MedCrave
Step into the World of Research

Journal of Psychology and Clinical Psychiatry

Short Communication

Open Access

CrossMark

Zopiclone use with depressed patients

Volume 6 Issue 4 - 2016

J Thomas Dalby
Department of Psychology, University of Calgary, Canada

Correspondence: J Thomas Dalby, Department of Psychology, University of Calgary, Suite 300, 160 Quarry Park Boulevard SE, Calgary, Alberta, Canada, Email Thomas.dalby@shaw.ca

Received: December 18, 2015 | **Published:** September 16, 2016

Short communication

Insomnia is a common medical complaint which is often therapeutically remedied with the prescribing of a hypnotic agent (in Canada-zopiclone is the preferred drug). With Major Depressive Disorder patients, sleep disturbance is one of nine cardinal symptom (in DSM-5 "insomnia or hypersomnia nearly every day") but there is no ready information on the standards of prescribing zopiclone for this specific population. A brief description of a sample of patients with Major Depressive Disorder shows that almost half received zopiclone and often remained on this medication for years. More systematic study of this practice and how it might impact other concurrent medications is warranted.[1]

Thase prudently advises clinicians about the lack of properly controlled, adequately powered, clinical trials on the employment of combinations of antidepressants for the treatment of major depressive disorder. A missing consideration in combined medication regimens for treating depressed patients is the concurrent use of hypnotics.

Zopiclone is a non-benzodiazepine hypnotic agent introduced as an alternative to benzodiazepines in 1986. Since then, accumulated empirical evidence has indicated that the drug has all the properties of benzodiazepines including adverse behavioral effects. This conclusion that zopiclone is a benzodiazepine clone is now biochemically logical as the drug binds at the benzodiazepine GABA sites as a full agonist. It is the most widely prescribed sedative hypnotic prescribed in Canada. Long term reviews of its clinical use in promoting sleep conclude that "zopiclone is effective, well-tolerated and an excellent alternative to benzodiazepines in the short term treatment of insomnia".[2] The Canadian product monograph also emphasizes short-term treatment and that "treatment with Imovane should not usually exceed 7-10 consecutive days. Use for more than 2-3 consecutive weeks requires complete re-evaluation of the patient.[3]"

The link between sleep disturbances and mental disorders is clear and substantial.[4] DSM-5 encourages concurrent diagnosis of sleep disorders although this is likely still under diagnosed. The Imovane (zopiclone) monograph issues a caution for the use of the drug with depressed patients, indicates that it is not a treatment for depression and that Imovane may even mask patients' symptoms. Yet, little information is available on what the standard of practice of using this drug with depressed patients is like.

Kassam & Patten[5] described Canadian population estimates of benzodiazepine and zopiclone use in Canada and showed that patients with Major Depressive Disorder had an elevated frequency in using these agents. However, those estimates (for the previous 12month period) are based on survey data beginning in the mid 1990's and did show increased use of zopiclone by six years later (12.3 percent in 2000/2001). Little additional information on the practice of zopiclone use with patients who had Major Depressive Disorder is available.

The files of one hundred consecutive patients (50 males; 50 females - mean age 40.1years) referred for mental health IME's from third-party disability insurers were reviewed, all who had a diagnosis of Major Depressive Disorder on referral (nearly all from family physicians) and whose diagnosis was confirmed through our assessment with formal objective psychological testing and clinical examination. Forty-six of these patients were taking Imovane at the time of their evaluation. As well, four more patients indicated that their use of a tricyclic antidepressant was taken in the evening to assist sleep rather than to specifically improve mood.

Patients using zopiclone were further reviewed regarding specifics of their use. The duration of their use at the time of examination ranged from 6months to 9years (mean 2.2years). Only two patients began to use zopiclone prior to their initial diagnosis of Major Depressive Disorder. Nearly all of the total patient sample was taking psychoactive medications: SSRI's 88; tricyclic antidepressants 10; narcotic analgesics 6. All patients taking zopiclone were receiving the standard 7.5mg dose and none reported varying this. While most patients had variability in their history using SSRI's - trials of different medications in this class and fluctuating doses - their use of zopiclone was remarkably steady from the initiation of this treatment. All patients taking zopiclone were also using an SSRI medication although depressed symptoms were still prominent.

This brief archival analysis indicates that almost half of patients with Major Depressive Disorder were receiving zopiclone to combat insomnia and the reported percentage of patients is substantially higher than prior survey data indicated. Obviously, insomnia is a major symptom that is being addressed by physicians for these patients. The use of this drug is not, however, "short-term" and therefore significantly departs from recommended practice for primary insomnia. This chronic use pattern for zopiclone has been reported in general medical populations, including the elderly.[6] Whether this chronic pattern is due to habitual behavior or avoidance of withdrawal symptoms with rebound insomnia is only speculative. Doses of zopiclone with depressed patients are not higher than the standard generally recommended. Given the wide-spread and long-term use of this medication with depressed patients it seems prudent

to initiate more controlled studies with zopliclone on these individuals as a "special patient population" to understand the possible impact of this drug on their depression symptoms, daily cognitive function and any interactions with concurrent antidepressant medication.

Acknowledgments

None.

Conflicts of interest

Author declares there are no conflicts of interest.

Funding

None.

References

1. Thase ME. Antidepressant combinations: widely used, but far from empirically validated. *Can J Psychiatry*. 2011;56(6):317–323.
2. Hajak G. A comparative assessment of the risks and benefits of zopliclone: A review of 15 years' clinical experience. *Drug Saf*. 1999;21(6):457–469.
3. Imovane - Product Monograph - sanofi-aventis Canada Inc. 2009.
4. Sculthorpe LD, Douglass AB. Sleep pathologies in depression and the clinical utility of polysomnography. *Can J Psychiatry.* 2010;55(7):413–421.
5. Kassam A, Patten SB. Canadian trends in benzodiazepine & zopiclone use. *Can J Clin Pharmacology*. 2006;13(1):e121–e127.
6. Cimolai N. Zopiclone: Is it a pharmacologic agent for abuse? *Can Family Physician*. 2007;53(12):2124–2129.