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Nitrazepam (Mogadon) Dependence

By P. C. MISRA

Introduction

Evidences suggest that the predisposed individual can develop dependence to various tranquillizers even to the extent of physical dependence similar to that seen with the barbiturates. Dependence can develop to benzodiazepine derivatives, and cases have been reported mainly for chlordiazepoxide, diazepam and oxazepam. These drugs can also produce withdrawal reactions (Hollister *et al.*, 1963; Barten, 1965; Krypsin-Exner, 1966; Bakewell and Wikler, 1966; Essing, 1966; Gordon, 1967; Ewing and Bakewell, 1967; Hanna, 1972).

Nitrazepam has not so far been reported to cause dependence; it is in fact advertised by the manufacturers as a safe, non-addictive drug. I report a case in which the psychological dependence on nitrazepam reached such a degree that it acquired all the characteristics of an addictive state.

Case Report

Miss N.C., born in 1920, is an unmarried woman who lives on her own. Her father a pharmaceutical chemist, was addicted to barbiturates but there is no other family history of mental illness. She had a very strict upbringing, and as a child she was nervous and anxious; in spite of this, at the age of 17 she became a dancer and worked at her profession for ten years, travelling all over the country and appearing in various shows including pantomime.

At the age of 33, in 1953, she was referred to a psychiatrist on account of two years alcoholism associated with depression. She was given a course of five ECTs; her depression resolved and she stopped drinking. She was prescribed barbiturates for insomnia, which she stopped after six months, as she felt that she did not need them. According to her general practitioner she remained apparently free of depression until 1964, but in that year she was admitted in a state of acute alcoholic delirium. At this time it was found that she had been taking carbromal regularly, as well as alcohol, in increasing quantities for eight months; she justified her drinking on the ground that she felt more confident and sociable with alcohol. After six weeks she was discharged home on small doses of chlorpromazine and amylobarbitone, in order to reduce the chance of recurrence of her craving for alcohol and because of her complaints of insomnia. Her craving for alcohol ceased, and she stopped taking her prescribed drugs after four to five months. Later, while attending the out-patient clinic she showed tension and irritability; these symptoms were partially relieved by diazepam (Valium) 5 mgm. t.d.s., and she was eventually discharged.

She was re-referred by her general practitioner in September 1968. According to him she had complained constantly for six months of not being able to sleep, feeling miserable, tired and tense, with lack of concentration and confidence. He reported that she had stopped taking diazepam four months after her discharge. She was now prescribed chlordiazepoxide, with nitrazepam (Mogadon) 5 mg., two tablets at night for her insomnia. She claimed that she had not taken alcohol, nor had any craving for alcohol for the past four years. After a short time she stopped taking chlordiazepoxide, but she started to consume increasing doses of nitrazepam. While still attending the out-patient clinic she sometimes obtained the drug from both the hospital and her own doctor and was in fact taking more than the prescribed dose of 10 mg. at night (taking approximately 40–50 mg. daily). The patient successfully took advantage of a new doctor (registrar) for getting additional prescription of these tablets. Her hospital out-patient appointments finally lapsed because of her failure to attend.

In August 1969 she was once more referred to the out-patient clinic, and it was found that she had been taking nitrazepam in addictive doses, at times up to 6–7 tablets in the course of the day. Efforts were made to wean her from the drug by substituting chlorpromazine 50 mg. t.d.s. and Mandrax, two tablets at night; but she became depressed, anxious and agitated, and continually complained that she could not manage without nitrazepam. She has therefore been allowed to take nitrazepam, one tablet q.i.d. for the past four years, and she still feels that she cannot cope without it. She claims that the tablets make her

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feel active and do not affect her attention and concentration.

At one of her regular out-patient appointments, in September 1973, she displayed for the first time symptoms of a paranoid psychosis. Neither the author, nor the consultant psychiatrist who saw the patient at regular follow-up appointments had previously detected any suggestion of persecutory delusions. The patient expressed the ideas that: 'At night police cars stop outside my house and flash their headlights', 'I am being watched by the police', 'The police have bugged my house and the telephone is being tapped', 'Neighbours are watching my activities inside my house', and so forth. In addition she showed herself antagonistic and suspicious, particularly towards her medical supervision. If it were not for the fact that she is drug dependent on nitrazepam, one would label her as paranoid schizophrenic, though her persecutory delusions were not accompanied by any other first rank symptoms.

Comment

Patient developed an intense dependence on nitrazepam after its use in treating her insomnia. She finds herself unable to live a normal life without this drug. This case shows clearly that nitrazepam dependence does occur. Symptoms of depression, anxiety and agitation occurred immediately after the drug was discontinued, and on two occasions were relieved by its reinstatement; they were probably withdrawal symptoms. It seems advisable, therefore, when prescribing nitrazepam to keep in mind the vulnerable personality of the patient.

Summary

A case of nitrazepam dependence has been described. This drug dependence could not be relieved by substituting other tranquillizers.

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