

Doctors turn to more addictive short-acting benzodiazepines

Figures recently released by the DHSS show that prescribing of the type of benzodiazepines thought most likely to lead to withdrawal problems has been increasing, even though the total number of benzodiazepines prescribed is falling. It also appears that while doctors have reacted to bad publicity about benzodiazepine dependence by cutting down on their use for daytime anxiety-relief, the message has not got through that benzodiazepines prescribed as sleeping pills may be just as likely to cause dependence.

The *British national formulary* — the official prescribing guide issued by the BMA and the Pharmaceutical Society — warns doctors that “Withdrawal phenomena are more common with the short-acting benzodiazepines.” The rapid elimination of these drugs from

the body causes a relatively steep fall in blood concentrations: the steeper the fall in blood concentrations, the more severe the withdrawal. In contrast, the slower rate of elimination of longer acting benzodiazepines such as diazepam provides a built-in tapering effect that helps minimise withdrawal problems.

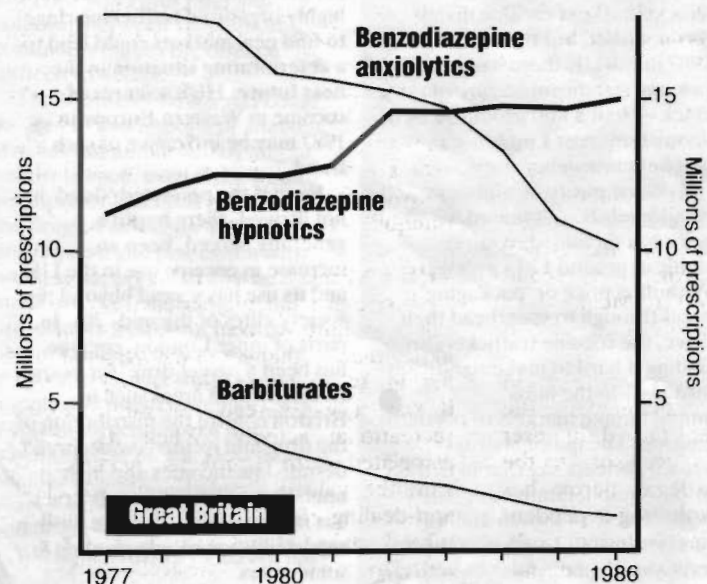
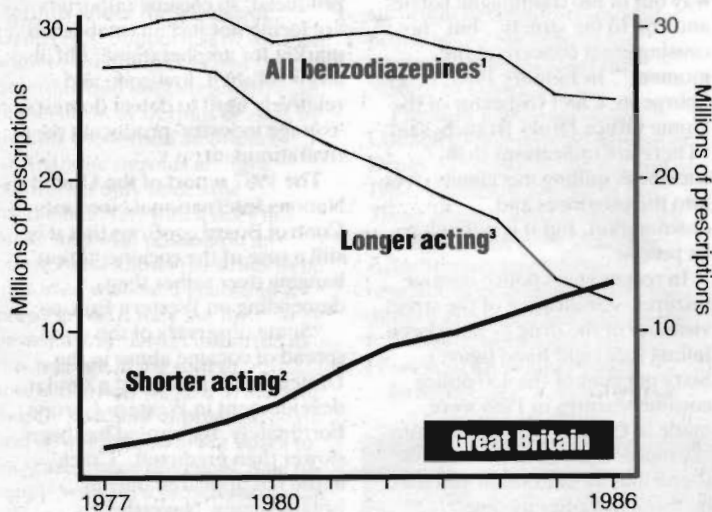
Prescribing of shorter-acting benzodiazepines has been increasing over the last 10 years (top figure). In 1977, they represented just over seven per cent of all the benzodiazepines prescribed in Great Britain; by 1986, nearly 53 per cent. Despite the greater risk of withdrawal and dependence, these newer drugs are increasingly used as hypnotics (to promote sleep) because their short duration of action helps prevent residual morning sleepiness (the ‘hangover’ effect). Used as anxiolytics (for anxiety-

relief), they minimise the extent to which the drug accumulates in the body as fresh doses pile up on the remains of the previous dose.

