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INTRODUCTION AND OBJECTIVES

Zolpidem is a non-benzodiazepine hypnotic indicated to treat insomnia, which selectively binds to GABAA alpha 1 unit receptors. The therapeutic doses range from 5mg to 10mg per day. Continuous or abusive use of zolpidem is associated with memory impairment, tolerance, dependence and withdrawal. On the other hand, abrupt discontinuation can cause anxious symptoms, sleep disturbances, autonomic dysfunction and seizures. However, there are no controlled studies about the treatment of zolpidem dependence in patients with psychiatric comorbidities.

Thus, the present study aims to analyze the association of psychiatric disorders in case reports in zolpidem dependence and to gather information about the treatment of dependence used in those cases.

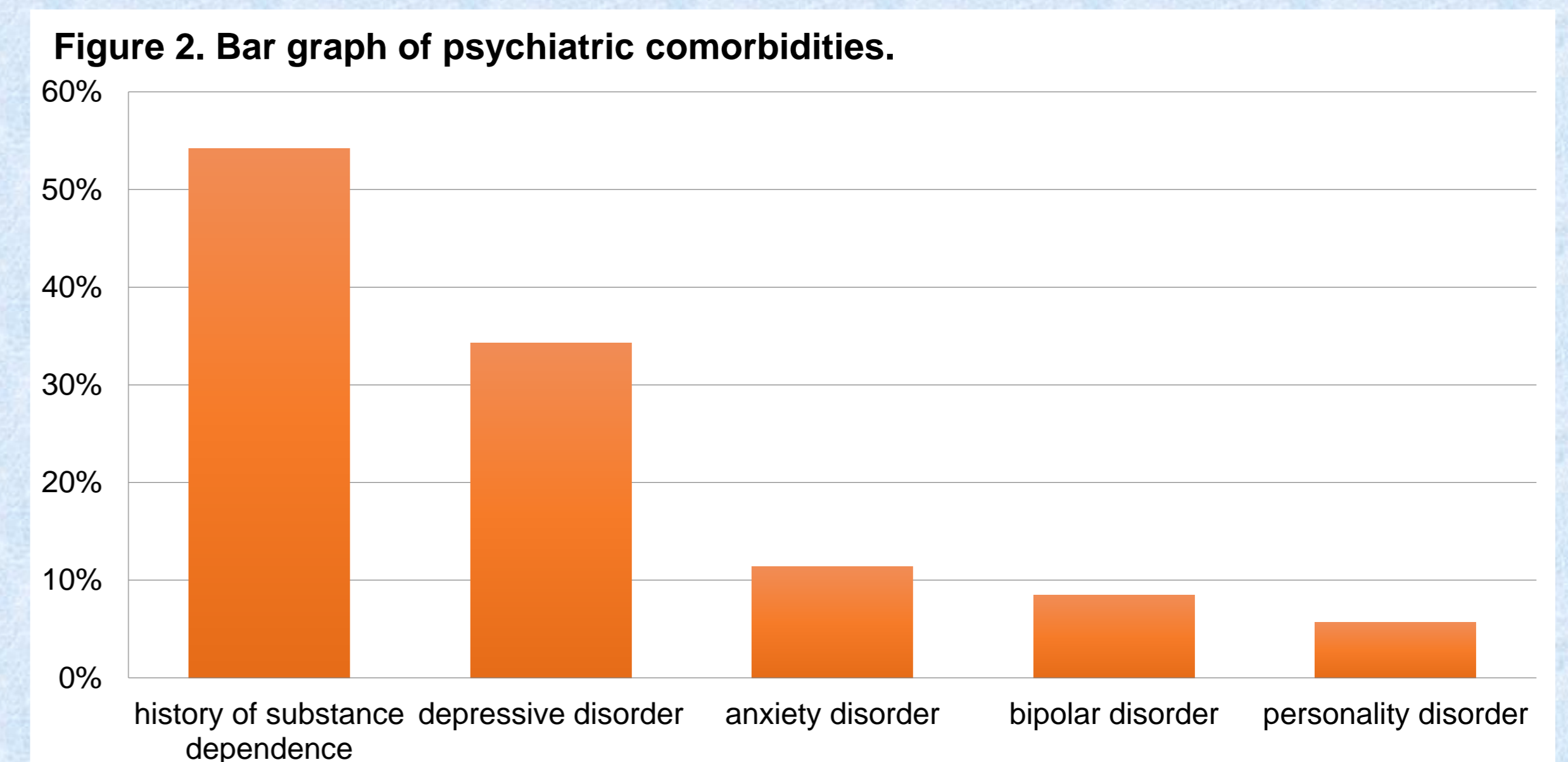
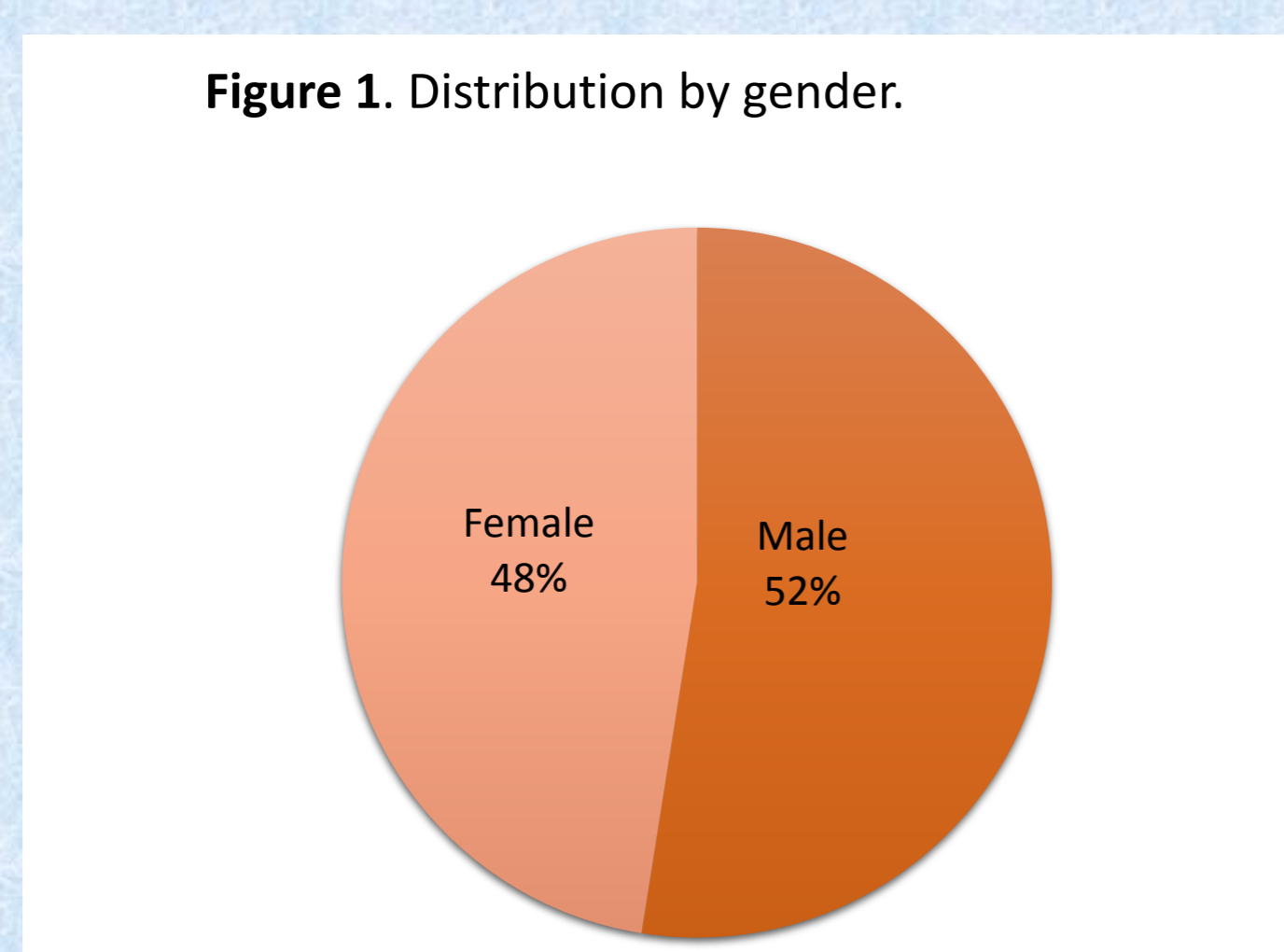
METHODS

