

Psychopharmacology for the Clinician

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.

Inappropriate benzodiazepine use in elderly patients and its reduction

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A 72-year old woman with a psychiatric history of anxious depression and insomnia is receiving ongoing psychotherapy and psychotropic management. Her mood disorder has been stable with escitalopram (10 mg/d) for 3 years. She has been taking lorazepam (1 mg nightly) since the death of her husband 12 years ago. Recent research about chronic benzodiazepine therapy leading to an increased risk of Alzheimer disease prompts a discussion about benzodiazepine cessation.¹

Benzodiazepines and other types of sedative-hypnotics, such as Z-drugs, are no longer recommended for treating insomnia in older adults and are considered inappropriate.² In addition to causing memory impairment, falls, fractures and motor vehicle accidents,³⁻⁶ data now show that sedative-hypnotics account for a substantial number of avoidable emergency department visits and hospital admissions.⁷ Even episodic use is associated with harm. A lifetime use of more than 90 doses of benzodiazepines, equivalent to twice a week for 1 year, has been shown to confer a 50% higher risk of dementia and to double the risk of death.^{1,8} The risk of hip fracture is greatest within the first 2 weeks of therapy, increasing with higher doses and concomitant administration of other centrally acting nervous system drugs.⁹

Patients may not be aware of the risks of chronic benzodiazepine use.¹⁰ Informing them of the latest research findings may elicit a desire to taper. Level 1 evidence supports patient education as an effective method for catalyzing benzodiazepine reduction.¹⁰ The EMPOWER trial exposed

150 chronic benzodiazepine consumers aged 65–95 years to a mailed 8-page educational brochure (www.criugm.qc.ca/images/stories/les_chercheurs/risk_ct.pdf) on the risks of taking sedative-hypnotics, along with a picture of a 20-week tapering protocol, showing when to take a full-, half- or quarter-pill dose to gradually withdraw from therapy.¹⁰ Within 6 months, 27% of individuals who received the intervention had completely discontinued use compared with 5% of controls, and an additional 11% had reduced their dose.¹⁰ Another randomized trial¹¹ in primary care showed that distribution of a written tapering protocol along with a 20-minute physician–patient discussion about benzodiazepine cessation led to a 45% reduction in use at 1 year follow-up, even without close monitoring. Patients with severe psychiatric disorders on antipsychotic therapy were not included in either trial.

No magic formula exists for tapering benzodiazepines, as different protocols have not been compared. Some authorities recommend tapering the dose by 25% every 2 weeks; in elderly patients a longer tapering schedule over 4–5 months is generally preferred.¹⁰⁻¹³ Withdrawal symptoms tend to be most severe during the last quarter of the taper.¹³ Updosing (returning to a higher dose) should be avoided. Patients should be maintained on their current doses until symptoms resolve or be encouraged to push through the taper until they are drug-free.¹³ Substitution with diazepam was previously recommended for formulations of benzodiazepines that could not be halved or quartered, but skipping doses every 2–3 days is a simpler strategy to gradually reduce drug levels.

Patients and providers hesitate to discontinue benzodiazepines because of fear of withdrawal symptoms or

relapse.^{10,14} Withdrawal symptoms occur in up to 50% of patients who succeed in tapering.¹¹ Symptoms of insomnia, tremor, irritability and anxiety are usually transient, and at 1-year follow-up they are no different in frequency between patients who do not taper and those who do.¹¹ Perceptual disturbances, gastrointestinal symptoms and seizures rarely occur.¹¹⁻¹³ No serious safety events were reported in a systematic review of 28 studies of benzodiazepine tapering among older adults with insomnia, depression and anxiety.¹¹⁻¹³

Cognitive behavioural therapy is effective for treating chronic insomnia and facilitating benzodiazepine tapering in older adults.¹⁵⁻¹⁷ Maintaining good sleep hygiene and using a sleep diary to monitor sleep efficiency during or after benzodiazepine withdrawal can be helpful.^{12,15-17} Patients are often reassured by the knowledge that normal sleep architecture changes with age and that older adults can be expected to sleep for fewer hours each night and experience more awakenings but still feel restored and rested in the morning.¹⁸

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