or 'hysterical', most seem genuine drug-related syndromes: perhaps long term use is accompanied by subtle changes in brain chemistry which take a long time to reverse.

The incidence of withdrawal reactions depends on the context in which the patients are studied. In general practice perhaps 15-25 per cent of patients tapering off benzodiazepines after six months use or more will get medically significant symptoms. In psychiatric outpatients the figures are probably double these. In specialist clinics and in self-help groups, practically all those attempting to withdraw will experience severe and often prolonged abstinence syndromes. This, of course, reflects the increasingly selected nature of these patients: they have all tried to withdraw previously, have failed because of severe symptoms and have sought specialist advice. But the reverse-side of these estimates is that most long-term users seen in general practice will withdraw uneventfully or with only minor discomfort.

Complete recovery is often slow and patients may have symptoms for many months.

The duration of treatment is an important factor in determining the incidence and perhaps the severity of withdrawal. In one study, patients treated continuously for less than eight months had an incidence of withdrawal reactions of five per cent; those treated for longer had an incidence just over 40 per cent. If the criteria for withdrawal symptoms is widened to include rebound effects as well, the incidence is much higher, and is the rule after treatments as short as four to eight weeks.

Dosage is also an important factor. High dose users are much more likely to have withdrawal reactions than those maintained on average clinical doses. However, no cut-off point has been identified: patients on even very small doses, such as 5mg a day of diazepam, may experience symptoms, even after tapering off.

The type of benzodiazepine influences the severity and duration of withdrawal, as it does rebound. Long-acting compounds such as diazepam are typically associated with moderate reactions lasting two to three weeks. Shorter-acting drugs such as lorazepam generally result in more severe reactions which endure for about a week. However, many exceptions have been noted, especially in very long-term users. There is a strong clinical impression that lorazepam is particularly difficult to withdraw from with a much higher relapse rate than that associated with other benzodiazepines. The reason for this is unclear.

Managing withdrawal

In general withdrawal is most economically attempted in the outpatient setting. Patients on high doses or with a history of seizures or psychotic episodes during previous attempts at withdrawal are more safely treated as inpatients.

No consensus exists on the precise duration of the withdrawal process or the size of each reduction in dosage. Four weeks is the minimum and programmes as long as 16 weeks have been recommended. It is probably counterproductive to prolong withdrawal beyond this. The rate of reduction should not be fixed at the outset but should be 'titrated' against the patient's withdrawal symptoms. So reduction in steps of not more than 2.5mg diazepam or equivalent (see table) should be made weekly until the first withdrawal symptoms emerge, at which stage the rate of reduction should be slowed. When the withdrawal symptoms have waned to the point where the patient is willing to contemplate the likely accentuation of symptoms, a further reduction should be attempted. After total withdrawal, it is a mistake to reinstitute benzodiazepine therapy, even if withdrawal symptoms continue.

Some advocate substituting long-acting for short-acting benzodiazepines before commencing withdrawal, as the long-acting drugs are associated with less severe withdrawal symptoms. However, substitution itself may be difficult and it is probably best not to try it unless previous withdrawal attempts have been unsuccessful.

Both clonidine and propranolol — which act on the sympathetic nervous system that controls anxiety reactions among others — have been evaluated in withdrawal. Neither is dramatically helpful, although some symptom relief may be forthcoming. Antidepressants may be needed if the patient becomes depressed but antipsychotic medication (major tranquillisers; neuroleptics) are not recommended. Barbiturates are also generally avoided, although some workers in California advocate the substitution of phenobarbitone.

Physicians should maintain close contact with their patients, seeing them at least weekly during withdrawal until the symptoms are definitely subsiding. Patients need constant reassurance that eventually they will recover (they do!); that they will not go mad (they usually don't!); and that the symptoms all have a rational basis (most do!). Keeping a diary is often helpful and the patient must be helped to take a realistic view of their life situation.

Formal psychological help such as relaxation treatment, training in anxiety management skills and cognitive therapy are only moderately successful. An important factor is social support, particularly from spouses and other close family members. The process of withdrawal should be explained to them. Some patients find local self-help groups useful. Unfortunately, but probably inevitably, the people most active in founding support groups are those most likely to have had the worst experiences of withdrawal with the least medical help. They may inadvertently set up unnecessarily gloomy expectations all round.

It is difficult to estimate accurately the likelihood of recovery. On gradual withdrawal in general practice, most patients are successful in achieving total abstinence. Among hospital outpatients, more of whom will have previously failed to achieve or maintain withdrawal, about a third successfully withdraw and remain symptom-free, a third remain drug-free but continue to experience medical or psychological symptoms, and a third relapse. Complete recovery is often slow and patients may have symptoms for many months.

A PREFERABLE STRATEGY is the prevention of dependence. Benzodiazepines should be prescribed only for severe anxiety unresponsive to more general measures such as reassurance, explanation of symptoms and counselling about immediate problems and the patient's responses to them. Benzodiazepines should not be prescribed for normal people at times of acute stress, such as bereavement or divorce. The duration of prescription should be decided in advance and set at as short a period as possible. The lowest effective dose should be used. Intermittent, flexible dosage should be encouraged. Repeat prescriptions should be avoided, especially for patients with major personality problems who are particularly likely to become dependent. □

ROUGHLY EQUIVALENT DOSES OF BENZODIAZEPINES

Long-acting	Short/medium acting
Diazepam 2.5mg	Lorazepam 0.5mg
Chlordiazepoxide 5mg	Oxazepam 7.5mg
Nitrazepam 5mg	Temazepam 5mg
	Triazolam 0.125mg