Clinical Practice Guideline on Benzodiazepine Tapering Comment Period

The American Society of Addiction Medicine (ASAM) allowed for public comment on a draft of its Clinical Practice Guideline on Benzodiazepine Tapering.

This guideline was developed in partnership with the American Academy of Family Physicians, American Academy of Neurology, the American Academy of Physician Associates, the American Association of Nurse Practitioners, the American Association of Psychiatric Pharmacists, the American College of Medical Toxicology, the American College of Obstetricians and Gynecologists, the American Geriatrics Society, and the American Psychiatric Association.

Contributors:

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Page Number	Comment
0	General Comments: much needed toolkit, very comprehensive and thought out, provides clear guidance that is evidence based and safety focused. Although lengthy, very organized and useful with breaking down the different sections/seniors. Appreciate that clear guidance is provided.
4	Line 19: Consider removing extra “and”: anxiety, mood disorders, insomnia, and seizures.
5	Line 12, When the risks outweigh the risks… update second “risks” to benefits.
5	Line 6, extra space after "level of care"
8	Line 18, considering adding geriatrics as example
9	Line 19: All patients undergoing a taper will experience some degree of sleep disturbance or anxiety. It may be beneficial to place a level of severity on the symptoms explaining when to pause or slow the taper
10	Line 28: Consider assessing at every prescription if the patient is prescribed a CII opioid rather than every 3 months.
10 (line 8); 41 (line 10)	Consider different terminology other than physiologic taper (i.e., use of long-acting agents or tapering to avoid withdrawal or short-term discontinuation). Ensure that it is clear that it is not standard of care but reserved for the exception type of cases.
11, 46	Harm reduction strategies section can be expanded (i.e. using with other people, using test doses first, safe disposal of old prescriptions). Including general harm reduction techniques rather than just harm reduction services.
14	Line 3-16, all acronyms have previously been defined.
14	Line 15, consider removing “clinically informed.”
14	Line 18, consider adding ‘are’ between “and FDA”
14	Line 19: Could considering adding “alcohol withdrawal” as some are FDA approved for this indication
15	Line 17, update ille.g.al to illegal. Also, consideration of adding counterfeit/ designer BZDs may also be a risk. Line 24, update co-prescribing to co-prescribed.
15	Line 17, “illegal” misspelled

19	Line 12: Remove “ironically”
19-23	Would like to see added: patients are often on benzos for a reason (i.e. anxiety, sleep), so if we are deciding to taper, should proactively think about starting other agents to treat those conditions. For example, starting an SSRI weeks prior to the initiation of a benzo taper
20	Line 1, consider changing “CPG” to ‘Guideline’ for consistency as previously stated
20	Line 29, extra space before and after “fractures”
22	Line 9, consider including catatonia or treatment-resistant catatonia. Important consideration as mentioned previously, initial reason for BZD initiation may not be clear.
35	Line 25, update general anxiety disorder to generalized ..
35	Line 28: Consider providing carbamazepine dosing when facilitating benzodiazepine withdrawal
39	Is there any discussion of post-acute withdrawal in this guidelines? Could be worth mentioning, especially in the section “tapering versus very long-acting agents”
39-40	The discussion on rapidly tapering people off of benzos could also use the addition of adjunct pharmacological agents, which are currently not mentioned here
41	Consider adding a “population specific” section on people with liver dysfunction, because there is a lot to discuss here re: management. Could even be more general “comorbid medical conditions”
42	Line 26: The more common abbreviation of the risk tool is RIOSORD vs. RIOSOIRD. Consider updating throughout.
136	Offer sample phenobarbital taper in IM or IV?
140	Tables in appendix K do not include previously mentioned adjunct agents carbamazepine, gabapentin, pregabalin
140	Table 1 says to avoid hydroxyzine in first trimester; Table 2 on page 142 says to avoid hydroxyzine in first trimester; However, Table 2 on page 145 suggests using hydroxyzine during first trimester for anxiety. There’s an asterisk noted, however this is conflicting and the group should consider selecting one recommendation.