First-line treatment of sleep disorders and insomnia in adults

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Content

General

This is the English summary. The complete guideline is available in Dutch and French at ebp-guidelines.be.

Description of the topic

First-line diagnosis and policy in adults with sleep disorders and insomnia.

Target population

Adults (18+) and elderly people with sleep disorders and/or insomnia.

Definitions

Sleep problems (or sleep disorders): disorders related to sleep-wake pattern, such as poor sleep, sleepiness during the day.

Sleeplessness or insomnia (insomnia, insomnia disorder): sleep disorder whereby the patient sleeps poorly at least three times a week, and as a result functions less well during the day, and suffers from tiredness, sleepiness, irritability, reduced concentration and reduced performance.

CBTi (Cognitive Behavioural Therapy for insomnia) is defined as a structured and multimodal non-drug technique in the form of cognitive behavioural therapy interventions, individually or in a group, for (chronic) insomnia and is provided by specially trained health care workers (e.g. psychologists trained in CBTi).

Obstructive sleep apnoea (OSA) is characterised by more than five sleep apnoeas (breathing stops) of ten seconds or longer per hour, with excessive sleepiness during the day or at least two of the following clinical phenomena: tiredness during the day, reduced concentration, disrupted breathing while sleeping and non-regenerative sleep.

Narcolepsy is a rare, but debilitating sleep disorder accompanied by symptoms such as insomnia, sleepiness during the day, attacks of cataplexy (brief paralysis triggered by, e.g. emotion), hypnagogic hallucinations (real-life dream experiences when falling asleep) and sleep paralysis (brief incapacity to move when falling asleep or waking up).

Sleep-wake disorder of the circadian rhythm is characterised by insufficient synchronisation between the endogenous circadian rhythm and the sleep-wake rhythm required by the physical environment or the social or professional schedule of the patient.

Parasomnias are strange, usually unwanted behaviours, perceptions or experiences that occur episodically during sleep. Forms of parasomnias of non-REM sleep include sleepwalking, confusional arousal and pavor nocturnus. They are the result of an incomplete awakening by an arousal stimulus, and in this state of reduced consciousness result in behaviour that is not normal or consciously controlled.

Restless legs syndrome (RLS) and **periodic limb movement disorder (PLMD):** these disorders are two examples of sleep-related movement disorders.

- Restless legs syndrome is a clinical diagnosis that the GP can make based on a specific pattern of symptoms. There are four essential diagnostic criteria:
    - an irresistible urge to move the legs (restless legs), usually accompanied or caused by unpleasant sensations in the legs;
    - the urge to move or the unpleasant sensations start or get worse during periods of rest or inactivity such as lying or sitting;
    - the urge to move or the unpleasant sensations are wholly or partially alleviated by movement such as walking;
    - the urge to move or the unpleasant sensations are worse in the evening or at night than during the day or only occur in the evening or at night.
- Periodic leg movement syndrome is a sleep-related movement disorder whereby the patient periodically and unconsciously moves the legs during sleep. The movements are usually very violent and jerky and can therefore significantly affect the sleep quality of the patient (and his/her partner).

