Letters to the Editor

Preference is given to letters commenting on contributions recently published in the JRSM. *They should not exceed* **300 words** *and should be* **typed double-spaced.**

Benzodiazepines in anxiety management

I read with interest the article by Deans and Skinner (February 1992 *JRSM*, p 83) on the general practitioners' views on the prescription of benzodiazepines for the management of anxiety.

When Sternbach first synthesized benzodiazepine in 1955, unlike other psychotropics, it did not attract much attention. It was only 5 years later that several open clinical investigations supported its anxiolytic properties[1]. Its anxiolytic properties were undisputed but the risk of dependence too was realized relatively early. In 1961 Hollister *et al.*[2] indicated that on sudden withdrawal an acute abstinence syndrome may result and later reports suggested that tolerance and acute drug seeking behaviour may result[3,4]. Benzodiazepines, however, were widely used and such reports were relatively uncommon. Marks[5] concluded that the risk of developing benzodiazepine dependence was 1 in 5 million months of all patient use and 1 in 50 million months of patients in therapeutic use suggesting that if prescribed for correct therapeutic indications the risk of dependence is insignificant. More recently, The American Psychiatric Association (APA) Task Force on Benzodiazepine Dependence, Toxicity and Abuse[6] noted that benzodiazepines are important therapeutic drugs when carefully prescribed for appropriate patients. It further added that clinicians should feel comfortable prescribing benzodiazepines for appropriate patients but the potential for toxicity and dependence must be considered before prescribing. The Task Force felt that at standard therapeutic doses, short-term treatment is usually without substantial toxicity or development of dependence.

In recent years the scare of benzodiazepine dependence has startled the practising fraternity. This fear may in fact be an over-exaggeration because of unwanted effects resulting from improper and indiscriminate prescription of benzodiazepines in the recent past. Sudden withdrawal of triazolam from the UK market on 2 October, 1991 seems to have taken the prescribing practice of the practitioners to the other extreme. Whereas earlier the benzodiazepines were prescribed for 'any thing and every thing', physicians now fail to prescribe it even when the patient should get the benefit of its remarkable pharmacological properties. It should not be forgotten that benzodiazepines are very useful anxiolytics and if prescribed for the right indications and for short duration, they are relatively safe as well. There is no doubt that non-pharmacological intervention is helpful towards final therapeutic aim of anxiety relief but it may be insufficient when anxiety is severe and in certain anxiety disorders such as panic disorders[7]. Benzodiazepines can be invaluable as a short-term adjunct to non-pharmacological treatment when anxiety is clearly immensely distressful to the patient and hinders any progress towards recovery.

Key to correct prescription is correct diagnosis. Anxiety disorders are incapacitating and can become chronic if not handled appropriately. Patients should not be denied the benefit of specialist advice if such a facility is accessible so that necessary pharmacological or non pharmacological measures, as the case may be, can be undertaken at the earliest.

D K Arya — Registrar in Psychiatry
University Hospital, Nottingham

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2 Hollister LE, Motzenbecker FP, Degan RO. Withdrawal reactions from chlordiazepoxide (Librium). *Psychopharmacologia* 1961;**2**:63-8
3 Gordon EB. Addiction to diazepam (Valium). *BMJ* 1967;**i**:112
4 Preskorn SH, Denner LJ. Benzodiazepines and withdrawal psychosis: report of three cases. *JAMA* 1977;**237**:36-8
5 Marks J. *The benzodiazepines: use, overuse, misuse and abuse.* Lancaster: MTP Press, 1978
6 Brown CS, Rakel RE, Wells BG, *et al.* Update on anxiety disorders and their pharmacological treatment. *Arch Intern Med* 1991;**151**:873-84
7 *Benzodiazepine dependence, toxicity and abuse.* A Task Force Report of the APA, Washington DC: APA, 1990

Age changes in the teeth

In his article 'Quantitative studies on age changes in the teeth and surrounding structures in archeological material: a review' (February 1992 *JRSM*, p 97) Dr Whittaker appears to misrepresent my views about crestal alveolar bone and the relationship of the junctional epithelium to the amelo-cement junction, if he implies that these views are contrary to those of Murphy. In a study reported nigh on 30 years ago[1] I showed that in health tooth attrition is accompanied by compensatory occlusal movement of teeth and supporting tissues with bone deposition at the alveolar crest and socket fundus so that facial height is maintained. During this movement the junctional epithelium stays at the amelo-cement junction. In normal function this process seems to take place throughout life. Because chronic destructive periodontal disease is so prevalent and usually intermittent over many years during which time attrition also takes place, the interpretation of bone morphology in archeological material, as Dr Whittaker indicates, is not straightforward.

J D Manson — 12 Wheatley Street,
London W1M 7PS

References

1 Manson JD. Passive eruption. *Dental Practitioner* 1963;14:2

The author replies below:

My reference to theories of periodontal bone loss and the findings of Manson were based on his phrase 'if one makes the assumption that bone loss starts at about the age of 20 years, total loss takes about 40 years'. I interpreted this as suggesting that horizontal bone loss may occur to some extent throughout life.

I am indebted to Dr Manson for referring readers to his earlier paper on passive eruption. This makes it clear that tooth attrition is accompanied by compensatory movement of teeth in an occlusal