Case Report

Benzodiazepine maintenance for alcohol dependence: A case series

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Abstract

Alcohol addiction is a chronic relapsing syndrome. Benzodiazepines remain as the mainstay for detoxification, taking care of the acute withdrawal syndrome. There is fear of dependence and abuse of benzodiazepines on prolonged use. Here, we selectively interviewed ten cases who were on longer duration of benzodiazepines to elicit their potential perceived benefits, attitudes, and any adverse effect. Three patients experienced adverse effects. None of them had features of benzodiazepine dependence. We opine that in select cases, benzodiazepine use should persist beyond detox period, and its benefits continue beyond the acute withdrawal phase while monitoring their safety/adverse effects.

Keywords: Addiction, alcohol, benzodiazepine, harm reduction, relapse prevention, substitution therapy

Introduction

The prevalence of alcohol use in general adult population in India is about 32% while alcohol dependence is 17%.[1] Alcohol dependence is a severe form of addiction. Benzodiazepine forms mainstay of treatment for acute withdrawal phase. The duration of benzodiazepine use is limited to 10–14 days in the acute phase of detoxification in most cases.[2]

Short-term relapse rate is described to be as high as 80%.[3] Moreover, cost considerations prevent the use of anticraving agents such as acamprosate or naltrexone effectively in all patients. Concepts such as "controlled drinking" may not work for a large proportion of alcohol-dependent patients in India. As an alternative, substitution therapy based on harm reduction principle is practiced for many addictions. For example, opioid substitution therapy for opioid dependence.[4]

Benzodiazepine substitution therapy may be considered for alcohol dependence because of their GABAergic properties that can make them effective substitutes for alcohol.[5] Persistent insomnia and craving are common reasons for relapse and therefore longer periods of benzodiazepine prescription. Simioni *et al.*, 2012[6] have proposed prolonged treatment with the benzodiazepine to prevent relapse in detoxified alcoholics. However, there is a tendency to limit benzodiazepine use to acute withdrawal phase, and there is fear of benzodiazepine abuse in this population. To support this, many textbooks advise not to continue benzodiazepine beyond 8 weeks for any condition.[7]

We selectively interviewed those patients under follow-up in our deaddiction clinic who were prescribed benzodiazepine beyond the acute detoxification period to assess harmful use or dependence to benzodiazepines, to check their perception about the treatment and for any adverse effect. This was done as a clinical audit and followed the principles of Ethics as envisaged in the Declaration of Helsinki 1964. We did not seek the Institute Ethics Committee approval for publication of this audit.

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Materials and Methods

Patients visiting psychiatry outpatient department (OPD) for alcohol dependence are evaluated, detoxified (either as inpatients or outpatients), and subsequently followed up in OPD once a fortnight for relapse prevention. We interviewed patients who were having alcohol dependence in the absence of any medical or psychiatric comorbidity and were on benzodiazepines for more than 8 weeks. We interviewed these patients along with their key informant on structured pro forma. We assessed for dependence or harmful use of benzodiazepine and their perception of benzodiazepine use beyond the period of detoxification.

Results

We interviewed ten selected patients currently maintaining abstinence from alcohol and taking treatment from the deaddiction clinic. All were male patients aged between 30 and 59 years (average of 44 years). All were married and employed: four skilled and six unskilled. Four of these were irregular at work. There was wide variation in the time taken for normalization of sleep pattern; it varied from 1 to 16 weeks after the end of detoxification. Seven people had missed a dose on occasions and only 2 of these reported sleep disturbance on those occasions [Table 1].

Five patients still reported an occasional manageable craving for alcohol while on benzodiazepine. Three reported adverse effects: two memory disturbance and one with daytime drowsiness. Five patients harbored negative attitude toward continuing of benzodiazepines while three patients told their friends made a negative remark on their use. No patient reported negative remarks made either by their family members or by any health staff on their use of benzodiazepines. On assessment, none of the patients had criteria fulfilled for either harmful use or dependence syndrome. Five said they will continue medication as long as advised by their doctor while two said they will take it for 1 year, and one said he will continue to take it for sleep. On the confidence of staying sober without the medication, five expressed less confidence [Table 2].

Table 1 : Parameters regarding dose, duration and sleep

	Mean±SD	*n*
Duration of ADS[yrs] Range: 3-29 yrs	13.6±8.9	
Duration on Prescribed Benzodiazepine [months] Range: 3-13months	7.8±3.6	
Current benzodiazepine: Diazepam equivalents (mg/day)	7.5±2.6	
Medical comorbidity: Peripheral neuropathy	1	
Other comorbid substance use: NDS	2	
Time taken for sleep to improve after detoxification initiated Range: 1-16 weeks	1 weeks	2
	2 weeks	3
	4 weeks	3
	16 weeks	2
Missed dose anytime: Yes	7	
Problems with missing does: Yes	2	

ADS: Alcohol dependence syndrome as per ICD-10

Table 2: Others parameters of interest

	n (%)
Craving for alcohol: Present	5 (50)
Adverse effects: Present (memory-2+drowsiness-1)	3 (30)
Patient has negative attitude toward: Yes	5 (50)
Negative remark by medical/paramedical staff: Yes	0
Negative remark by family member: Yes	
Negative remark by friend: Yes	3 (30)
Current–harmful use/dependence symptoms	0
Intended duration	
As per doctors' advice	5 (50)
For 1 year	2 (20)
For sleep	1 (10)
Presence of anxiety disorder	0
Confident of staying sober without benzodiazepine: Low	5 (50)

Discussion

In select cases of alcohol dependence syndrome, detoxification with benzodiazepines for more than 8 weeks revealed no attempt of abuse or dependence to benzodiazepines. Patients continued to use even after the sleep improvement had happened. About 50% felt they could stay sober even without the benzodiazepine. Some had a negative attitude toward continued use which is probably taken as a sign of moral weakness.

Although there were no cases of harmful use or dependence developing in the interviewed patients, three patients had reported adverse effects such as memory disturbances and increased sedation.

Benzodiazepines are safe, have negligible abuse potential compared to barbiturates and alcohol.[8] Even in anxiety disorders, the presence of alcohol abuse does not increase the risk for benzodiazepine abuse.[9,10]

Conclusion

Our case series suggests that extension of the use of benzodiazepines beyond the recommended acute phase of detoxification may be considered in select cases with due monitoring of safety and adverse effects. Benzodiazepines may have utility in "harm reduction" strategies for alcohol-dependent patients who are unable to abstain by other long-term strategies. Trials of 3–6 months duration testing the efficacy of benzodiazepines may be considered in the future in patients who have repeated relapses after acute phase treatment.

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Conflicts of interest

There are no conflicts of interest.

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