

The present patient did not have any of these associated conditions, nor were any shown in a limited study of his family. He did have undoubted myasthenia and enough features of systemic lupus erythematosus to fulfil the M.R.C. (1961) diagnostic criteria (high E.S.R., neutropenia, arthritis, lymphadenopathy, strongly positive L.E. cell preparation). The association between these two diseases is known (Harvey *et al.*, 1954), and rarely systemic lupus erythematosus appears to be precipitated by thymectomy in a patient with myasthenia (Alercón-Segovia *et al.*, 1963). It might therefore be argued that thymectomy would be best avoided in the myasthenic patient who has features of systemic lupus erythematosus. In this case azathioprine was given in the hope of preventing the appearance of a more florid systemic lupus erythematosus rather than mitigating the myasthenia, which is affected minimally by immunosuppressive therapy (Namba and Grob, 1969).

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References

- Alercón-Segovia, D., Galbraith, R. F., Maldonado, J. E., and Howard, F. M., jun. (1963). *Lancet*, **2**, 662.
 Beardwell, A. (1969). *Annals of the Rheumatic Diseases*, **28**, 518.
 Haines, D. (1967). *Journal of the Royal Naval Medical Service*, **53**, 75.
 Harvey, A. M., Shulman, L. E., Tumulty, P. A., Conley, C. L. and Schoenrich E. H. (1954). *Medicine*, **33**, 291.
 Howel-Evans, W., McConnell, R. B., Clarke, C. A., and Sheppard, P. M. (1958). *Quarterly Journal of Medicine*, **27**, 413.
 Medical Research Council (1961). *British Medical Journal*, **2**, 915.
 Namba, T., and Grob, D. (1969). *Neurology*, **19**, 173.
 Parnell, D. D., and Johnson, S. A. M. (1969). *Archives of Dermatology*, **100**, 7.

Diazepam, Alcohol, and Barbiturate Abuse

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It has been recognized for some time that dependence is a potential hazard of benzodiazepine use (Hollister *et al.*, 1963; Aivazian, 1964; Essig, 1966; Kryspin-Exner, 1966; Relkin, 1966; Holmsberg, 1969). This report is of a case of diazepam abuse in a woman who originally sought treatment for disturbed sleep and who over a period of six years became severely dependent on diazepam, alcohol, and barbiturates.

Case Report

A 39-year-old woman was admitted to the Bethlem Royal Alcoholism Unit for treatment of dependence on alcohol and drugs. There was a strong family history of depressive illness coupled with heavy drinking. As a child the patient had been nervous of the dark, but her school career was normal, and she had then worked for five years as a telephonist. Shortly after marriage at 21 years she suffered her first panic attack when travelling on a train. She was ill at home for two weeks and changed her job, thus avoiding train travel. She had a second panic attack after the birth of her first child four years later. Her second child was born when she was 31, and soon afterwards she became irritable, anxious, and depressed. Her sleep deteriorated, the panic attacks worsened, and she was afraid to go out alone. Her general practitioner prescribed amylobarbitone sodium 390 mg at night. Over a three-year period she increased the dose to 1,170 mg daily, while her symptoms fluctuated. In 1967 she was referred by another general practitioner to the psychiatric outpatient department at her local hospital. She received monthly injections of amylobarbitone sodium for six months, but this was terminated after she became unconscious during a treatment. Her doctor began to reduce the barbiturate prescription. Her symptoms worsened and she began taking alcohol for relief, at first half a bottle of sherry daily, but increasing over 18 months to one or two bottles a day.

In February 1970 she was admitted to the Bethlem Royal Day Hospital and had a withdrawal fit shortly after admission. She was treated for her phobic symptoms with progressive desensitization, barbiturates were discontinued, apart from a night dose, and diazepam by mouth was substituted. After four months she was discharged symptom-free on diazepam 20 mg three times a day

and amylobarbitone sodium 195 mg at night. Within two weeks she had persuaded her general practitioner to increase the diazepam to 90 mg daily and to prescribe the tablets monthly. She increased her consumption steadily and was soon exhausting her monthly supply in 7-10 days, taking up to 500 mg of diazepam daily. Sherry was substituted whenever she ran out of diazepam. During the two months before her readmission she experienced regular morning shakes, slurred speech, gross ataxia, and withdrawal fits, symptoms which she relieved with alcohol or diazepam.

On admission to the alcoholism unit she was undernourished and underweight. There were multiple bruises on her body and one large bruise under her left eye. There was a coarse tremor affecting all her limbs and her deep reflexes were brisk. She was restless, anxious, and continually demanding medication for sleep. There were no depressive or phobic symptoms.

Within seven days she had been withdrawn from all drugs and alcohol. Over the subsequent month she complained of a mild tremor of her arms and legs and an intense craving for tablets. Her sleep remained disturbed throughout her stay and was characterized by short periods of restless light dozing and nightmares. After two months she was discharged, sleeping a little better and not on medication. Follow-up over a period of five months confirmed that she had remained free of symptoms, had obtained a full-time job, and that her sleep had returned to normal.

Comment

Despite a family history of alcohol abuse and a personal history of barbiturate excess this patient was prescribed diazepam in large dose for her phobic symptoms. This reflects the widely held view that the benzodiazepines are non-addictive even in predisposed and highly anxious patients. Glatt (1967) argued that the risk of developing dependence with diazepam is slight but must be considered in those patients on high doses or those treated for lengthy periods. This patient, however, was on diazepam for only a matter of weeks before she began to misuse the drug and manifest signs of dependence.

It is suggested that the sanguine view held by many members of the medical profession towards the minor tranquillizer has been transmitted to the lay public and militates against attempts to remove patients from unnecessary and potentially harmful treatment with these drugs.

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References

- Aivazian, G. H. (1964). *Diseases of the Nervous System*, **25**, 491.
 Essig, C. (1966). *Journal of the American Medical Association*, **196**, 714.
 Glatt, M. M. (1967). *British Medical Journal*, **2**, 444.
 Hollister, L. E., Bennett, J. L., Kimbell, I. jun., Savage, C., and Overall, J. E. (1963). *Diseases of the Nervous System*, **24**, 746.
 Holmsberg, G. (1969). *Svenska Läkartidningen*, **66**, 77.
 Kryspin-Exner, K. (1966). *British Journal of Addiction*, **61**, 283.
 Relkin, R. (1966). *New York Journal of Medicine*, **66**, 1970.

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