

# A Patient's Perspective on Benzodiazepines, Co-Dispensed Opioids, and Mortality among Patients Initiating Long-Term In-Center Hemodialysis

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I am commenting on the article appearing in *CJASN* entitled “Benzodiazepines, Co-Dispensed Opioids, and Mortality among Patients Initiating Long-Term In-Center Hemodialysis,” by Muzaale *et al.* (1). I am a registered dental hygienist. I have lived with chronic pain for decades, and I greatly appreciate the opportunity to offer my comments on this article.

My opinions are on the basis of my experience as a kidney patient and as a chronic pain patient (both for 22 years), and on the basis of my education and professional experience as an allied health care provider for roughly 40 years. The cause of my kidney disease and the majority of my chronic pain is an autoimmune disorder. However, I also have repetitive occupational injuries, due to my professional obligations of treating patients.

I am encouraged to see the crisis of palliative care being addressed in the kidney population. Obviously, opioids aren't the only crisis that should be addressed. Although I am thankful to see other sources of respiratory crisis investigated, I am left wondering, “Why would a benzodiazepine be coprescribed with an opioid, regardless of whether it is short- or long-acting?” A mortality risk of 1.9-fold for short-acting benzodiazepine with an opioid is self-explanatory. However, I was confused by the authors' explanation of the mortality risk of long-acting coprescribed benzodiazepine as “no differential risk”; yet, “these results should be interpreted with caution as there is always the potential for channeling bias, unmeasured/unmeasurable confounders or other forms of bias that would lead to a non-causal association.”

Although the statistics from the study were from 2013 to 2014, I was surprised to learn that “benzodiazepine mortality had already been identified as a growing concern for white women.” I am a white female with chronic pain for the last 22 years. I interact with other kidney patients regularly and chronic pain/depression is something I hear about from all patients, not only white females. I firmly believe that patients, other than white females, live with the same struggles as I do.

I am thankful to have a nephrology team that listens to my concerns and struggles. With chronic pain, if you

don't start out with depression, you will eventually find yourself depressed. I feel like a criminal when I am faced with requesting a prescription for my chronic pain. Minorities and men likely feel the same physical challenges as I do but are afraid to discuss them with their doctors. They may even experience bias due to preconceived stigmas of addiction or that they might sell their medication for profit. It is important that our health care professionals remember to engage with patients, rather than avoiding discussions about our pain management.

I live south of Houston, Texas. I waited 10 months to see a neurologist at my local hospital, which has a chronic shortage of neurologists. I've been to pain management, which recommended injections into my cervical spine every 3 months with sedation. And, when that failed, the pain management center referred me back to my nephrologist, because they didn't want to harm my transplant. They had essentially run out of treatments. I have full medical coverage, so going to multiple specialists is fortunately a small burden to me. Other patients are not as lucky. Limited access to care is yet another hurdle for patients and a reason why they might not report chronic pain.

I am thankful for the opportunity to share my thoughts about this article and to the nephrology teams that work tirelessly to keep us (your patients) safe. I am grateful for your expertise and dedication, even in the time of chaos and a global pandemic. You are all truly heroes.

I am especially thankful to have a nephrology team that cares about my wellbeing and continually assists me in the management of my pain and my kidney health, for they are both a part of me. In the future, when COVID-19 has subsided, I hope to see more advances, research opportunities, and treatment options in palliative care for all people who have kidney disease.

## Acknowledgments

Ms. Thomas is a renal transplant recipient and a registered dental hygienist. In addition to being a patient advocate with the Kidney Support Network, Ms. Thomas has

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authored several articles in dental and dental hygiene publications regarding the dental management of patients with CKD, ESKD, and kidney transplantation. She welcomes comments to Catblue30@aol.com.

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**References**

1. Muzaale AD, Daubresse M, Bae S, Chu NM, Lentine KL, Segev DL, McAdams-DeMarco M: Benzodiazepines, codispensed opioids, and mortality among patients initiating long-term in-center hemodialysis. *Clin J Am Soc* 15: 794–804, 2020

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See related article, “Benzodiazepines, Codispensed Opioids, and Mortality among Patients Initiating Long-Term In-Center Hemodialysis,” on pages 794–804.