Letters to the Editor

The Journal welcomes Letters to the Editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication.

LONG-TERM BENZODIAZEPINE USE

To the Editor:

For nearly two decades I have been caught in the middle between patients who claim that they are unable to be fit wives, tolerant mothers, or productive workers, and medical professionals who say that if I prescribe an anxiolytic agent to a patient for more than 6 months I am a bad doctor. When I do not prescribe these medications, patients claim that they tend to be abusive to their children, less tolerant of stresses in their marriages, and unable to cope with the demands of their careers. The far-reaching effects of these complaints are predictable. When I prescribe reasonable doses of tranquilizers, these patients claim that they are then able to function in what they perceive is a "normal" manner.

I have tried over the years to substitute other therapies for chronic tranquilizer use. I have referred many patients to psychiatrists who usually substitute major tranquilizers or tricyclic antidepressants for the anxiolytic drug. The majority of the time, unfortunately, patients' symptoms are not as well treated with the newly prescribed drugs and the side effects of the new medications are far greater. But the excuse is always that at least these drugs are not habit forming.

I cannot help but believe that there are thousands of physicians like myself who want to do the right thing for their patients and also conform to standard medical practice. If medications like the benzodiazepines were not on a list that is called "controlled substances," would that make a difference in how professionals view their use?

Dr Farnsworth (*Farnsworth MG. Benzodiazepine abuse and dependence: misconceptions and facts. J Fam Pract 1990; 31:393–9*) states that physicians who inappropriately prescribe benzodiazepines are "dated," "deceived," "impaired," or "criminal." What we need are accurate discussions about what is the appropriate use of benzodiazepines. If a patient has hypertension, we do not cure the hypertension, but simply control it with chronic medication. If a patient has a disabling anxiety disorder, often it also requires chronic therapy. Despite psychotherapy and family support measures, any of these patients do poorly until medicated with tranquilizers.

We could tell chronically anxious patients that they simply must "tough it out," but we do not do that with patients who have diabetes, hypertension, psoriasis, or other chronic, debilitating problems. Administration of moderate doses of benzodiazepines, which modify the stimulation of a patient's environment, is one therapeutic method available to the physician. Why is it wrong, then, to use this medication, which is the least costly and has the fewest side effects?

Joseph Baum, MD
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The preceding letter was referred to Dr Farnsworth, who responds as follows:

I thank Dr Baum for his interesting letter. Some of his concerns are legitimate concerns that have been expressed to me in the past by numerous primary care physicians and are what prompted both the research and recommendations presented in my paper. The bulk of clinical research supports Dr Baum's contention that when he prescribes reasonable and appropriate doses of benzodiazepines to patients with chronic anxiety disorders, they function normally.

As I stated, anxiety disorders tend to be chronic in nature and require chronic treatment. I did not imply and, in fact, strongly discourage substitution of a benzodiazepine with an antipsychotic medication on the rationale that an antipsychotic medication is not habit-forming. Quite the contrary. One of my goals was to demonstrate that the abuse potential of benzodiazepines is far less than is generally believed by most physicians and that a specific population of polysubstance abusers may be abusing benzodiazepines recreationally. On the other hand, many primary care physicians have mistakenly treated the anxiety component of a depressive disorder with a benzodiazepine and never approached treatment of the depressive disorder with the appropriate tricyclic antidepressant. In those cases, I strongly urge treatment of the primary mental disorder.

I agree with Dr Baum that our antidepressant and antipsychotic medications have serious and significant side effects. I disagree that they are frequently disregarded when discussing therapy, at least not in my practice. I believe that any well-informed physician will do a relative risk-benefit assessment of each medication contemplated in the treatment of a specific psychiatric disorder. For example, in the treatment of panic disorder, prescribing a tricyclic antidepressant, a monoamine oxidase inhibitor, or a benzodiazepine may be appropriate treatment. Each carries specific risks and specific side effects. As I clearly stated, medication selection must be based on a specific diagnosis and must take into consideration the patient's symptoms, lifestyle, and preferences, as well as possible side effects.

Dr Baum erroneously contends that I state that physicians who inappropriately prescribe benzodiazepines are either dated, deceived, or impaired. I did suggest that physicians need to be aware of the medicolegal climate in which they practice

and that they should critically examine their prescribing practices.

When physicians treat other chronic illnesses such as diabetes or hypertension, periodic reassessment of serum glucose, blood pressure measures, and medication are integral aspects of management. I encourage a similar approach with benzodiazepines (or any psychotropic medication) in the treatment of anxiety.

Documentation, assessment of benzodiazepine risks, development of a therapeutic alliance with the patient, identification of target symptoms, employment of drug holidays, maintenance of pill counts, and documentation of telephone contacts appear to be reasonable, prudent, and appropriate medical practice.

Overall, the tone of Dr Baum's letter illustrates the anxiety and frustration physicians feel about the topic of benzodiazepine use or abuse and the ambivalence the medical profession has for the treatment of chronic psychiatric disorders. I believe that physicians' anxiety regarding benzodiazepines is overblown. Long-term maintenance of chronic anxiety disorders may be necessary, but physicians should also critically reexamine their diagnosis and treatment plans on a periodic basis to ensure that their patients are receiving the appropriate and best treatment they can receive.

