

GPs should prescribe more benzodiazepines for the elderly

YES

We should stop moralizing and start prescribing benzodiazepines when required (for the elderly and others).

I am currently cautious about prescribing benzodiazepines as I am concerned that, if I am too liberal, my colleagues may think I am a low quality physician. I am sure this is the prevailing mood amongst GPs, although I sense that psychiatrists are less cautious than we are. Many years ago I was involved in a practice where we (the new GPs) thought too many of the patients were on benzodiazepines and proceeded to wean them off. This was a difficult task that required a lot of confrontation and conflict with the patients and, in many cases, we were unsuccessful in 'assisting' them to stop. The patients were functioning well and the problem seemed to be ours not theirs. Their only concern was getting their repeat prescriptions as they realised they would have uncomfortable nights of sleep if they stopped them suddenly. Thus the 'harm' for these patients was my/our high moral stance of thinking they should stop. Over the years I have seen many patients on long-term benzodiazepines, rarely prescribed by myself, and have

had to suppress the mild irritation I feel if my colleagues start patients on these medications. In recent times I have had a rethink. I recently wrote a chapter on anxiety for a British medical textbook (in press) and was aware that benzodiazepines are effective for anxiety but there is concern about habituation and 'addiction'. The issue came to light recently when I was confronted by a 71-year-old patient who was having nightmares so severe they were affecting her the next day. She was not clinically depressed, nor did she have anxiety on gold standard questionnaires. I discussed with her the options. She could try a low dose tricyclic, a benzodiazepine or even quetiapine. I said the benzodiazepine would probably eliminate her nightmares but she would probably be on it forever and that when she was in her 80s she may be more prone to fall and break her hip (the numbers needed to harm, i.e. break a hip in this situation is 91).¹ She was not concerned by the falling and I felt I had fully informed her of her options. Even more recently I spoke to an 87-year-old man who is on 0.5mg of lorazepam prescribed by his GP. He is sleeping well now, but previously complained endlessly about his poor sleep. He has also had a number of falls since starting this medication. I asked him what would he prefer: having a good night's sleep and having falls, or not sleeping and having

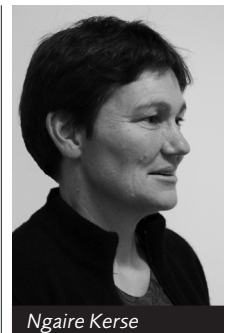
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While evidence can help inform best practice, it needs to be placed in context. There may be no evidence available or applicable for a specific patient with his or her own set of conditions, capabilities, beliefs, expectations and social circumstances. There are areas of uncertainty, ethics and aspects of care for which there is no one right answer. General practice is an art as well as a science. Quality of care also lies with the nature of the clinical relationship, with communication and with truly informed decision-making. The **BACK TO BACK** section stimulates debate, with two professionals presenting their opposing views regarding a clinical, ethical or political issue.



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BACK TO BACK this issue:

fewer/no falls? He chose the former. He now goes to the toilet at night with his walking stick to ensure that he does not fall. I have asked a number of elderly patients about their benzodiazepines and they all prefer the good night's sleep. Sleeping poorly is a considerable bother to those that suffer from it and the promise of sleeping well is immediate and welcomed. I would contend most would choose the short-term option against the hazard of a (small chance of) fractured hip at some distant point in the future.

Insomnia and anxiety are often chronic conditions. It is interesting to consider that we consider diabetes a chronic condition and are happy to give long-term metformin, aspirin and statins to all, in spite of the (small) harms that accompany

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these medications. Anxiety is a long-term condition, yet when standard treatments fail, we are reluctant to consider long-term benzodiazepine. Is this moralizing on our part or perhaps can we be a bit more rational? We know that the numbers needed to treat for cognitive behavioural therapy are about five for anxiety² and that for SSRIs they are also about five.³ For some patients no other treatment works, so in those situations we should consider offering benzodiazepines. We need to fully inform the patients. We need to say: this will help you sleep, but you may not be able to stop taking it (hence you will be on it indefinitely) and you may be more likely to fall when you are older. The risk of breaking your hip when not taking these medications (antidepressants and anxiolytics) is 10.1% and with these medications 11.2%.¹ What would you like to do? I would imagine most insomniac elderly patients would go for the benzodiazepines and take the risk. Insomnia is only a trivial condition for those who don't have it. Philosophically I am not sure I want the whole nation on benzodiazepines as in Aldous Huxley's *Brave New World* where the citizens were on their soma, but anxiety and insomnia are two conditions that are very prevalent in primary care (4.9% of men over 65 and 7.8%

of women over 65 have anxiety⁴) and 44% report insomnia from our unpublished data (2008).

How should we do it? There is evidence that falls are more likely in the first five days of starting benzodiazepines (odds ratio 3.43), but after 30 days this risk becomes non-significant.⁵ What I would take from this is that we should start with a low dose (e.g. 0.25mg lorazepam) and slowly increase as necessary. We should also monitor the risk of falling and encourage the use of walkers and walking sticks.

Summary

For the elderly (and for any age) I think it is worth trying other treatments for insomnia and anxiety. Where those treatments do not work, I think we should abandon our moral superiority and fully inform patients about a legal and therapeutically-effective medication that has some adverse effects (like any medication). We need to be more patient-focused and less concerned about what our colleagues think of us. We should stop moralizing and start prescribing benzodiazepines when required (for the elderly and others).

References

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