EastwoodGroupPractice

Insomnia

Sleep disturbance is a very common problem in general practice, with over 30% of the population complaining of poor sleep at some point in their lifetime. Insomnia is defined as a disturbance in initiation, duration, consolidation or quality of sleep resulting in impairment of daily functioning.

The average adult sleeps between 7-8 hours a day, but can vary from 4-10 hours. As we age, our requirement for sleep declines by roughly half an hour per decade, so the average 80 year-old may only need 6-7 hours of sleep a day. Medications are commonly requested (and prescribed), but are associated with dependence, side effects, falls in the elderly, and become ineffective. There are alternatives treatment strategies available.

Secondary Causes

Secondary causes account for over 70% of insomnia, and their treatment usually results in the improvement of sleep. Often several causes co-exist.

Secondary Cause	Prevalence	Management
Obstructive Sleep Apnoea	10%	CPAP + weight loss
Depression and anxiety	40%	CBT and medication
Physical health problems	25%	Treat pain and breathlessness
Excess alcohol	8%	Alcohol reduction
Delayed Sleep Phase Disorder	12%	Sleep hygiene
Illicit Drugs	4%	Drug withdrawl programmes
Parasomnias	1%	Sleep clinic assessment and intervention

Obstructive sleep apnoea is common and increasing in prevalence. It results from under breathing and causes unrefreshed sleep with daytime naps. Often individuals will complain of a dry mouth or headaches on awakening, and partners may complain of snoring or of the individual stopping breathing for periods of time.

Delayed sleep disorder is under recognized and causes the individual to have problems going to sleep at 'normal times'. Individuals often go to bed late, and have difficulty in waking in the morning, with their sleep improving at the weekend when they can sleep in late.

Primary Insomnia

Primary insomnia (for which no secondary cause can be identified) accounts for 30% of cases, and in over half of cases will improve with sleep hygiene. It is diagnosed when all other causes have been excluded. Sleep hygiene will improve the sleep of most patients.

Sleep Hygiene

ACTIONS	RATIONALE
Limit caffeine, alcohol and cigarettes	All are stimulants and delay sleep onset, and reduce sleep quality
Avoid sleep until tired	Frustration and worry about not being able to sleep results in stimulation and further reduced sleep
Avoid napping	Reduces 'sleep pressure' delaying onset, and increasing frustration about not being able to sleep
Insure sleep environment is conducive to sleep	The room should be dark and noise free
Avoid exercise within a few hours of sleep	Results in stimulation
If not asleep within 20mins, get out of bed and return only when drowsy	Affirms positive association between bed and sleep, reducing frustration

Sleep Diary

Sleep diaries are extremely useful and record the sleep patterns for 2 weeks, reflecting trends, habits, and often allow the individual to reflect upon their own sleep. An excellent diary can be found at http://www.patient.co.uk. They are often the starting point of initial assessment.

Non-drug Therapies

Psychological and behavioural therapies are effective in the treatment of chronic insomnia. These include CBT, restriction of time in bed and stimulus control.

Cognitive Behavioural Therapy (CBT) has a strong evidence base and is as effective as any other process, and has long lasting effects (unlike

medications). Unfortunately there are few trained psychologists within this field and access to this treatment is limited.

Bedtime restriction is a simple and effective treatment with a small evidence base. The techniques overlap with CBT, but are helpful for people who spend a long time in bed but can't sleep

Bed Time Restriction

BED TIME RESTRICTION FOR PRIMARY INSOMNIA
Advise not to perform if driving or operating heavy machinery
Estimate the time spent in bed versus the time spent asleep. A sleep diary is useful for this. Restrict the total time spent in bed to the estimated time asleep.
Perform this for 2-weeks insuring that sleep hygiene is also followed (see above)
If sleep is improved and patient is functioning well, then nothing else need be done, and this schedule can be continued. If the quality of sleep is improved but they feel sleep deprived then increase the amount of time spent in bed by 30 minutes/week, until the feelings of sleep deprivation are reduced.
If sleep is still poor then reduce bedtime by 30 minutes and continue for 2 weeks
Sleep restriction should not be less than 5 hours a night

Stimulus control therapy relates to only spending time in bed when sleepy, if sleep not achieved in 20 minutes then to get out of bed. To avoid naps and to arise the same time each day.

Drug Therapies

Drugs are commonly prescribed and include the Z-drugs (zopiclone), benzodiazepines (temazepam) and tricyclic antidepressants (amitriptyline). They are effective in the short-term but longer-term, are less effective and can result in dependence. Melatonin is a novel medication, which acts to 'reset' the bodies normal circadian rhythm. Medication should be used if behavioural therapies have failed

References

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