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Short Communication

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On the Clinical Use of High doses of Benzodiazepines

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A small percentage of benzodiazepine users end up to a long-term use of high doses of benzodiazepines [1]. In clinical guidelines this is usually considered a sign of tolerance and drug dependence that should be avoided almost by any cost. In my own clinical experience of almost fifty years many of these chronically anxious patients have, however, ended up to the use of high doses of benzodiazepines after multiple failures with several other drugs or psychotherapies. Neither have these patients of mine belonged to the group of polysubstance abusers who use benzodiazepines in high doses adjunctively with alcohol or opioids to enhance a high or to alleviate the withdrawal symptoms of these drugs [2].

Surprisingly there is an almost a total lack of even case studies of these often stigmatized and neglected patients [3, 4]. The idea of "tolerance" development as the reason for the high doses is uncritically accepted, as a clinically meaningful tolerance to the anxiolytic effects of benzodiazepines is known to be rare or even non-existent [5]. In my own experience the high dose of benzodiazepines does not increase after the subjectively effective high dose up to 8-12 mg clonazepam per day has been reached. The plasma levels of benzodiazepines of these patients of mine have been within normal limits and the replacement of benzodiazepines by sedative antipsychotics has required exceptionally high doses of antipsychotics. The clinical need for high-doses may thus reflect genetically determined differences in the pharmacokinetics or -dynamics of these patients. There are many other unanswered questions on the evolution and reason of the high doses of benzodiazepines.

On what basis is the long-term use of antidepressants or off-label use of sedative antipsychotics with their numerous side effects considered per se safer or better than the maintenance use of high doses of benzodiazepines? If a patient must use antihypertensives or antipsychotics in high doses to treat his blood pressure or schizophrenia, is he considered "drug-dependent"?

What is the problem of the high dose if the patient has clear benefit from it and does not have or suffer from clinically meaningful cognitive or other side effects of benzodiazepines? Patients may themselves prefer mild side-effects of the drug over the continuous anxiety or anxiety-driven insomnia.

Anxiety is a subjective experience with no objective measure. There is no sense in using subjectively ineffective dose in the maintenance treatment of serious anxiety disorders. A subjectively subclinical dose is only bound to drive the patient to unnecessary polypharmacy, to illegally obtained drugs or to resort to anxiolytic effects alcohol or opiates. In clinical practice you must listen to the patient when determining the individually effective maintenance dose of benzodiazepines [6, 7]. This practice requires a confidential and mutually respective doctor-patient relation.

It is true that some patients with high doses of benzodiazepines can be gradually tapered off of the use of the benzodiazepines. But it is also true that many of the chronically anxious patients do need maintenance use of high doses of benzodiazepines. The trial of tapering off the benzodiazepines should, however, be done individually and agreed by the patient [8]. An abrupt or forced withdrawal of the long-term used benzodiazepines poses a serious risk for the patients [9].

The register-based epidemiological studies do not share any light what-so-ever on the characteristics of these often-neglected patients and thus on the clinical appropriateness of the high doses of benzodiazepines. Thus, there is an urgent need to conduct systematic clinical research on the history and of the clinical characteristics of the often-neglected patients with long-term use high doses of benzodiazepines.

Conflicts of Interest

The author does not have any conflicts of interest

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