



Recognizing and Treating Insomnia

Sleep problems are seen daily in primary care practices, but are frequently overlooked because they are commonly comorbid with a variety of physical and mental disorders. Even when sleep problems are reported, many patients assume they will go away. They may be certain that they can handle it themselves, or they may be afraid to take medication. This newsletter addresses such important issues as how the primary care clinician can improve the likelihood of recognizing insomnia, how the type of insomnia affects treatment choice, and how treatment choice affects adherence. This discussion should enable you to better understand how to optimize outcomes for your patients with insomnia.



* Not an actual patient

She's your first patient of the day—Mary Sylvan*, a 48-year-old woman in perimenopause who works on an assembly line. You've been treating Ms Sylvan for more than 20 years. She's come in for a routine follow-up visit to check on her response to fluoxetine, prescribed 6 weeks ago for depression.

Her first bout of depression began postpartum, 15 years earlier, and resolved after 6 months of antidepressant therapy. About 2 months ago, her depression recurred. As she sits in the waiting room, she completes a patient information form, to which you've recently added questions to screen for sleep problems.

Screening for sleep problems in the waiting room

Do you have difficulty falling asleep? yes no

How long does it take? _____

How frequently do you have difficulty falling asleep?

Often Sometimes Never

Do you wake up during the night? yes no

How many times? _____

Can you return to sleep after you awaken? yes no

How many nights per week do you awaken in the middle of the night? _____

Do you feel refreshed after a night's sleep? yes no

Do you find yourself dozing during daily activities like reading, watching TV or theater, or sitting in a car as a passenger? yes no

Sources: References ^{1,2}

Reviewing her responses to the sleep questionnaire, you note that Ms Sylvan has been suffering from intermittent, possibly situational insomnia. When you question her further, she tells you that she's been awakening several times per night, but she cannot predict when it will happen. She attributes her awakenings to night sweats and complains that she cannot get back to sleep. She's worried that this has begun to affect her work and she is afraid she might have an accident.

A recent review of systems during her annual physical found everything within normal limits, with 2 exceptions: she has mild hypertension and a body mass index of 28. Ms Sylvan also reported smoking less than a pack of cigarettes per day. Following the physical, you discussed exercise and diet with her, as well as smoking cessation. Since she stated that she prefers “natural” approaches to medical problems, and dislikes taking prescription medications, you both agreed that she should try 2 to 3 months of lifestyle changes before adding any other drugs to her fluoxetine regimen. On the next follow-up visit, Ms Sylvan admits that although she has been trying hard to comply with your recommended changes, there have been several lapses, which she blames on her frequent hot flashes and night sweats.

Measuring Impairment

The addition of patient self-screening questions to your intake forms can prompt a discussion about sleep with your patient, when appropriate. A more detailed evaluation of insomnia, such as the Pittsburgh Sleep Quality Index³ may also help you to elicit information from your patients. Insomnia may be associated with daytime impairment. Look for signs, symptoms, and patient reports of fatigue or malaise; attention, concentration, or memory impairment; social, vocational, or educational dysfunction; mood disturbance or irritability; daytime sleepiness; reduced motivation, energy, or initiative; errors or accidents at work or while driving; tension headaches; GI symptoms; and concerns or worries about sleep.⁴

You recommend that Ms Sylvan complete a sleep diary (the National Sleep Foundation has several versions available at their Web site, www.sleepfoundation.org) for 1 or 2 weeks. In the diary, patients record information about their sleep schedule (time to bed, time of awakening, total sleep time); time to sleep onset; number of nocturnal awakenings; sleep quality; and emotional, physical, or environmental factors that may have contributed to poor sleep. Such information can give the patient and the clinician a sleep picture—a night-by-night account that describes the patient's sleep hygiene and allows the clinician and the patient to assess the effectiveness of treatment.

Recognizing Insomnia

Insomnia symptoms vary from person to person. One person may toss and turn for a couple of hours before finally falling asleep, referred to as difficulty initiating sleep. Another may wake up too early, or complain of poor-quality (nonrestorative) sleep. In Ms Sylvan's case, she has had difficulty maintaining sleep. Of course, insomnia may not be limited to only one form.⁵ Insomnia symptoms also can be described in terms of their frequency and duration of occurrence as well as their effect on social or occupational functioning.⁶

Ms Sylvan experiences intermittent, situational insomnia, which may be difficult to treat. Because she can't predict when she'll have insomnia, she may have to take medications just in case, to ensure a good night's sleep. Several factors complicate the picture even more. She has comorbid depression, is taking a selective serotonin reuptake inhibitor (SSRI) antidepressant, and has been experiencing night sweats.

