Dealing with the sleepless patient

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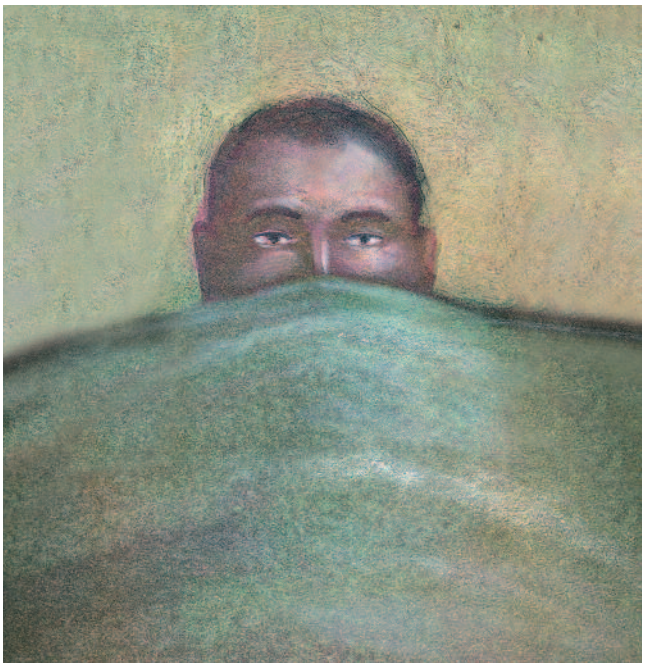

Remember

- 'Ideal' sleep is considered to have a sleep latency of half an hour, one waking of less than half an hour, and a total sleep time of around eight hours.
- In practice there may be an extended latency, up to three wakings, and a total sleep time of five to 10 hours. Elderly people require less total sleep time.
- Insomnia is defined as a sleep latency of greater than half an hour and more than three wakings of greater than half an hour.
- In chronic insomnia (defined as insomnia for more than one month), 30 to 50% of cases have associated psychological or psychiatric disorder.
- Complaints associated with insomnia include:
  - poor sleep profile
  - fatigue and lethargy
  - poor concentration and forgetfulness
  - anxiety and irritability
  - depression
  - headache
  - poor co-ordination and tremulousness.

Assessment

- Identify the patient's sleep pattern and symptoms. Obtain a collateral history from a suitable source.
- Examine the patient.
- Assess psychological, neurological and medical disorders (see Table).
- Enquire about the intake of alcohol, drugs and medication (Table).
- Refer for a sleep study if necessary.

Management

- The National Prescribing Service (phone 02 9699 4499, fax 02 9699 5155, website http://nps.org.au/) provides a useful two-page patient education handout that can be photocopied. It deals with general 'sleep hygiene' as well as providing advice for patients who are in the process of reducing hypnotics and sedatives.
- Essential advice to convey to the patient includes:
  - keep regular hours for retiring to bed and for getting up
  - avoid daytime naps and undertake regular activity
  - keep the evening for relaxation: avoid heavy exertion, late meals and intense work activity immediately prior to bed
  - avoid alcohol and caffeine (tea, coffee, cocoa, cola etc) late at night
  - use the bed only for sleep and sex, not for eating, work, reading or watching TV.
- Other general measures are:
  - progressive advancement of the sleep–bed cycle for inverted rhythms, one hour a week
  - sound or light attenuation, background 'white' noise, or phototherapy
  - relaxation techniques: physical relaxation and visual imagery
  - cognitive restructuring: deal with negative thoughts and expectations
  - avoidance of regular changes of shift rosters, by fixing shifts or, if necessary, changing jobs
  - treatment of psychological, medical and neurological disorders and consideration of medication effects
  - keeping demented patients active by day and providing night lights and signs on doors.
- If a benzodiazepine is to be used, select a shorter acting one, for just one to two weeks. Try temazepam (Euhypnos, Nocturne, Normison, Temaze, Temtabs) or possibly oxazepam (Alepam, Murelax, Serepax). Avoid the anxiety rebound and waking of the short acting lorazepam and alprazolam, and the

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Table. Causes of insomnia

Primary insomnias
- Conditioned psychophysiological response to low grade stress, irregular work hours (shifts) or unfavourable settings
- Subjective perception: insomnia claimed and not substantiated

Primary sleep disorders
- Sleep apnoea syndrome
- Narcolepsy
- Nocturnal myoclonus, restless legs and periodic leg movements
- Fatal familial insomnia

Medical disorders
- Pain syndromes: arthritis, headache
- Dyspnoea: cardiac failure, asthma, chronic obstructive pulmonary disease
- Renal: chronic disease, prostatism
- Delirium: elderly patient with infection, medication or hallucinosis
- Thyroid or menopausal problems
- Dementias

Psychiatric disorders
- Acute anxiety state: situational factors or adjustment disorders
- Panic attacks: acute physical symptoms
- Post-traumatic stress disorder: recurring, disturbing dreams or nightmares of accident or trauma; fear of going to sleep
- Mood disorder: depression with initial and terminal insomnia and awaking with brooding; hypomanic/manic behaviour with singing, shouting, housework or phone calls
- Psychosis: disturbed circadian rhythm, delusional and hallucinatory experiences, agitation

Drug intake
- Alcohol: initiating sleep then disrupting it
- Benzodiazepines: irregular use disturbing sleep; withdrawal insomnia and rebound symptoms; occasional delirium
- Amphetamines: patient is restless and paranoid, and may also use benzodiazepines

Medication
- Newer antidepressants: may cause sedation but often cause insomnia, restlessness and vivid or disturbing dreams
- Antiparkinson drugs: may give vivid dreams or nightmares that wake the patient
- Drug withdrawal: older tricyclics and newer antidepressants, antipsychotics (traditional and novel) and benzodiazepines

sluggishness and 'hangover' of the long acting clonazepam and nitrazepam.

- Of the nonbenzodiazepines, the options are zolpidem (Stilnox) and zopiclone (Imovane), promethazine (Phenergan), tryptophan and chlormethiazole (Hemineurin; short term use in elderly hospitalised confused patients).
- Antidepressants are used if there is coexistent depression, but tricyclic use as an hypnotic in the absence of depression is inappropriate.
- Antipsychotics should not be used for insomnia in the absence of psychosis or major depression.
- In the elderly, if underlying or associated medical conditions have been addressed, and cognitive and relaxation techniques and the general measures outlined above are unsuccessful, a trial of a nonbenzodiazepine should be considered. However, in a significant number of patients already on long term benzodiazepines, where the dose is not excessive or mounting, it may ultimately be reasonable to maintain them on the existing regimen.
- Codeine preparations (15 to 30 mg) are helpful with restless legs, and carbamazepine (Carbamazepine-BC, Tegretol, Teril) or clonazepam (Paxam, Rivotril) may be used with disturbing periodic leg movements.
- With any reduction or withdrawal of high doses of benzodiazepines, the changes should be made slowly.
- Using general measures of 'sleep hygiene' with relaxation and cognitive techniques, it is possible to improve sleep patterns in 30 to 50% of subjects with insomnia without recourse to medication. Careful selection and monitoring of those requiring medication will further improve outcome without necessarily encountering problems of tolerance and dependency. MT

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