

IMPORTANT MESSAGE

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Professor Ashton would like to draw attention to the following points which are mentioned in the manual but not always heeded by doctors or patients:

1. It is worth pointing out to your prescriber that the withdrawal schedules provided in the manual are only intended as *general guides*. **The rate of tapering should never be rigid but should be flexible and controlled by the patient, not the doctor, according to the patient's individual needs which are different in every case.**

The decision to withdraw is also the **patient's decision** and **should not be forced by the doctor**.

2. Note that alcohol acts like benzodiazepines and should be used, if at all, in strict moderation as advised in this manual.
3. Antibiotics for some reason, sometimes seem to aggravate withdrawal symptoms. However, one class of antibiotics, the quinolones, actually displace benzodiazepines from their binding sites on GABA-receptors. These can precipitate acute withdrawal in people taking or tapering from benzodiazepines. It may be necessary to take antibiotics during benzodiazepine withdrawal but if possible the quinolones should be avoided. (There are at least six different quinolones - ask your doctor if in doubt).

C. H. Ashton, January 2007

Also:

WHY SWITCH TO DIAZEPAM?

1. Diazepam [Valium] is one of the most slowly eliminated benzodiazepines. It has a half-life of up to 200 hours, which means that the blood level for each dose falls by only one half in about 8.3 days. The only other benzodiazepines with similar half lives are chlordiazepoxide [Librium], flunitrazepam [Rohypnol] and flurazepam [Dalmane] all of which are converted to a diazepam metabolite in the body. The slow elimination of diazepam allows a smooth, gradual fall in blood level, allowing your body to adjust slowly to a decreasing concentration of the benzodiazepine. With more rapidly eliminated benzodiazepine e.g. lorazepam, (Ativan) (which has a half-life of 10-20 hours) the blood concentration drops rapidly and withdrawal symptoms can occur between doses, because your body has little time to adjust to low concentrations.

2. Diazepam comes in the smallest dosage levels of all benzodiazepines – 2mg tablets which can be halved to give 1mg doses. This means you can reduce in stages of 1mg every 1-4 weeks or more. It is difficult to obtain such low doses of other benzodiazepines. For example the lowest dose of lorazepam in the UK is 1mg, equivalent to 10mg of diazepam. (In the US 0.5mg lorazepam are available, but these are equivalent to 5mg diazepam).
3. Many other benzodiazepines are more potent than diazepam. For example lorazepam (Ativan) is 10 times stronger and it is difficult to reduce from this gradually. Temazepam [Restoril], though less potent than diazepam, has a shorter half-life and the smallest tablet is 10 mg (equivalent to 5mg diazepam).
4. Because of the slow elimination and small available dosage strengths of diazepam, it is often advisable to switch to diazepam when withdrawing from other stronger or more rapidly eliminated benzodiazepines. This switch allows you to tail off your benzodiazepine dosage smoothly and gradually and minimises withdrawal symptoms.
5. When making the switch it is important to do it gradually, replacing one dose at a time and at approximately weekly intervals and making allowance for the difference in potency. For example, if you are taking lorazepam 1mg three times daily, first change the night dose to 10mg diazepam. (This can be done in two stages if necessary e.g. lorazepam 0.5mg (half a 1mg tablet) plus diazepam 5mg; then drop the lorazepam and go on to diazepam 10mg). A week or two later change one of the day-time doses, and two weeks later change the other day-time dose.

C. H. Ashton, April 2001