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Benzodiazepine Prescriptions on the Rise

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Trying to gauge the stress level of a community can only be attempted indirectly by using a variety of indicators. A daunting endeavour would be to conduct an epidemiological research to ascertain the prevalence of stressful events in a population and its correlation to psychiatric morbidity – a longitudinal study is necessary to ascertain in a large cohort whether an increase in stressful events is followed by a concomitant increase in psychiatric morbidity. Mental health professionals may argue that suicide data and the number of psychiatric consultations are approximate indicators – another is the prescription of tranquillisers, especially benzodiazepines.

Benzodiazepines were introduced in the 1960s and have anxiolytic, hypnotic, muscle relaxant and anticonvulsant actions[1]. They soon became popular drugs, widely prescribed for insomnia and anxiety. This popularity is due to apparent effectiveness and low toxicity compared with barbiturates. By the late 1970s, concerns were raised about cognitive and motor impairment and the emergence of dependence in some patients.

Prescription of the common benzodiazepines in Singapore[2] from 1995 – 1997 are shown in Tables I and II. The exponential increase is observed in the newer short-acting benzodiazepines, eg. Midazolam and Bromazepam, and also the older long-acting benzodiazepines, eg. Diazepam and Chlordiazepoxide. Other benzodiazepines like Flurazepam, Alprazolam, Temazepam and Lorazepam also show a consistent increase.

The steady rise in benzodiazepine prescriptions is a cause for concern. Does it mean that doctors are prescribing too readily or is it another ominous sign of escalating stress levels?

In the National Mental Health Survey conducted in 1996[3], the prevalence of common psychiatric disorders (anxiety and depression) was 12% and the prevalence of sleep problems, 17%. Many people who seek treatment from their doctors for stress related problems are prescribed benzodiazepines to help relieve sleep problems or anxiety.

Long-term use of benzodiazepines should be discouraged because there are other non-drug treatments for anxiety or insomnia. Long-term use has adverse effects, particularly on memory, and withdrawal effects due to partial tolerance. The most common dose-related side effects are tiredness, drowsiness and lassitude. The elderly are particularly at risk and may manifest psychomotor slowing, ataxia and confusion. Another side effect relates to the so-called 'paradoxical responses' with increased feelings of aggression and hostility, sexual improprieties or excessive emotional responses[4].

Both psychological and physical symptoms of anxiety are common during the withdrawal phase and include apprehension, uneasiness, insomnia, palpitations, vertigo, sweating, tremor and

Table I – Benzodiazepines sold in Singapore (1995 – 1997)

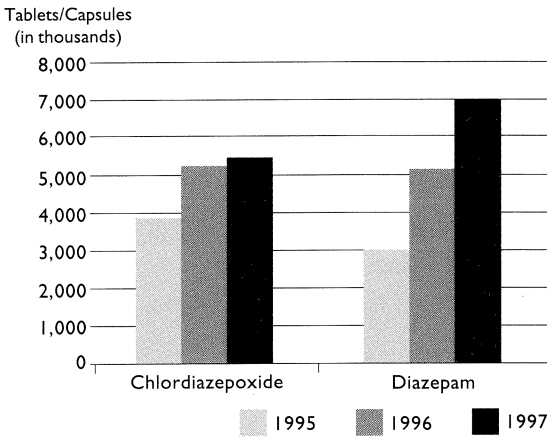
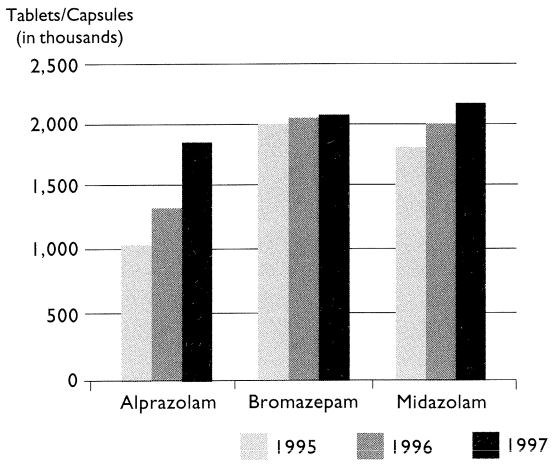


Table II – Benzodiazepines sold in Singapore (1995 – 1997)



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abdominal upset, often developing into panic attacks and agoraphobia. Withdrawal is also characterised by symptoms of increased sensory perception such as hyperacusis, photophobia, paraesthesia, hypersomnia and hypersensitivity to touch and pain. Muscle aches and muscle spasms, unsteadiness and clumsiness are also common. More serious signs of withdrawal are paranoid psychosis and epileptic fits. The withdrawal syndrome generally comes on within 2 – 3 days of finally stopping a short- or medium-acting benzodiazepine and within 7 – 10 days after stopping long-acting drugs.

The principal strategy in mental health awareness is primary prevention and it is therefore pivotal to teach stress management techniques to help people cope better – this could begin at school or work. Equally important is secondary prevention to detect early symptoms. Improving skills of general practitioners and other primary care doctors through continuing medical education is crucial. The focus of future mental health care should be at the level of the primary care doctors who should be confident to manage patients with anxiety and depression using psychotherapeutic and behavioural techniques instead of merely prescribing benzodiazepines.

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