Session 3

Diane E. Hindman: I know that historically we have been taught about thiamine deficiency and Wernicke's when dextrose given. I have heard that this is not still current thinking. Please comment on the evidence around this thinking.

- Andrea Leigh Lubeck: I WORK in an addiction unit we still give and the in pt. units give thiamine
- Reuben Strayer: classic teaching of avoiding glucose prior to thiamine is no longer thought to be true
- Dr. Restrepo: The evidence is to follow what can help your patient. I hope you do not take the risk not to give Thiamine to a person in acute withdrawal with strong past h/x of ETO use disorder. Wernicke syndrome and Korsakoff syndrome (WKS) are distinct but overlapping disorders that occur due to a deficiency of thiamine (vitamin B1). Wernicke syndrome, also known as Wernicke encephalopathy, is a neurological disease characterized by three main clinical symptoms: confusion, the inability to coordinate voluntary movement (ataxia) and eye (ocular) abnormalities. Wernicke syndrome is considered the acute phase of WKS and if left untreated, transitions to the chronic irreversible Korsakoff syndrome. When these two disorders occur together, the term Wernicke-Korsakoff syndrome is used. In the United States, most cases occur associated with chronic consumption of alcohol but can occur in individuals who have malnutrition, eating disorders or other conditions that cause a deficiency in thiamine. Additionally, studies indicate that there may be some genetic predisposition for the disease.
- Dr. Restrepo: Chandrakumar A, Bhardwaj A and 't Jong GW. Review of thiamine deficiency disorders: Wernicke encephalopathy and Korsakoff psychosis. J Basic Clin Physiol Pharmacol 2019; 30(2): 153–162 https://doi.org/10.1515/jbcpp-2018-0075

Diane E. Hindman: I worry about the recommendation to use gabapentin in the context of thinking that it doesn't cause addiction liability. There is evidence that these drugs also have dependence/addiction concerns as well now.

- Adam Lake: It is the tramadol of benzodiazepines...
- Dr. Restrepo: You are right. It is important always to be aware of the potential use and the risk and benefits of it. Do not give 5 refills when you prescribe it. Try to use monthly and use your clinical expertise

Sheila Chapman, MD: can you comment on the use of phenobarb in treatment of the acute alcohol withdrawal syndrome? Thanks.

- Dr. Restrepo: It is a useful approach that some people feel comfortable using. I would not do it on the output settings. On the Benzo lecture I am explaining in detail the best scenario to use it and how.
- Sunil Khushalani: Phenobarb tapers can take weeks. It is hard to do this as an inpt as most patients cannot stay on an inpt for that long. It can be started as an inpt but has to be continued as an outpatient

Bruce Burns: Wonder what growth of prescription stimulants is compared with benzos??

- Dr. Restrepo: Benzo es prescribe more but stimulant use is growing. In California as you now the methamphetamine use is growing again

Adam Lake: Is this prescribing by specialty the new starts or all prescriptions?

- Adam Lake: In primary care, I find that many of my patients on benzos had them started by other specialties and then they defer to me to continue them...
- Dr. Restrepo: Not really. It is an important topic of dialogue between us. Many people advocate for just psychiatrist prescribing it. I think all of us are capable to prescribe medications in the best way we can with good guidelines and clinical approach which can benefit our patients

Tonya: Does the increase in PCP Rx use by BZD include the zolpidem, etc?

- Dr. Restrepo: I am not sure about it

Helene Alphonso: I noticed the sample test questions stressed that benzo's alone are relatively safe and less likely to be fatal in OD when used alone. Keep that in mind during the test. I missed these questions.

Luther Philaya: I recently treated a patient who was prescribed 35 mg of zolpidem qhs by his psychiatrist. Had been on this dose for 2+years Detox was understandable arduous. Anyone ever seen this high dose

- Leslie Hayes: Wow. Strong work for being able to detox the patient.
- Adam Lake: ever seen more than 12.5mg qHS, that's got to be a rough post-acute withdrawal for this patient
- Luther Philaya: He was miserable. Interestingly he did best with phenobarbital load and SLOW taper. Worked better than diazepam.

Kamakshi Neelkantan: How does one relay to PCPs to look at another medication for Anxiety instead of Benzodiazepine on patients on on treatment for OUD.