Diagnosis

Symptoms and clinical signs

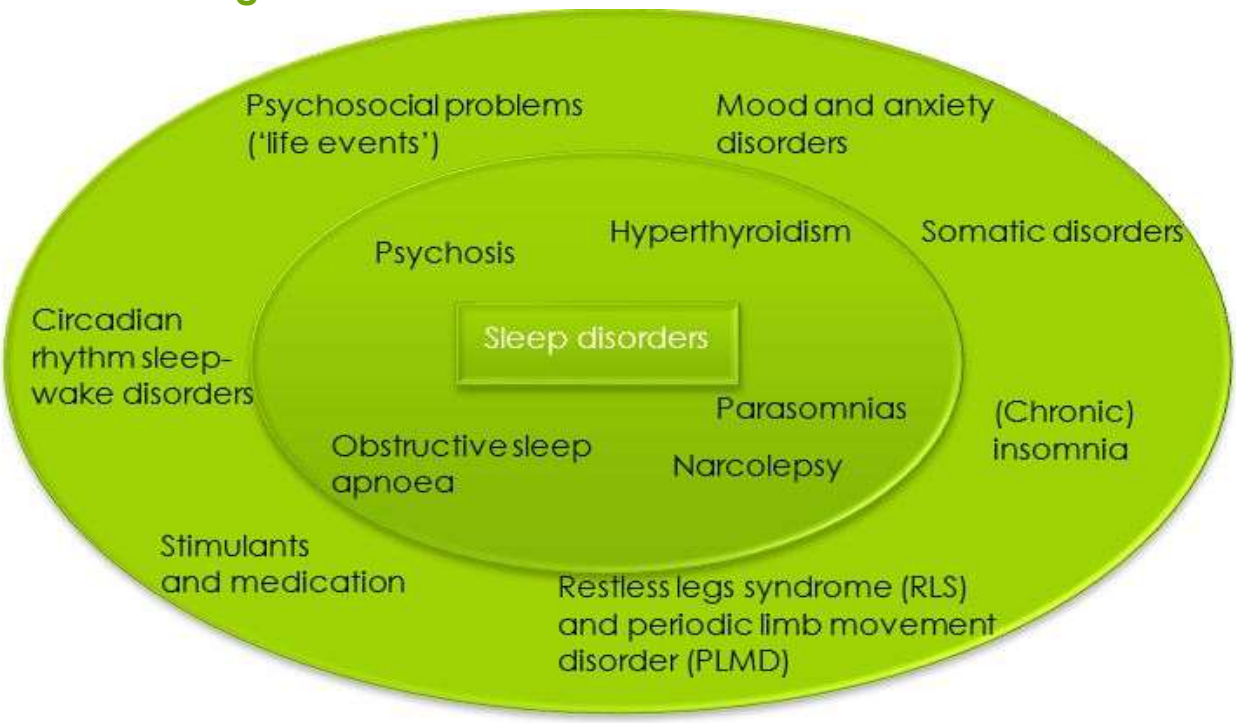
What should the GP focus on when diagnosing sleep disorders and insomnia?

- Assess the ideas, concerns and expectations of the patient (ICE) (GRADE 1C).
- Ask about the nature and duration of the symptoms, as well as the impact of the insomnia on the way the patient functions (GPP).
- Run through the diagnostic landscape to find a possible cause of the insomnia (comorbid insomnia) (GPP).
- While looking over the possible causes, first exclude the following diagnoses: psychosis, hyperthyroidism and specific sleep disorders such as obstructive sleep apnoea (OSA), narcolepsy, parasomnias, as well as

sleep-wake disorders of circadian rhythm, restless legs syndrome (RLS) and periodic limb movement disorder (PLMD) (GPP).

- Consider getting the patient to keep a sleep diary for two weeks (GRADE 2C).

Differential diagnosis



Treatment

Drug therapy

When should drug therapy be considered?

- Consider prescribing a short-term course of sedatives for patients with an acute presentation of severe insomnia accompanied by severe suffering (GRADE 2C).
- Do not prescribe sedatives for patients with acute or chronic insomnia who are not in a crisis situation and who need a multimodal approach based on the principles of cognitive behavioural therapy (GRADE 1B).
- There is no place for drugs in the first-line treatment of insomnia in the elderly (GRADE 1C).
- Discuss a stopping strategy at the beginning of the treatment with sedatives (GRADE 1C).
- At the same time, offer the patient information about a non-drug approach to insomnia and/or underlying problems (GPP).

Which drug therapy should take preference?

- Consider an intermediate-acting benzodiazepine (lormetazepam) or a Z drug, at the lowest possible dose and for the shortest possible duration (one week maximum) (GRADE 2C).

Non-drug therapy

Which non-drug interventions can the GP offer?

1. Choose a phased approach and use a practical combination of non-drug interventions, whereby the nature of the problem, the patient's preferences and your expertise determine the choice of methods to be employed (GPP).

2. As a first step, we recommend the use of a sleep diary, good patient education and sleep hygiene advice (GPP).
    - A *sleep diary* is used for collecting information about the daily sleep routine and is useful for getting a picture of the sleep as experienced by the patient (the frequency and duration of waking periods as well as sleep efficiency). Sleep efficiency is the percentage ratio of the total time asleep compared to the time spent in bed.
        - Sleep efficiency can be calculated as follows: TST/TIB x 100, whereby TST stands for Total Sleep Time and TIB for Time in Bed.

