JUDICIOUS PRESCRIBING OF BENZODIAZEPINES

MYTHS

PITFALLS

OPTIONS

Judicious Prescribing of Benzodiazepines

Problem defined

1.7 million prescriptions filled by 440,000 NYC residents: 2014

301 benzodiazepine-related deaths

53% of opioid analgesic related deaths

41% of heroin related deaths

Reduction of Risk

Appropriate first line treatment anxiety/insomnia

Only when clinically indicated

Taper off long term benzodiazepine treatment

Educate patients re all of above

Myths and Facts

Benzodiazepines

Myth: Use as first line treatment for anxiety

Fact: Use for SEVERE anxiety

- Duration: 2-4 weeks
- Diminish in effectiveness after 4-6 weeks

Myths and Facts

Myth: Use as first line treatment for insomnia

Fact: Short term for SEVERE insomnia/1-2 weeks

Appropriate while stabilizing on first line treatment

Once stopped/sporadic or erratic use: rebound insomnia

Not effective for chronic insomnia or late-night insomnia

Myths and Facts

Myth: low doses not addictive

Fact: physical dependence can occur at any dose

Frequently used to prevent perceived/anticipated or actual withdrawal

Rather than original intended purpose

Myths and Facts

Myth: Ambien safer than benzodiazepines

Fact: Bind to GABA receptors/similar to benzos

Not recommended long term use: no evidence of efficacy

Placebo effect

No safety benefit

Older Adults: risk of falls/frequently on multiple medical drugs

Non Benzodiazepine Treatments Anxiety/Insomnia

Treat primary condition

SSRI's/SNRI's

Other meds

Low dose Doxepin

Trazodone/Remeron are options

Increasing doses common:

Trazodone: side effects increase

Remeron: sedative effect decreases with increasing doses

Prescribing Principles

Medical history/list of all meds/PSYCKES

I STOP

Check list for drug-drug interactions/increased potential for over sedation

Substance use: past/present

Review all current psychotropic meds for potential interactions

Never with opioids

Diversion

Potential risk factors

History: drugs/dealing

Failure to respond

Demanding increasing dosages

Explore with patient essential information: how meds are secured particularly if residing with others

Tips: Interpersonal Dimension

Avoid emotional prescribing based on pressure/stress

Be aware of impact of prescribing controlled substance: decision making/relationship with patient

Maintain conservative approach

Adopt an educational role

Consult with colleagues

Patients with Substance use: past/present

Detailed history

If sober/abstinent: proceed with caution

Clarify short term intervention/provide time line

Previous slide: psychoeducation