Most insomnia is comorbid with another condition, so Ms Sylvan's insomnia could very likely be depression-related.¹⁷ Depression is a common comorbidity and insomnia is one of its symptoms.⁵ Currently, it is not known if insomnia causes depression, or if depression is a cause of insomnia. It has been hypothesized that they have a common pathology that makes a person susceptible to both.⁷

If the sleep disorder is depression-related, treatment of depression may improve sleep. However, SSRIs can lighten and fragment sleep, which is not a desirable effect.⁸ This effect has led some clinicians to prescribe a hypnotic agent or a sedating antidepressant⁸ with the SSRI. Combination therapy with an SSRI and a hypnotic reduces the time to antidepressant response and heightens the magnitude of antidepressant response.⁹

Insomnia is extremely common among women with severe hot flashes. In one study of more than 3200 women,¹⁰ approximately one third had hot flashes; of those, half also experienced night sweats. As the severity of the hot flashes increased, insomnia increased. Among the women with severe hot flashes, more than 80% had chronic insomnia symptoms, including difficulty initiating sleep, nonrestorative sleep, difficulty maintaining sleep, and global sleep dissatisfaction. Perimenopausal and postmenopausal women felt that their insomnia was menopause-related. There are conflicting data regarding studies that measure the effects of hot flashes on sleep.

Why Sleep is Important

No one knows how much sleep is really needed. Sleep needs differ across age groups, from person to person, and even within the same person. It is generally recommended that adults get between 7 and 9 hours of sleep per day.¹¹ Sleep promotes health and wellness, affecting memory and cognition, attention, emotions, and motor performance, as well as immune and endocrine function. Too little sleep produces a sleep debt that must be paid back. This debt results in waking neurobehavioral deficits that the person may be unaware of, demonstrating that the effects of sleep loss are not benign.¹² Ms Sylvan has noticed changes in her work habits that she finds very troubling.

Choosing Treatment

You decide to switch Ms Sylvan's antidepressant from fluoxetine to a more sedating antidepressant agent, trazodone. Antidepressants are not indicated for sleep disorders and there are few studies that demonstrate their efficacy. Recognizing that she will need to be closely monitored for adverse effects (worsening of depression, an increased risk of suicide, orthostatic hypotension with resultant falls, and possible lethality in overdose),^{8,13} you schedule a 2-week follow-up appointment.

When Ms Sylvan returns for her follow-up visit, you administer the Patient Health Questionnaire (PHQ-9), a depression screening tool, and note that her depressive symptoms have improved significantly, from a score of 17 to 10. Although she has shown improvement in depressive symptoms, her insomnia persists. She continues to awaken in the middle of the night, with difficulty returning to sleep. You review her sleep diary and find that she has felt stressed before going to bed. Together you discuss her progress with lifestyle modifications and review sleep hygiene suggestions listed in the table. You recommend that she exercise more and set a date to quit smoking.

Sleep Hygiene Suggestions

- Reduce or eliminate caffeine, nicotine, and alcohol use, particularly close to bedtime
- Avoid stress, including work, close to bedtime
- Don't exercise close to bedtime
- Don't watch the clock if you awaken
- Keep the bedroom temperature comfortable
- Don't allow pets in the bed
- Cover windows to prevent early morning light
- Maintain regular sleep times

Source: Reference⁶

You have read that combination therapy with an SSRI and a hypnotic reduces the time to antidepressant response and heightens the magnitude of antidepressant response.⁹ Based on these findings, you decide to prescribe zolpidem. Ms Sylvan schedules a 3-week follow-up visit.

When Ms Sylvan returns, you find that her depression rating is much improved—from a 10 on her previous visit to a 6 on the PHQ-9. She mentions that she has been taking the zolpidem regularly, despite the fact that her insomnia has been sporadic. She reports that her night sweats have decreased and that she is able to return to sleep after awakening, but she is concerned about becoming dependent on zolpidem. She feels that she is taking more medication than is necessary; after all, she has not been having sleeping problems every day. Recognizing her concerns, you're worried about the possibility of nonadherence. Zolpidem is an effective agent, but may not be the best choice for managing nocturnal awakenings in this formulation.

Agents on the Horizon

You would like to be able to tailor treatment to your patients, but recognize the limitations of available agents. The future is bright for insomnia management, with new agents that involve different formulations, dosing ad-

vantages, and sites of action. Indiplon, a selective benzodiazepine-receptor agonist hypnotic, has a fast onset of action and a short half-life. In studies in patients with middle-of-the-night awakenings, improvements were seen in latency to sleep onset, subjective total sleep time postdosing, and sleep quality, with no next-morning residual impact on alertness. These properties may make it a useful agent for a woman like Ms Sylvan, who would be able to take it only when needed.¹⁴ A low-dose zolpidem dissolving lozenge, with rapid action and short duration of sedation may provide another as-needed option for sleep maintenance insomnia.¹⁵ Other agents in development have modes of action that target histamine receptors, serotonin receptors, orexin receptors, H1 and H3 receptors, and substance P.

Summary

Treating nocturnal awakenings can be challenging for a clinician, particularly when comorbidities are present. In this case, treatment for Ms Sylvan's insomnia is a compromise because she does not have the option to take an agent just when she needs it. This could affect adherence, and result in greater impairment. New agents may soon provide alternatives for patients like Ms Sylvan.

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