- *Patient education*
  - There is no exact standard about the number of hours that someone should sleep.
  - The 'inbuilt' circadian clock determines the fluctuations in body temperature and the sleep-wake rhythm, and can get out of balance due to circumstances, such as irregular sleep-wake times or in the event of jetlag.
  - It is not abnormal for there to be variations between individuals in the time necessary for getting to sleep.
  - As night progresses, sleep becomes less deep and short periods of wakefulness are normal.
  - The elderly sleep less deeply, and often for shorter periods spread over 24 hours. They are also more likely to be awake in the middle of the night.
  - Catching up on sleep during the day (with naps before the scheduled bedtime, e.g. falling asleep in front of the TV) perpetuates the sleeping problem. A prolonged sleep provides little to no benefit in terms of sleep quality. The best way to catch up on sleep is to stick to your sleep-wake rhythm for a few nights.
  - …
- *Sleep-wake advice*
  - Get up at fixed times, go to bed when you feel sleepy and do not stay in bed longer after a bad night's sleep.
  - Try and find a way to relax before you go to bed.
  - Make sure your sleeping environment is dark, quiet and not too warm.

3. If these measures do not help, then a combination of the following non-drug interventions may be used: stress-reduction techniques, cognitive techniques, stimulus control, sleep restriction and exercise (GRADE 1B). The following can hereby be recommended if necessary.
   - *Stress-reduction techniques*
     - The 'buffer zone': This technique consists of creating an 'unwinding hour' before going to sleep.
     - Structured information processing before going to sleep, with for example the constructive peak moment in the early evening or making a to-do list for the next day.
     - Relaxation
   - *Cognitive techniques*
     - Cognitive therapy deals with the ideas about sleep and the sleeping problem that may perpetuate or maintain the sleeping problem. Those ideas can be discussed at length, questioned and corrected.
   - *Stimulus control*
     - Only go to bed when you are sleepy (as distinct from tired) and not earlier!

        - Get up when you can't sleep, do something quiet and relaxing in a relatively dark environment and go back to bed when you are sleepy again. Repeat if necessary.
        - Use the bed and bedroom for sleeping only (and, if relaxing, for sex). Make sure that you wake up at the same time every day, regardless of how well or how much you have slept and get up within 10 to 15 minutes.
        - Do not take naps during the day.
    - *Sleep restriction or 'time-in-bed restriction'*
        - The principle behind this technique is that the need to sleep increases by limiting the time in bed to real sleep time.
    - *Exercise*

4. Specific points of attention for the elderly:
    - When choosing non-drug therapy, consider the cognitive and physical capabilities of the elderly patient (GPP);
    - For elderly patients in a residential care facility, check together with the coordinating physician how the nurses and/or paramedical personnel and/or external caregivers can be deployed to put into practice the non-drug therapy either on an individual basis or at the collaborative care level (GRADE 1C).

Practical application

Follow-up

What is the follow-up policy for first-line treatment of insomnia?

- Plan a follow-up consultation after 1 week in patients with an acute presentation of severe insomnia who have been prescribed a sedative. Reiterate the arrangements in place for stopping the drug therapy and apply the recommendations concerning the non-drug approach (GPP).
- Plan a follow-up consultation after 2-3 weeks in patients that do not present with severe insomnia who have not been prescribed a sedative (GPP).
- If the patient adheres to the recommendations, but there is no change after five to ten weeks, a referral can be discussed (GPP).

Referral

When and to whom can the GP make a referral?

Consider a referral to a *sleep centre* (GPP) in the following cases:

- suspected sleep disorder such as obstructive sleep apnoea (OSA), narcolepsy, …;
- unwanted experiences and/or behaviour during sleep, suggesting a sleep disorder such as sleep walking (parasomnias);
- problems with the biological clock/the sleep-wake rhythm such as delayed sleep phase syndrome (DSPS);
- severe fatigue and/or sleepiness during the day (hypersomnolence) which may be the result of a sleep disorder such as narcolepsy (possibly accompanied by cataplexy);
- doubts concerning the original diagnosis, e.g. when a first-line approach does not work;
- chronic insomnia that does not respond well to a first-line approach

Consider referral to a *psychiatrist* in the event of severe psychiatric comorbidity (GPP).

Refer the patient to a *specialist psychotherapist* for a structured multimodal approach based on the principles of cognitive behavioural therapy (CBTi):

- if the non-drug approach initiated by the GP does not work
- if there is insufficient expertise in this area
- in the event of chronic insomnia with a serious impact on functioning (GRADE 1B).

Consider a referral to the *physiotherapist* specialising in relaxation techniques where appropriate, if the GP lacks the expertise for this treatment and there is insufficient self-help material (GPP).

Translation

English translation by The Language Gap.