- Dr. Restrepo: The most important message is to assess the indication, to see the risks and benefits and make the right decision based on your clinical skills and needs

Mike Weddle: Comments on increased mortalities after starting BNZ and Z drugs, and specifically assoc of malignancies thought ? due to immune dysfunction due to sleep cycle disruption?

Anyse Storey: I have a patient on Tianeptine 1500mcg/day .I am trying to taper and induct with buprenorphine. I can't find a lab to test for tianeptine in Toledo, Ohio.

Helene Alphonso: Because Belsomra is an orexin inhibitor would it still be grouped with the other Z drugs?

- Adam Lake: Looks like the cancer risk might not be as high, but limited data so far: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4648222/
- Dr. Restrepo: The potential for psychological dependence is similar to that of zolpidem

Denise Szczucki: Can you comment the risk of car accidents related to benzodiazepine use?

Leslie Hayes: What do you feel are appropriate uses for benzos?

Margaret Russell: As a PCP I have never started someone on benzodiazepines but I have many patients who have been on them for years or decades. It's extremely difficult to taper them off. Any recommendations?

- Leslie Hayes: So frustrating. We recently had a clinical prescribing psychologist lose his ability to practice. I inherited 10 patients on alprazolam, 6mg daily, most of whom were also on methadone or buprenorphine. I have been slowly tapering, but the patients are so resistant.
- Adam Lake: Same here. So hard to get buy in, especially if they are looking at the benefit being long term and the short term being tougher.
- Dr. Restrepo: If they are taking the medication appropriately why to taper?
- Dr. Restrepo: It is important that you assess with them the dosage, the reason, the amount and the consequences
- Leslie Hayes: I have been tapering because they were sedated and using with methadone which seemed dangerous.
- Margaret Russell: Same. Tapering because they are on other high-risk medications, have high risk comorbidities, or are having symptoms like falls, memory lapses - often more than one of the above - plus aging on high doses
- Donald Foster: Same I'm the only doc that treats Addiction in our rural area mostly OUD and i have pts on Benzos for years and stable w/o relapse or mis use my concern to stop benzos would be relapse on heroin especially given my psych in the area is severely lacking.
- Margaret Russell: Also in many cases they are taking ad previously prescribed, but that is no longer what we consider appropriate use. It'd difficult especially because the patient hasn't done anything "wrong" but they have developed significant dependence because of practices that were common decades ago.

JChen: May I know if atypical BZD has similar pharmacodynamic/ kinetic as typical BZD? Equal with unhealthy use risk?

Adam Lake: does the CIWA-Ar have any role in managing acute benzo withdrawal?

Luther Philaya: I've done long benzo tapers on those with SHA dependence as they are for the most part compliant. Those with SHA Use Disorder, however, tend to not follow a taper program; rather they just more.

- Luther Philaya: Just use more and quickly go through their taper Rx
- Adam Lake: I've had some anecdotal success with weekly delivery of medisets with set doses of valium
- Luther Philaya: There is an AM specialist at the U of Minnesota who prescribes long term low dose phenobarbital for protracted BZD withdrawal. Thoughts?

Ayesha: how do you differentiate between protracted withdrawal from reemergence of anxiety symptoms?

- Dr. Restrepo: Good question. May be this article will help you. https://store.samhsa.gov/sites/default/files/d7/priv/sma10-4554.pdf

Abbie Ewell: Can you comment on the rate of BZD taper for patient's admitted medically with acute sedative withdrawal?

Abbie Ewell: With the long half-life of phenobarbital, why are we dosing it TID or QID?

- Dr. Restrepo: You are right. Some people use it twice a day
- Dr. Restrepo: It is almost similar in way when you give diazepam or chlordiazepoxide. They have long half-life but considering withdrawal you need to monitor when it is necessary to give a second or third dose

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Michael Fiori: We give 10mg/kg of ideal body weight, in 3 divided doses--no sig danger, but sig improvement in patient acceptance so far.

- Sid: is that PO? and then how do you tend to taper it?
- Luther Philaya: Yes po. He uses 32.4 mg/day. Found no research supporting this but he is emphatic it works and patients are compliant. Good question about the taper... I'll ask him.

Adam Lake: what are the "GHB binding sites"?

Lisa Marie Orlandi: Would you consider baclofen over benzodiazepines for the management of GHB withdrawal?