A literature review based on PUBMED database using the term "zolpidem" combined with "pharmacodependence", "abuse", "dependence", "dependency", "addiction", "reward", "reward system", "tolerance", "withdrawal" and "abstinence." Only case reports were included and there were no limitations as to language or publication year.

RESULTS

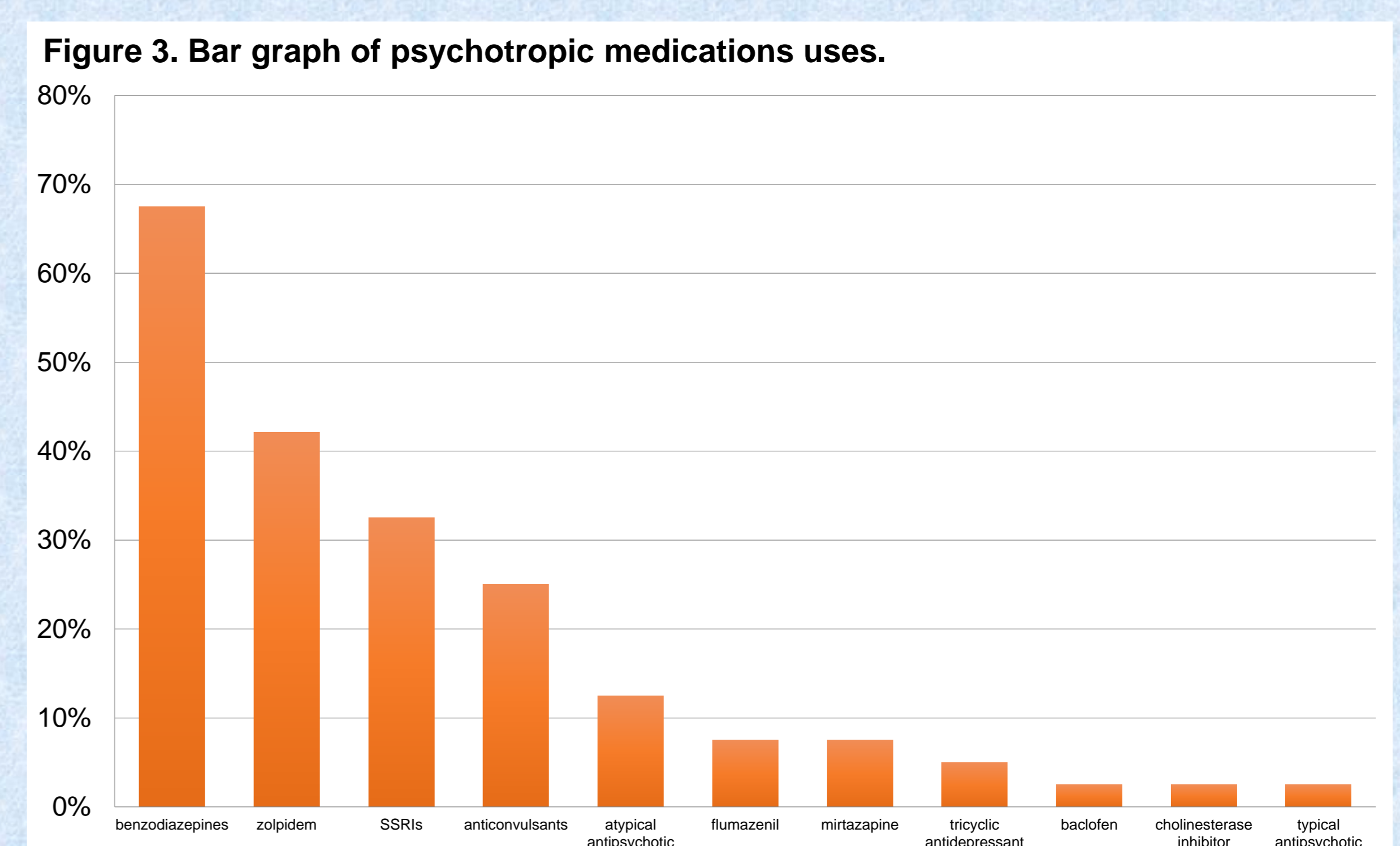
A total of 86 studies of zolpidem dependence were identified, but only 40 clinical case reports referred to treatment of zolpidem dependence. Both genders were described in a similar proportion and the average age was 42.35 years old (Figure 1).

In 35 (87.5%) cases, at least one psychiatric comorbidity was reported. Most of the patients (54.2%) had a history of substance dependence, 34.3% depressive disorder, 11.4% anxiety disorder, 8.5% bipolar disorder and 5.7% personality disorder (Figure 2).



Doses of zolpidem ranged from 30 to 2.000 mg per day. Abstinence symptoms were reported in 74.3% of the cases, within which 51.7% had seizures and had used a Zolpidem dosage greater than or equal to 130mg per day.

Several psychotropic medications were used to treat zolpidem dependence, including benzodiazepines (67.5%), zolpidem (42,1%), SSRIs (32.5%) and anticonvulsants (25%). In the cases in which zolpidem was used, 56.25% of them were given in a gradual reduction of dose and 43.75% by cross-titration with others. However, monotherapy was found in only 14 (35,9%) cases (Figure 3).



CONCLUSIONS

The results suggest that the presence of psychiatric comorbidities may be a risk factor for the development of zolpidem dependence. It reinforces the necessity of caution during the prescription of this substance. However, controlled clinical trials are required to enhance the knowledge of zolpidem dependence, to determine the prevalence of association with other psychiatric disorders, and to develop treatment protocols for this dependence.

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