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4.1 Hypnotics and anxiolytics

Most anxiolytics ('sedatives') will induce sleep when given at night and most hypnotics will sedate when given during the day. Prescribing of these drugs is widespread but dependence (both physical and psychological) and tolerance occurs. This may lead to difficulty in withdrawing the drug after the patient has been taking it regularly for more than a few weeks (see Dependence and Withdrawal, below). Hypnotics and anxiolytics should therefore be reserved for short courses to alleviate acute conditions after causal factors have been established.

Benzodiazepines are the most commonly used anxiolytics and hypnotics; they act at benzodiazepine receptors which are associated with gamma-aminobutyric acid (GABA) receptors. Older drugs such as meprobamate and barbiturates (section 4.1.3) are **not** recommended—they have more side-effects and interactions than benzodiazepines and are much more dangerous in overdosage.

PARADOXICAL EFFECTS

A paradoxical increase in hostility and aggression may be reported by patients taking benzodiazepines. The effects range from talkativeness and excitement, to aggressive and antisocial acts. Adjustment of the dose (up or down) usually attenuates the impulses. Increased anxiety and perceptual disorders are other paradoxical effects. Increased hostility and aggression after barbiturates and alcohol usually indicates intoxication.

DRIVING

Hypnotics and anxiolytics may impair judgement and increase reaction time, and so affect ability to drive or operate machinery; they increase the effects of alcohol. Moreover the hangover effects of a night dose may impair driving on the following day. See also Drugs and Driving under General Guidance.

DEPENDENCE AND WITHDRAWAL

Withdrawal of a benzodiazepine should be gradual because abrupt withdrawal may produce confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens. Abrupt withdrawal of a barbiturate (section 4.1.3) is even more likely to have serious effects.

The benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting benzodiazepine, but may occur within a few hours in the case of a short-acting one. It is characterised by insomnia, anxiety, loss of appetite and of body-weight, tremor, perspiration, tinnitus, and perceptual disturbances. These symptoms may be similar to the original complaint and encourage further prescribing; some symptoms may continue for weeks or months after stopping benzodiazepines.

A benzodiazepine can be withdrawn in steps of about one-eighth (range one-tenth to one-quarter) of the daily dose every fortnight. A suggested withdrawal protocol for patients who have difficulty is as follows:

1. Transfer patient to equivalent daily dose of diazepam(1) preferably taken at night
2. Reduce diazepam dose in fortnightly steps of 2 or 2.5 mg; if withdrawal symptoms occur, maintain this dose until symptoms improve
3. Reduce dose further, if necessary in smaller fortnightly steps(2); it is better to reduce too slowly rather than too quickly
4. Stop completely; time needed for withdrawal can vary from about 4 weeks to a year or more

Counselling may help; beta-blockers should **only** be tried if other measures fail; antidepressants should be used **only** for clinical depression or for panic disorder; **avoid** antipsychotics (which may aggravate withdrawal symptoms).

CSM advice

1. Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term

psychosomatic, organic or psychotic illness.

2. The use of benzodiazepines to treat short-term ‘mild’ anxiety is inappropriate and unsuitable.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress.

Sub-sections

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(1) Approximate equivalent doses, diazepam 5 mg
=chlordiazepoxide 15 mg

=loprazolam 0.5–1 mg

=lorazepam 500 micrograms

=lormetazepam 0.5–1 mg

=nitrazepam 5 mg

=oxazepam 15 mg

=temazepam 10 mg

(2) Steps may be adjusted according to initial dose and duration of treatment and can range from diazepam 500 micrograms (one-quarter of a 2-mg tablet) to 2.5 mg