control group. They observed that 'The death rate in the test group (10.6%) was not significantly different from that of the control group (15.9%)'. Presumably the sample size was determined by the list of the practice in question, but any study which failed to find a significant difference between mortality rates of this magnitude was too small.

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The prevention of convulsions during benzodiazepine withdrawals

Sir,

Benzodiazepine misuse and dependency are common problems in general practice.[1] While many patients are dependent solely on these drugs, poly-drug abusers also include them in the range of substances which they misuse.[2] Withdrawing from such misuse may be straightforward but a substantial proportion of patients suffer from various complaints, with major convulsive seizures being among the most serious objective disorders encountered.[3] To minimize the risks to patients during withdrawals it is now generally recommended that a gradual reduction in dosage takes place.[4] Four to 16 weeks or even longer are advised though confusion may be caused by the 10 day course of detoxification recommended by one authorative source.[5] Personal experience of dealing with relatively large numbers of patients admitted to a residential drug rehabilitation unit suggested that a short course of oral diazepam was effective in preventing convulsions during withdrawals. The study reported here was designed to test this.

All patients with a history of benzodiazepine misuse admitted to the unit from 15 September 1989 to 18 December 1989 were prescribed 60 mg of oral diazepam per day. This was reduced in 10 mg steps per day to zero over six days. No other drugs with any potential anticonvulsant action were given.

Nineteen patients were eligible for the study. Four defaulted during the first six days of residence and were excluded. Of the 15 patients remaining in the study five were women and 10 men; their age ranged from 18 to 27 years. Nine (60%) had a history of convulsions during previous benzodiazepine withdrawals, 13 (87%) had been injecting themselves with benzodiazepines and all patients had been taking other substances. Temazepam was the most frequently abused drug with a mean daily dose in the month prior to admission of over 350 mg. The interval between the last self administered illicit dose and the first dose of prescribed diazepam ranged from 10 to 96 hours (mean 39 hours). The patients remained in residence and under observation from 11 to 58 days (mean 38 days).

No patient convulsed during the study. While no formal attempt was made to assess other symptoms during detoxification, no major pschiatric disorders developed. Indeed it was apparent that many patients found the process less demanding than they had anticipated. The optimistic and caring environment created in the unit by its staff may well have contributed to this positive outcome. It seems probable that such support, especially from close family members, would be equally helpful in general practice. With a significant proportion of poly-drug abusers spending periods in prison and hospital it is likely that the short course of detoxification described here could also prove useful in these areas.

It is concluded that the standardized 'sliding scale' of diazepam outlined above is effective in preventing benzodiazepine withdrawal fits when used in a residential setting.

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References

1. Higgit A, Lader MH, Fonagy P. Clinical management of benzodiazepine dependence. *Br Med J* 1985; 291: 688-690.
2. Scott RTA. Medical aspects of drug misuse during one year in a drug rehabilitation unit. *J R Coll Gen Pract* 1986; 36: 514-516.
3. Robertson JR, Skidmore CA, Roberts JJK. Benzodiazepines and convulsions. *Lancet* 1988; 2: 504-505.
4. *British national formulary.* London: British Medical Association and The Pharmaceutical Press, 1989; number 18: 142.
5. Banks A, Waller TAN. *Drug misuse. A practical handbook for GPs.* Oxford: Blackwell Scientific Publications, 1988: 229-230.

Characteristics of long-term benzodiazepine users in general practice

Sir,

The paper by Simpson and colleagues (January *Journal*, p.22) made interesting reading. As a psychiatrist with research interest into benzodiazepines I have been studying the same phenomenon from a different angle.

Much of the published research on the management of benzodiazepine dependence has been based on hospital outpatient samples and I suspected that these findings might have limited applicability to patients in general practice. I have therefore made a comparison of patients attending a hospital clinic for treatment of dependence (n = 60) with long term benzodiazepine users in a local general practice (n = 104). The characteristics of the latter group agree almost exactly with the findings of Simpson and colleagues. The model patient is aged, physically ill and taking hypnotic benzodiazepines in 'normal' thereapeutic doses. The hospital clinic patients were on average 25 years younger (mean 40.2 years) and were using higher doses of anxiolytic medicine (mean 38 mg diazepam equivalent daily). Major physical disease was uncommon (12%) but major psychological disease was common (64%). The most dramatic difference concerned the motivation of the patient to withdraw from their drugs. All the hospital patients rated themselves as at least moderately motivated to discontinue use. Determined efforts were made to assess the motivation of the general practice patients to discontinue their drugs. A mail shot, telephone contact with patients and discussions with general practitioners and other health workers resulted in only two consultations.

I would concur that the management strategy applicable to younger anxiolytic dependent patients in the hospital setting probably has little relevance to the population of benzodiazepine users in general practice. However, in view of seemingly poor motivation on the part of patients it is difficult to know what the best approach is.

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The patient as consumer?

Sir,

Professor Campbell's editorial 'The patient as consumer' (April *Journal*, p.131) has highlighted ethical problems which are causing great concern, not only among the medical profession, but also among the patient population. The title would perhaps have benefited by the addition of a large question mark, not only because the concept of patient as consumer is highly controversial and far from achieving general acceptance, but also to indicate that widespread debate is necessary on this all-important issue.

The Patients' Liaison Group of the Royal College of General Practitioners has great difficulty in equating the patient with consumerism. It has for a number of years been concerned to strengthen the