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Response

I welcome the positive comments from Fleming et al, and I thank the Editor for the opportunity to further an open discussion on these very important issues. The

topic of psychotropic pharmacotherapy has a history of impassioned debate in Canada,¹ and whether pedagogic or merely academic, such discussions will hopefully lead to an improvement in patient care.

The definitions of abuse, dependence, and addiction are certainly shaped by the eye of the beholder. One need only examine the varying definitions published by Fleming et al in their letter, described by the Centre for Addiction and Mental Health,² and noted in a reference cited by Fleming et al.³ Perhaps those on the street who suffer such maladies might add to the controversy and critique those definitions further.

Fleming et al indicate that amitriptyline abuse can be fatal, unlike benzodiazepine abuse. It is too bad that those who have died after a benzodiazepine overdose are not available to speak for themselves.⁴

Fleming et al rightfully examine the alternative explanations for zopiclone misuse, such as in patients with obsessive-compulsive disorder.⁵ This reference, however, details a large group of pediatric patients. The latter have little similarity to the older patients who typically request zopiclone and who admittedly abuse prescription medications. In addition, it is generally futile to overly speculate, particularly retrospectively, about the few details that are offered by case reports.

Confusion over insomnia and its treatment is best illustrated in consideration of the following:

- Fleming et al highlight the review of Hajak et al⁶ as an indication that zopiclone use is safe, while Fleming previously found other work by the same authors capable of evoking “a wry smile.”⁷
- Fleming previously indicated that sleep medication should be used at the lowest dose and for the shortest period of time,⁸ but now proposes in his letter that such a recommendation is obsolete.
- Samuels once recommended staying away from benzodiazepines for primary insomnia and recommended zopiclone as the best choice⁹; Fleming et al now state in their letter that benzodiazepines have been treated prejudicially. Samuels also recommended tricyclic antidepressants and trazodone, the latter of which he stated to be “an excellent alternative.”
- MacFarlane provided an excellent review article on insomnia¹⁰ but indicated there were few choices for primary insomnia: temazepam, zopiclone, and zolpidem (now discontinued in Canada).
- MacFarlane and colleagues once proposed zopiclone as an agent to alleviate the symptoms of benzodiazepine withdrawal, but identified the lack of a control group—in addition to potential confounding and other side effects—as a limitation to the conclusion.¹¹
- Fleming found, in an industry coauthored paper, that zopiclone had advantages over all then-available benzodiazepines, although he only compared zopiclone directly with triazolam in his study.¹² Holbrook’s meta-analysis, however, did not find zopiclone to be superior to benzodiazepines in any of the outcome measures.¹³

Zopiclone and benzodiazepines are excellent pharmacologic agents in their own right and for specific indications. They are also potential agents of abuse. In my recent experience, and having seen literally hundreds of self-proclaimed drug addicts (whether they have consciously adhered to Fleming et al’s definition of *addict* or not), zopiclone is among the most commonly sought prescriptions, alongside codeine and oxycodone. I have yet to witness any of these same individuals making a request for amitriptyline or trazodone, or raising discussions of off-label compounds.

I have no qualms about endorsing the Editor’s Key Points in my article. They are and remain sensible and pragmatic comments. Whereas Fleming et al espouse the benefits of zopiclone, one must weigh others’ evidence against that claim,^{14,15} some of which raises the concern of *iatrogenesis imperfecta*.¹⁴ The use of zopiclone and benzodiazepines, as well as the issue of insomnia, are worthy of interest to non-industry-funded prospective trials, supported perhaps by national granting agencies. Such research is generally less well funded than other fashionable topics in medicine. Such a study could then, hopefully,

provide a measure of science that would be applicable to a street-level discussion.

—*Nevio Cimolai MD FRCPC
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by e-mail*

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Corrections

In the article "Telehomecare for patients with multiple chronic illnesses. Pilot study," which appeared in the January 2008 issue (*Can Fam Physician* 2008;54:58-65), the name of one of the authors was misspelled. The correct name is Jennie Humbert, RN(EC), MHSc. The on-line version was corrected ahead of print.

In the letter to the editor entitled "Labour pains," which appeared in the January 2008 issue (*Can Fam Physician* 2008;54:28-9), an error was made in the units provided; 75 mg should have read 75 µg in the following statement: "Having tried many combinations of [intrathecal] drugs, however, my spinal anesthetic of choice for cesarean section is heavy bupivacaine (9 to 10 mg), with morphine (75 µg), and midazolam (2 mg)." *Canadian Family Physician* apologizes for this error and any confusion it might have caused. The on-line version was corrected ahead of print.

In the article "Complete health checkup for adults. Update on the Preventive Care Checklist Form®" published in the January 2008 issue (*Can Fam Physician* 2008;54:84-8), access to the form was provided through a link to the College of Family Physicians of Canada website. The recommendation to screen or vaccinate women of child-bearing age to prevent congenital rubella syndrome was inadvertently deleted from the female version of the Preventive Care Checklist Form. The female form has been corrected and is available on-line at www.cfpc.ca.

—*Karl Iglar MD CCFP FCFP
Toronto, Ont
by e-mail*

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