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APPROACH TO PNEUMOMEDIASTINUM

To the Editor:

Holmes and McGuirt (*Holmes KD, McGuirt WF. Spontaneous pneumomeditastinum: evaluation and treatment. J Fam Pract 1990; 31(4): 422–9*) state that "all patients with pneumomediastinum should be admitted to the hospital and observed for signs of serious complications." This statement was not referenced. They do provide a number of references, but it is unclear which specifically address the risk of serious complications in stable-appearing patients with this condition. Particularly apropos would be the incidence of tension pneumothorax, cardiac tamponade, or other conditions that could progress rapidly.

In my experience in family practice and emergency medicine, spontaneous pneumomediastinum is relatively common and is often treated on an outpatient basis, in reliable patients only, of course. I even speculate that in these days of nursing shortages, children with attentive parents or any patient with a "significant other" might get closer observation at home.

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BROWN SPIDER BITES

To the Editor:

The article by Sendovski et al[1] leaves several important questions unanswered. As the authors state, brown spiders are known to exist in North and South America, but they do not say if these spiders have been reported in Israel. Brown spider bites have been confused with other conditions such as snake, tick, and scorpion envenomations; pyodermas; foreign bodies; artifactual ulcers; focal vasculitis; and other lesions.[2]

The authors advocate corticosteroids and broad-spectrum antibiotics without citing specific support for this view. They also imply that many other treatments are appropriate. In the face of so many possible treatments (they do not cite hyperbaric oxygen[3]), might one opt appropriately for more conservative management?[4]

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References

1. Sendovski U, Rothman MG, Fried M, Har L. Brown spider bites. J Fam Pract 1990; 31:417–20.
2. Anderson PC. Necrotizing spider bites. Am Fam Physician 1982; 26:198–203.
3. Svendsen FJ. Treatment of clinically diagnosed brown spider bites with hyperbaric oxygen: a clinical observation. J Ark Med Soc 1986; 83:199–204.
4. Bradley JG, Starkey DJ. Necrotic spider bites in Kansas. Kans Med 1988; 89: 166–8.

LIVING WILL AMENDMENT TO PROTOCOL

To the Editor:

The article by Hahn and Berger (*Hahn DL, Berger MG. Implementation of a systematic health maintenance protocol in a private practice. J Fam Pract 1990; 31:492–504*) was very impressive in demonstrating what a family physician can do in a private practice relative to prevention. I would like to see one addition to the protocol, however.

In these litigious and ethics-conscious times, I would like to see the physician reminded by the protocol to discuss with the patient (no matter what age, but especially the elderly) whether he or she has made clear his or her wishes about the management of terminal illness—death and dying—to physicians, the family in all of its significant branches, lawyers, spiritual advisors, and any very close friends; and whether these wishes have been recorded in a living will with durable power of attorney and in a values statement.

This necessary, but often overlooked, preplanning can play a primary role in medical decisions under circumstances that are becoming relatively common. Although the topic is not one that many of us enjoy when the subject is us, the tragedy of publicized legal cases from Quinlan through Cruzan serves to emphasize the importance of having these desires documented and well discussed by all concerned.

Wisdom requires us to over-

come our intuitive aversion. With a small addition, the protocol could remind the physician to interject this particular wisdom.

J. D. Deisher, MD
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The preceding letter was referred to Dr Hahn, who responds as follows:

Dr Deisher raises several important points in his letter. First, he suggests that eliciting patients' wishes about the management of their possible terminal illness can aid in medical decision making; he also seems to imply that doing this may avoid some legal and ethical dilemmas which have occurred in circumstances where the patient's wishes were unknown. I absolutely agree that discussing these issues with patients is important, and that doing so should be considered an integral part of primary medical care, especially in the case of the elderly. The state of Wisconsin has a uniform living will form on which patients can express their personal desires in this regard. I imagine that other states have a similar legal document with which physicians should become familiar; I suggest that physicians practicing in states without such a document become involved in the process of formulating one.

Second, Dr Deisher suggests that wishes about terminal care should be systematically elicited from all patients by a reminder incorporated into the systematic health maintenance protocol. Systematic application of procedures may be facilitated by use of a reminder system (*Hahn DL, Berger MG. Implementation of a systematic health maintenance protocol in a private practice. J Fam Pract 1990; 31:492–504*). I would urge any physician who wishes to do so to add this item to his or her personalized reminder system. I am uncertain, however, whether this particular item (which I would classify as counseling) should be recommended for universal application to an entire primary care practice before certain questions are answered: How much time will it take? Will the time taken divert resources from more important activities? What proportion of patients (and physicians) will accept it? Should this item be applied to all ages, or only to a high-risk group (eg, the elderly)? Will appropriate performance of this item improve outcome (my intuition tells me it should). These and other questions need to be answered before a universal recommendation can be made. Fortunately, all these questions are amenable to research in the primary care setting; I would encourage Dr Deisher and others to answer them for us.

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