Sleep problems

Sleep problems - F51 (Clinical term: Non-organic sleep disorders Eu51)

Insomnia

Presenting complaints

- Difficulty falling asleep.
- Recurrent waking during the night.
- Feeling unrefreshed (ie easily exhausted or fatigued) by sleep.
- Falling asleep at inappropriate times during the day.

Insomnia is associated with:

- complaints of poor memory and concentration
- irritability
- prone to accidents at work
- underperformance at work, or educational problems in young people
- psychosocial difficulties
- impairment
- reduced quality of life
- more frequent use of health services due to general ill health
- chronic dependence on hypnotic medication and sometimes alcohol as a (ineffective) means of 'sleeping' better.

Differential diagnosis

It is essential that the cause of insomnia be identified rather than attempting to treat the problem symptomatically, as treatment depends on cause.

- **Transient insomnia** (several days duration; commonplace) may result from worry about an anticipated event, upset related to a family dispute, unfamiliar sleeping environment, brief illness, withdrawal from hypnotic drugs.

- **Short-term insomnia** (several weeks) might result from longer illness and worries about being ill, financial problems or difficulties at work, bereavement (may become prolonged if not resolved), psychiatric disorder with fluctuating course.

- **Chronic insomnia** (months or years) may result from:
  - persistent psychological problems, especially stress
  - poor sleep hygiene, eg sleeping environment not conducive to sleep (including snoring or restless bed partner), excessive intake of caffeine or overuse of nicotine or alcohol, especially at night
  - physical disorders that disturb sleep, eg painful conditions, respiratory disorders
  - psychiatric disorders, including Depression - F32#, Generalized anxiety - F41.1, psychotic states
  - medication, including some bronchodilators, decongestants, antidepressants and stimulants
  - other sleep disorders, including Restless legs syndrome

- conditioned insomnia where original cause no longer applies but bed has become associated with being awake.

Assessment should include a full sleep history from patient (also bed partner, family, etc if possible), examination of mental state and review of medical, psychiatric and family histories. Screening sleep questionnaires and a sleep diary can be valuable.

Essential information for patient and family

- Temporary sleep problems are common and do not require treatment.
- People vary in the amount of sleep they need.
- If insomnia lasts more than a few days, advice should be sought and the cause identified (most causes are treatable).
- Generally avoid self-medication with over-the-counter or someone else's medication; using alcohol to sleep better; taking sleeping pills for more than a few days (and preferably not at all); lying awake in bed for long periods.

General management and advice to patient and family

(ref 218-220)

- Encourage the patient to practise good sleep hygiene:
  - Keep to regular hours for going to bed and getting up in the morning, including at weekends
  - Make plans or think about problems before retiring to bed
  - Keep a pen and pad next to the bed for writing down troublesome thoughts which can then be reviewed
  - Avoid caffeine and alcohol in the evenings
  - Avoid daytime naps.

- Daytime exercise can help the patient to sleep regularly, but evening exercise may contribute to insomnia.
- Behavioural treatment is safer and more effective than medication (eg cognitive therapy, stimulus control, sleep restriction, relaxation). (see Learning to relax)
- Self-help leaflets, books and groups may be useful. (see Sleep problems)
- Sleep diaries are often useful in assessment and monitoring of progress. (see Sleep problems)

References

218 Kupfer DJ, Reynolds CF. Management of insomnia. N Engl J Med 1997, 336: 341-346.

219 Ancoli-Israel S. Insomnia in the elderly: a review for the primary-care practitioner. Sleep 2000, 23(Suppl 1): S23-S30.

220 Edinger JD, Wohlgemuth WK. The significance and management of persistent primary insomnia: the past, present and future of behavioural insomnia therapies. Sleep Med Rev 1999, 3: 101-118.

Medication

- Address underlying psychosocial, psychiatric or physical conditions.
- Make changes to medication, as appropriate.
- A brief, time-limited use of hypnotic medication may sometimes be useful.
- Hypnotic medication may be used occasionally. Risk of dependence increases significantly after 14 days of use.
- Melatonin is only justified for jetlag

Referral

Most cases will be dealt with in primary care.

Depending on likely cause of insomnia, referral may be appropriate to general medicine, neurology or psychiatry.

Referral for behavioural interventions may be useful where locally available.

Refer to a sleep disorders clinic, if available, if diagnosis is uncertain or treatment has failed.

Excessive daytime sleepiness (EDS)

Presenting complaints

- Prolonged overnight sleep.
- Falling asleep during the day.
- Feeling constantly tired, exhausted or fatigued.
- Poor memory and concentration.
- Irritability or depression.
- Automatic behaviour in a sleepy state.
- Periods of sleepiness alternating with normal periods.

Excessive daytime sleepiness is associated with:

- Poor occupational or school performance
- Increased accident rate (including road traffic accidents)
- Impaired marital relationships and social activities
- Misdiagnosis as laziness, depression, intellectual decline.

Differential diagnosis

It is important to distinguish between sleepiness and fatigue without prominent sleepiness, which may be caused by physical disorders (eg anaemia) or primary psychiatric disorder.

- Chronic lack of sleep.
- Circadian rhythm sleep disorder, including irregular sleep-wake schedule or shift work.
- Disrupted (poor quality) sleep caused by obstructive sleep apnoea (common); caffeine, alcohol or nicotine excess; other non-prescribed drugs (including withdrawal phase).
- Increased sleep tendency, eg narcolepsy (characterized by sleep attacks and cataplexy), over-sedation by medication.

