Global Journal of
Pharmacy & Pharmaceutical Sciences
ISSN: 2573-2250

Juniper Publishers
key to the Researchers

Opinion
Volume 7 Issue 2 - March 2019
DOI: 10.19080/GJPPS.2019.07.555708

Glob J Pharmaceu Sci

Physician – First Do No Harm

Malcolm Lader*

Emeritus Professor of Clinical Psychopharmacology, King's College London, UK

Submission: February 17, 2019; **Published:** March 11, 2019

***Corresponding author:** Malcolm Lader, Emeritus Professor of Clinical Psychopharmacology, Institute of Psychiatry, Neurology and Neuroscience, PO56, King's College London, Denmark Hill, London SE5 8AF, UK

Abstract

I draw attention to the repeated and apparently unending dependence and abuse problems associated with a series of psychotropic medications including the barbiturates, benzodiazepines and opioids.

Introduction

My professional life has been punctuated by a recurrent and disturbing theme. As a medical student in the 1950's, I became aware of the dependence and abuse problems with the numerous barbiturates available then. Regularly, a star of the media would enter a rehabilitation center for treatment of an addiction, or a death would be reported from an overdose: the prescribing physician would be identified but only excoriated for a brief time. The problem would be forgotten until the next time. And for every tragedy that hit the headlines, a substantial but unknown number of ordinary people would run into difficulties. Doctors did not appreciate that the dangers of dependence, abuse and overdose were risks which had to be balanced against the purported benefits of the medication. Gradually it was realized that the barbiturates were dangerous, especially in overdose and safer alternatives were sought [1].

The first was meprobamate which enjoyed a brief vogue until it became apparent that it, and its congeners like carisoprodol, shared many of the disadvantages of the barbiturates [2]. It was soon ousted by the first of a seemingly inexhaustible stream of a new class of compound – the benzodiazepines. These had the property of being much safer than the barbiturates in overdose, at least on their own. Prescriptions ballooned and for a time this group of sedatives and sleeping tablets were the most widely used of all medications [3]. In some mysterious way, the proven safety in over dosage was extrapolated to an assumption that these medications were less likely to be associated with dependence and abuse: the medical profession and the drug manufacturers issued reassurances. Their complacency seemed to be supported by the relatively uncommon finding of an escalation of dosage on long-term use.

How wrong everyone was! It was established that chronic usage – over 3 months or so - was accompanied by normal-dose or iatrogenic dependence in which a substantial proportion of users developed a dependence syndrome that rendered withdrawal a painful, prolonged and tedious process. The subsequent 40 years has seen a failure to recognize this problem with the lack of both preventative and curative services [4]. In desperation users set up their own supportive and therapeutic services but these were mere drops in a vast and tempestuous ocean. In some countries such as the UK and Australia, attempts were made to educate the prescribers; in others such as France and the USA, the problem was largely ignored. Often the pharmacy profession was most concerned as it saw repeated prescriptions without proper physician monitoring. Then, it became apparent that the benzodiazepines were capable of inducing abuse behavior, and the scheduling of these drugs was strengthened somewhat. It subsequently became apparent that the "z-drug" hypnotics were associated with similar problems [5].

Another epidemic started which is still increasing [6]. Opioid analgesics are being increasingly prescribed long-term for chronic pain. People are not warned adequately and dependence and then abuse has burgeoned. Death by inadvertent overdose has become a major cause of death: these tragedies are still increasing in the USA and are spreading to many other countries.

Why do physicians assume that long-term use of a whole range of substances, especially those with psychotropic effects, is innocuous? Appropriate studies are not carried out: manufacturers will not fund them, and prescribers refuse to confront their responsibilities. Long-term effects of psychotropic

effects are ignored despite a growing appreciation that the risk-benefit is adverse in many cases. Why do regulatory bodies overlook these problems until too late?

Conclusion

When will it end? I suspect not until the legal profession establishes that such usage without careful monitoring could be a negligent act incurring financial damages. Let us hope that pharmacists continue their vigilance.

References

1. Dundee JW, McIlroy PDA (1982) The history of the barbiturates. Anesthesia 37: 726-734.
2. UK Government Medicine and Healthcare Products Regulatory Products (2008) Carisoprodol and Meprobamate: Risks outweigh benefits. UK.
3. Lader M (1978) Benzodiazepines - The opium of the masses? Neuroscience 3(2): 159-165.
4. Lader M (2011) Benzodiazepines revisited – will we ever learn? Addiction 106(12): 2086-2109.
5. Brandt J, Leong C (2017) Benzodiazepines and Z-Drugs: An updated review of major adverse outcomes reported on in epidemiologic research. Drugs 17(4): 493-507.
6. National Institute on Drug Abuse (2019) Opioid overdose crisis. US.

DOI: 10.19080/GJPPS.2019.07.555708