

are present and the fluctuation of enzyme in psychotic patients without NMS is not investigated.

HARI D. MAHARAJH

*St Anns Hospital  
Port of Spain, Trinidad, West Indies*

#### Reference

ZILVA, J. F. & PANNALL, P. R. (1981) *Clinical Chemistry in Diagnosis and Treatment*. London: Lloyd-Luke.

#### Benzodiazepine addiction in heroin addicts

SIR: The recent article by Gossop *et al* (*Journal*, March 1989, **154**, 360–363) on opiate withdrawal symptoms was broadly in keeping with previous work showing that 80% of heroin addicts could be withdrawn as in-patients using methadone, and also that withdrawal symptoms have a large psychological weighting and are therefore more severe around the time of completion of the programme. The 10-day withdrawal regime was, however, associated with a higher drop-out rate soon after, and as they point out, this is likely to be due to variables other than opiate withdrawal.

There has been little work on why 20% of addicts fail to finish their detoxification, and it would prove methodologically difficult to study this adequately. One possible reason that might account for a proportion of the 20% would be concurrent benzodiazepine addiction, and this might also explain some of the cases of higher relapse after the 10-day detoxification.

A study of 298 addicts attending the drug dependence unit at St George's Hospital, London, found benzodiazepines in the urine of nearly 60% (Beary *et al*, 1987), and in a study of 79 addicts in Sheffield, 90% said that they used benzodiazepines, with regular use in about 50% (Perera *et al*, 1987). Rebound anxiety can occur if benzodiazepines have been used for three weeks, and about half of patients who have taken them for three years experience a specific withdrawal syndrome (Noyes *et al*, 1988). If we hypothesise that 30% of benzodiazepine users experience rebound anxiety or a withdrawal state on abrupt discontinuation, and that 50% of addicts take benzodiazepines, then we could expect 15% of heroin addicts to experience some form of withdrawal reaction if detoxified using methadone alone.

The symptoms of rebound anxiety and some of the symptoms of benzodiazepine withdrawal would lead to a score on the Opiate Withdrawal Scale, but the perceptual abnormalities seen in benzodiazepine withdrawal would not. The symptoms, however, would not necessarily respond to methadone. With

short-acting benzodiazepines, a withdrawal reaction may be seen within 24 hours. For the more commonly used benzodiazepines, however, they are more likely to present at about 5 days and peak at about 10 days. The combination of this and finishing the methadone withdrawal regime, which is a psychologically difficult time for the addicts, may partly explain the higher drop-out rate in the 10-day withdrawal group than in the 21-day programme in the study of Dr Gossop *et al*.

I feel that this is an aspect of opiate withdrawal that warrants further attention if we are to successfully treat heroin addicts.

RHODRI HUWS

*Northern General Hospital  
Herries Road  
Sheffield S5 7AU*

#### References

- BEARY, M. D., CHRISTOFIDES, J., GHODSE, A. H. *et al* (1987) The benzodiazepines as substances of abuse. *The Practitioner*, **231**, 19–20.
- NOYES, R., GARVEY, M. J., COOK, B. L. *et al* (1988) Benzodiazepine withdrawal: a review of the evidence. *Journal of Clinical Psychiatry*, **49**, 382–389.
- PERERA, K. M. H., TULLEY, M. & JENNER, F. A. (1987) The use of benzodiazepines among drug addicts. *British Journal of Addiction*, **82**, 511–515.

#### Post-traumatic stress

SIR: McFarland (*Journal*, February 1989, **154**, 221–228) comments that past history of treatment for psychological disorder was a better predictor of post-traumatic morbidity than the degree of the exposure to the disaster or the losses sustained. He suggests that his results raise doubts about the postulated central aetiological role a traumatic event plays in the onset of morbidity.

In my study of burn victims who had been admitted for seven days or more to a burns unit (White, 1981), over a third of 86 patients who were followed-up one year after their accident had marked psychological sequelae. Only three of those patients had a past psychiatric history of a neurotic illness (requiring admission to hospital or two or more psychiatric consultations). The main predictors for a poor psychological outcome after a year were the severity of the injury and the length of stay in hospital. The presence of anxiety, depression, or a personality problem at the time of the initial interview (within seven days of the accident) was also related to an increased incidence of psychological sequelae. Other factors found to be important were age, social class, and whether patients lived on their own or had large