

of acute dystonia in our case. In fact, we excluded the primary and secondary causes of acute dystonia before we attributed the acute dystonia to midazolam. There were no causes of the secondary dystonia as metabolic diseases, toxins, trauma, and infections. No drug known to cause dystonia, except midazolam had been administered to patient. Primary dystonia was excluded because there was no history of consanguinity and neurological disorders including dystonia in the family, and magnetic resonance imaging brain was normal. There was no history of neurologic disorder in the past. Midazolam-induced acute dystonia is rare, and there are only a few cases in the literature about the midazolam-induced acute dystonia.^[2-4]

Although midazolam and diazepam are both in benzodiazepin family, we used diazepam because acute dystonia persisted despite flumazenil and biperiden lactate administration. Diazepam has anti-dyskinetic effects and was shown to be effective in the treatment of acute dystonia previously.^[5,6] The authors are right that both midazolam and diazepam act at the same receptor and theoretically should show the same response, but diazepam has anti-dyskinetic effects. We think that this effect may be explained by the structural heterogeneity of GABA_A receptors. Further studies are needed for the detailed explanation of this subject.

We used a higher than the recommended dose of midazolam for premedication because enough sedation couldn't be obtained till a total of 0.2 mg/kg midazolam was administered.

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Authors' reply

Dear Editor,
We read with interest the letter about our article entitled "Midazolam-induced acute dystonia reversed by diazepam,"^[1] in which the authors recommend us to search for another cause

University Press, 1997. p. 454-70.

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