Published 28 August 2008, doi:10.1136/bmj.a658
Cite this as: BMJ 2008;337:a658

Practice

10-Minute Consultation

New patient asking for a benzodiazepine prescription

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Your final patient on a Friday is a 26 year old man who is new to the list. He asks you for a repeat prescription for two months of diazepam, 5 mg up to four a day. He says he has been taking these for a while for his "nerves" and he has run out. You do not hold this patient's records.

What issues you should cover

You have to weigh up whether the risks of prescribing diazepam to this particular patient outweigh those of not prescribing. You should be as helpful as possible while checking whether he genuinely needs the prescription.

Is it appropriate to prescribe diazepam to this patient?

History—Is any information available about his previous consumption and medical history? This may be a repeat prescription slip or packaging giving details of the drug and amount prescribed. It may be possible to speak confidentially to his previous doctor or pharmacist by telephone while he waits (or early the next week). Most genuine patients can provide information about their previous general practitioner or pharmacy and are willing to wait while checks are made.

Indication—It is worth exploring why benzodiazepine treatment was started. However, whether it is an appropriate treatment for the long term may need to be explored in later consultations.

Dependency—Is the dosage he asks for likely to have resulted in dependency? Does he show signs of withdrawal? Anxiety, sweating, tremor, and insomnia are common features. Severe withdrawal symptoms, including seizures, are associated with prolonged use, a high dosage, short acting and potent benzodiazepines, and rapid withdrawal.

Is it safe to prescribe?
Take advice—Your computer system and drug formulary have information about interactions and contraindications.

Comorbidity—A history of seizures should lead to caution and a slow withdrawal of benzodiazepines, because of the risk of recurrence.

Polypharmacy—Benzodiazepines, where part of polypharmacy, are more likely to result in overdoses and, particularly in elderly patients, confusion and falls.

Substance misuse—Benzodiazepine use in association with misuse of alcohol, opiates, or other psychoactive substances raises the risk of respiratory depression and death. Benzodiazepines are misused by a large proportion of polydrug misusers, although legitimate prescriptions are not the major source of misused benzodiazepines, and their street value is low.

Further reading

Benzodiazepine addiction, withdrawal and recovery. www.benzo.org.uk (the "Prof Ashton" link is very useful, especially the "Ashton manual")

Voshaar RC, Couvee JE, van Balkom AJ, Mulder PG, Zitman FG. Strategies for discontinuing long-term benzodiazepine use: meta-analysis. *Br J Psychiatry* 2006;189:213-20

Kan CC, Hilberink SR, Breteler MH. Determination of the main risk factors for benzodiazepine dependence using a multivariate and multidimensional approach. *Compr Psychiatry* 2004;45:88-94

Department of Health. *Drug misuse and dependence: guidelines on clinical management*. London, TSO, 1999

National Institute for Health and Clinical Excellence. *Epilepsy* (CG20). www.nice.org.uk/CG020

What should you prescribe?
Short term prescription—Prescribing a benzodiazepine for a short period such as <5 days may minimise the risk while giving you the opportunity to contact his last doctor for information.

Substitution—Prescribe longer acting benzodiazepines rather than short acting drugs, as they are safer and less likely to be misused and may reduce the likelihood of withdrawal symptoms. Example equivalent doses and half lives are set out in the table♣. The equivalent doses are a guide, and specific advice should always be obtained from the *British National Formulary* (www.bnf.org/bnf/) or equivalent or from a pharmacist.

Effect, half life, and equivalent dose of benzodiazepines

Drug	Effect	Approximate half life (hours)	Approximate equivalent dose
Lorazepam	Short acting	10-20	1 mg
Diazepam	Long acting	20-100	10 mg
Temazepam	Short acting	8-20	20 mg
Chlordiazepoxide	Long acting	5-30	30 mg

Consequences—You should address his expectations about future prescriptions up front, conforming to practice policy and the best evidence.

What you should do

- Assess your personal risk. Patients who are desperate for a drug may be manipulative or aggressive. Examples of manipulative behaviour include playing one doctor off another: "Doctor X understands me and always prescribes what I need." They may pose mild threats such as leaving the list or not leaving the room until they get what they want. All consulting rooms should have panic buttons, and their use should be rehearsed periodically.
- If you have some doubt about prescribing a benzodiazepine or consider that he is at risk from sudden withdrawal, prescribe a few days' treatment while you make further checks.
- If you prescribe a drug, advise him to take it at appropriate intervals.
- Arrange a review appointment the next week to discuss possible benzodiazepine withdrawal or substitution and to develop a shared management plan.
- Your practice should have a standard approach to acute prescribing and for tailing off long term prescriptions. Our practices prescribe five to seven days of acute prescriptions, avoiding follow-up on Monday or Friday. Other practices have one doctor who deals with all the practice's cases of drug dependency. If you do not have a standard approach, word may get around about which GPs "prescribe." Audit your practice policy. Primary care trusts' prescribing advisers can often benchmark your practice's prescribing with that of other practices.

Cite this as: *BMJ* 2008;337:a658

Competing interests: None declared.

Provenance and peer review: Not commissioned; externally peer reviewed.

This is part of a series of occasional articles on common problems in primary care. The *BMJ* welcomes contributions from GPs.

(Accepted 3 May 2007)