

GPs should prescribe more benzodiazepines for the elderly

NO

The answer is undoubtedly 'no', we are using too many of these dangerous, unnecessary medications and should be prescribing fewer. Resist the urge to take the easy way out—undoubtedly proposed by Professor Arroll—and to use these drugs for inappropriate indications where the risks clearly outweigh the benefits. The risk for older people from using benzodiazepines is high.

How much are we using them?

Taking residential care as a key setting: 46% of residents in 1999 took psychotropic medication.¹ In 2005, 25% were taking short-acting sedatives,² with benzodiazepines being one of the most commonly used. In the community it is more difficult to gauge accurate estimates of benzodiazepine use. The age standardised prevalence rate of benzodiazepine use in Auckland general practice was 3.4% for patients over 20 years of age in 1992; however use was predominantly in the elderly (70% were over 60 years of age) and female (62.5%).

In the 2004–2005 Australian National Health Survey, anxiolytics, hypnotics and sedative prescriptions make up approximately 4–5% of the total prescriptions written by Australian general practitioners and 10% of patients used medication for anxiety or nerves.³

How much should we be using them?

Anxiety disorder may be one of the only appropriate indications, where the benefits outweigh the risks of prescribing benzodiazepines.

The prevalence of anxiety in the community is 14.8% over one year and only 9.8 for the previous month.⁴ The MaGPIe study primary care mental

health survey in New Zealand shows that 15% of all people get treated with psychotropic medication;⁵ however 12-month prevalence of anxiety disorder in general practice attenders aged 65+ was only 4.9% for men and 7.8% for women in 2003. There is a clear mismatch between diagnosis and prescribing and it is likely that much of the benzodiazepines use observed in community dwelling older people is related to treatment of sleep disorder.

What's wrong with using them in late life?

There is little right with using benzodiazepines in late life. Reactions to benzodiazepines are often paradoxical and long-term management is notoriously problematic.⁶ Apart from the risk of confusion and development of tolerance, falls are the most problematic result of benzodiazepine use. The effects of hypnotics on balance, gait and equilibrium are the consequence of differential negative impacts on vigilance and cognitive functions, and are highly dose- and time-dependent. It is not surprising that almost no guideline recommends use of benzodiazepines for older people, i.e. Beers criteria for appropriate use of medications.⁷

More importantly, the risk of fracture is increased by over 30%. The RR of fracture associated with use of benzodiazepines was 1.34 (95% CI 1.24, 1.45) in one systematic review of 23 studies.⁸ While any benzodiazepines carried the risk, it was higher for those taking the short-acting high-potency benzodiazepine (IRR, 1.27; 95% CI, 1.01–1.59), during the first two weeks after starting a benzodiazepine (IRR, 2.05; 95% CI, 1.28–3.28), during the second two weeks after starting a benzodiazepine (IRR, 1.88; 95% CI, 1.15–3.07), and for continued use (IRR, 1.18; 95% CI, 1.03–1.35), so short half-life benzodiazepines

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are not safer than long half-life benzodiazepines. Hip fracture risk is highest during the first two weeks after starting a benzodiazepine. Those older people that just want something in the short-term as a result of a recent stress are at highest risk of hip fracture from your prescriptions. Even with a reasonably high NNT, hip fracture is a devastating event. Less than 50% of those with hip fracture regain pre-fracture function and 20% die within 12 months after hip fracture.

In a large group of cognitively normal Canadians, the frequency of falls was 60% greater in benzodiazepine users compared to non-users. Our own Professor John Campbell successfully reduced the risk of falls to 18% (an NNT to cause a fall of 2), in an RCT of older people on benzodiazepines, by reducing the dose of benzodiazepine gradually over six months and continuing a placebo tablet. Unfortunately after unblinding, half of the older people in the intervention group returned to the GP to get their prescription successfully renewed! Systematic reviews also identified that chronic consumers of benzodiazepines are more susceptible to the appearance and progression of many acute and chronic diseases (infectious and malignant diseases).

The risk of using this medication usually far outweighs the benefits and use should be restricted to those with moderate to severe anxiety disorders.

Are they needed for insomnia?

Benzodiazepines do improve sleep; however more patients receiving benzodiazepines reported adverse effects, especially daytime drowsiness and dizziness or light-headedness (common odds ratio 1.8, 95% CI 1.4 to 2.4) compared with other sleep treatments. Cognitive function decline including memory impairment was reported in several of the studies and Zopiclone was not found to be superior to benzodiazepines on any of the outcome measures examined.

A large systematic review compared sleep pharmacotreatments. Benzodiazepines were no better than non-benzodiazepines in reducing time to sleep. All drug groups had a statistically significant higher risk of harm compared to placebo, but benzodiazepines had the highest risk difference.

Non-pharmacological treatment for insomnia is very effective. When identified accurately, primary insomnia responds best to sleep restriction techniques and medications are seldom needed for those in late life. If it is not primary insomnia then an underlying disorder, such as pain, depression or restless leg syndrome should be sought and appropriate treatment started.

Can we stop them?

It is relatively easy to encourage stopping benzodiazepines. A simple letter to patients using these drugs may be effective in reducing usage. Recognised tapering protocols are available and reasonably successful. Older people sleep less and relaxation and sleep hygiene along with sleep restriction can be very successful in improving satisfaction with sleep. Take it slow and make sure the older person wants to stop.

So don't be persuaded by the Professor. We are currently using too many benzodiazepines in older people and exposing them to unacceptable risk associated with their use.

We are definitely NOT under-prescribing benzodiazepines for older people.

References

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