Most popular of the shorter acting anxiolytics is lorazepam (Ativan, etc), now prescribed almost three times as often as chlordiazepoxide (Librium, etc). At 3,149,000 prescriptions in Great Britain in 1986, lorazepam is the second most frequently prescribed anxiolytic. The steep fall in blood levels characteristic of short-acting drugs is aggravated in the case of lorazepam by difficulties in achieving a gradual reduction by taking smaller doses, leading to particularly severe withdrawal problems (see page 14 of this issue of *Druglink*).

Any benzodiazepine used in lower doses has an anxiety-relieving effect and in higher doses promotes sleep, but differing pharmacological profiles, tradition and marketing have led to the drugs being divided into anxiolytics and hypnotics. Publicity about dependence problems has concentrated on the daytime use of benzodiazepine anxiolytics such as Valium. Between 1977 and 1986, doctors reduced their prescribing of these drugs by over seven and a half million prescriptions. However, prescribing of benzodiazepine hypnotics shows no signs of falling off, having remained stable at 14-15 million prescriptions for the last five years (second figure).

These latest statistics raise queries about the extent to which any reduction in dependence problems associated with the drop in benzodiazepine prescribing may have been counteracted by increasing use of shorter acting compounds. They also suggest that attempts to achieve further major reductions in prescribing will have to tackle the less dramatic but now more widespread use of benzodiazepines as hypnotics. One seemingly unqualified bright spot in recent prescribing trends is the continuing drop in the prescribing of the overdose-prone barbiturates, down to just 1.3 million prescriptions in 1986.



1. Excluding clonazepam, which is marketed only for treating epilepsy.
2. Includes: temazepam, lorazepam, triazolam, oxazepam, lormetazepam, loprazolam, alprazolam, bromazepam, ketazolam.
3. Includes: nitrazepam, diazepam, chlordiazepoxide, clobazam, flurazepam, clorazepate, flunitrazepam, medazepam, prazepam.

■ For the first time the Home Office has issued a separate set of statistics detailing drug addiction and offence rates by police force area.¹ The figures are for 1986 and reveal, for example, that the number of police seizures of drugs varied from 1,171 per million of the population in London to just 147 per million in Cleveland. In Scotland, just two out of 1,836 drug offenders were cautioned by the police compared to 22 per cent of offenders in England. Merseyside had the highest rate of new notifications of addiction — 440 per million of the population.

1. Home Office. *Statistics of the misuse of drugs United Kingdom, 1986. Area tables.* Available from H.O. Stat. Dept., Lunar House, 40 Wellesley Rd, Croydon, Surrey CR0 9YD, price £2.50.

■ The new form for doctors to notify patients addicted to opiates or cocaine (HS2A 1(rev)) includes the question: “Does the patient inject any drugs being misused (include non-notifiable drugs, such as amphetamines)?” is to gather information on the risk of HIV-transmission through injecting. Gone are the old form’s questions about the addict’s appearance, designed to help expose those using pseudonyms to obtain prescriptions from more than one doctor.

■ Six pharmacies, a voluntary drugs agency, and a hospital in Sheffield, are cooperating in a novel ‘commercial’ needle-exchange project.¹ Addicts requiring injecting equipment from the pharmacies must first receive counselling from the drugs agency or hospital on safe sex and safe injecting practices. From then on the equipment is sold to them in the usual manner. According to the organisers, this straightforward commercial procedure is more acceptable to many addicts.

1. Godfrey K.E. “Sheffield needle exchange.” *Pharmaceutical Journal*: 21 November 1987, p.607-8.

■ Interviews with a sample of chronic solvent misusers in Leeds showed that more than a third had suffered accidents related to their sniffing and nearly all had stolen to support their habits.¹ While intoxicated, these experienced sniffers could create hallucinatory experiences “almost at will”. Delusions of being able to fly or swim had sometimes led to dangerous behaviour.²

1. Evans A.C. and Raistrick D. “Patterns of use and related harm with toluene-based adhesives and butane gas.” *British Journal of Psychiatry*: 1987, 150, p.773-776.

2. Evans A.C. and Raistrick D. “Phenomenology of intoxication with toluene-based adhesives and butane gas.” *British Journal of Psychiatry*: 1987, 150, p.769-773.