Assessment should include sleep histories and a general review. Sleep questionnaires, sleep diary or actigraphy can be valuable. Polysomnography is often needed, including respiratory measures. Other specific interventions may be appropriate, eg toxicology screen.

Essential information for patient and family

- Medical advice should be sought for sleepiness affecting everyday functioning.
- Underlying condition can usually be treated if correctly diagnosed.
- Do not use stimulant drugs to stay awake.
- Avoid driving or other potentially hazardous activities until sleepiness is corrected.

General management and advice to patient and family

As for insomnia (click here)

Chronotherapy (retiming of sleep phase) may be appropriate for circadian rhythm sleep disorders.

Medication

- Stimulant drugs are appropriate for narcolepsy.
- Continuous positive airway pressure for obstructive sleep apnoea.

Referral

Drug treatment should be reserved for specialist recommendation.

Parasomnias

Presenting complaints

Some parasomnias (recurrent episodes of disturbed behaviour, experiences or physiological change occurring exclusively or predominantly in relation to sleep) are subtle, others are dramatic and frightening to experience or witness.

Diagnostic features

Primary parasomnias:

- Pre-sleep period or sleep onset: sleep starts (sudden jerk or sensation often alarming); rhythmic movements, eg headbanging, rocking
- Early in the night in light non-rapid eye movement (NREM) sleep: teeth grinding, periodic limb movements (repetitive jerky movements)
- Early in the night in deep NREM sleep: confusional arousals (mainly in young children), sleepwalking, sleep (night) terrors
- Later in the night in REM (ie dreaming) sleep: nightmares, REM sleep behaviour disorder (in which dreams are acted out)
- On waking: sleep paralysis
- At various times during sleep: sleep talking, sleep-related eating disorders.

Secondary parasomnias:

- Physical: nocturnal epilepsy, awakenings associated with sleep-related breathing difficulties
- Psychiatric: panic attacks, post-traumatic stress disorder, pseudoparasomnias (when the person is actually awake).

Differential diagnosis

The various parasomnias are often confused with each other and all dramatic parasomnias can mistakenly be called ‘nightmares’ or ‘night terrors’.

Assessment:

- Requires precise description of subjective and objective changes from start to finish of parasomnia, together with timing and circumstances in which they occur
- Audio-visual recording is very valuable
- Polysomnography with audio-visual recording is required in complicated cases
- A family history may be instructive, eg sleepwalking/sleep terrors
- A physical and psychiatric review is important.

Essential information for patient and family

- Many parasomnias of childhood improve spontaneously but protection may be necessary in the meantime (eg in sleepwalking).
- It is important to have the correct diagnosis.
- It should not be assumed that something is psychiatrically wrong with the person.

General management and advice to patient and family

(ref 221)

- Ensure the correct diagnosis on which treatment depends.
- Good sleep hygiene generally helps.

References

221 Stores G. Dramatic parasomnias. J R Soc Med 2001, 94: 173-176.

Referral

- Most common parasomnias should be identifiable in primary care, if assessed thoroughly.
- Refer to a sleep disorders clinic in complicated cases or uncertainty about type of parasomnia or significance.

Special considerations in children and adolescents

Parental factors feature prominently in the cause, management and prognosis of children's sleep problems.

- Children and adolescents have the same basic sleep problems as adults but the underlying causes differ in certain ways, eg sleeplessness is often the result of parenting practices where the child has failed to acquire good sleep habits or has developed unsatisfactory ones.
- The clinical manifestations of basically the same disorder can be different in young and adult patients, eg obstructive sleep apnoea in children is usually caused by large tonsils and adenoids, is not particularly limited to being overweight, and instead of sleepiness, it may result in overactivity and learning and behaviour problems.
- Medication plays even less of a role in treatment. Behavioural approaches are particularly important, although they require effective involvement of parents.
- Prognosis is better than in adults, where the condition may have become well established and complicated by the long-term consequences of the sleep disturbance.

Resources for patients and families

Learning to relax

Sleep problems

British Sleep Society
Email: Martin.King@papworth_tr.anglex.nhs.uk; website: http://www.british-sleep-society.org.uk
UKAN (Narcolepsy Association UK) 020 7721 8904
Email: infor@narcolepsy.org.uk; website: http://www.narcolepsy.org.uk
Provides help for those suffering from narcolepsy.

British Snoring and Sleep Apnoea Association 0800 0851 097
Email: info@britishsnoring.demon.co.uk; website: http://www.britishsnoring.com
Leaflets available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk): Sleeping well, Tiredness.

Coping with Sleep Problems and Coping with Children's Sleep Problems. The Royal College of Psychiatrists. Talking Life, 1A Grosvenor Rd, Hoylake, Wirral CH47 3BS; tel: 0151 632 0662; website: http://www.talkinglife.co.uk.
Advice, information and strategies on tape for coping with insomnia (sleeplessness) and other disorders that lead to excessive daytime sleepiness. They present practical strategies to help parents cope with the sleep difficulties of their babies and young children.

Understanding Sleep Disorders in Adults by G Stores. Family Doctor Publications / British Medical Association, 2003. A guide for the general public to sleep disorders in adults.

Solve Your Child's Sleep Problems by R Ferber. Dorling Kindersley, 1986.