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Prescribing for Sleep

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Goal

- To provide practical advice on selecting, using, and stopping hypnotics.

Selecting a hypnotic

- When do you want it to work?
- What side-effects are acceptable?
- How long do you intend to prescribe it?
- What medical or psychiatric co-morbidities are there?
- Is there a risk of substance misuse?

When do you want it to work?

- Onset of action is more-or-less the same for all hypnotics.
- Insomnia can be initial, middle, terminal, or a combination.
- Select the hypnotic according to it's half-live in order to cover the period you want.

Some examples….

Drug	½ life (hours)
Zopiclone	5-6
Zolpidem	1.5-2.5
Circadin (Melatonin MR)	3.5-4
Temazepam	8-20
Mirtazapine	20-40
Trazodone	10-12 (biphasic)
Clonazepam	35-40

What side-effects are acceptable?

- Discuss with the patient.
- Zopiclone can cause a metallic taste in up to 40% patients (Tsutsui, 2001).
- “Hangover” side-effects are more common with e.g. Zopiclone and Clonazepam.

The *Falls* Controversy

	T½	T½ in the elderly
Zopiclone	3.5 – 6hrs	9 hrs
Zolpidem	2 -2.5hrs	3hrs
(Amitriptyline		*36hrs (Ziegler 1978))*

- Falls and hypnotic literature is a mess.
- Insomnia is a risk factor for falls (Avidan, 2005).
- Shorter acting hypnotics are probably safer (Wilson, 2010).
- If the hypnotic is not working, STOP it.

What medical/psychiatric co-morbidities are there?

- Benzos have muscle relaxant effects - caution in Sleep Apnoea.
- Be mindful of drug interactions in the elderly.
- Can you control/optimise treatment of the medical/psychiatric condition and insomnia with the one drug?
- Be mindful of polypharmacy and risk of overdose in vulnerable patients.

Is there a risk of substance misuse?

- Any drug is potentially addictive.
- Risk of addiction with sedative anti-depressants and Circadin is very low (Kyrstal et al; 2010).
- For patients self-medicating with alcohol, it may be better to use a hypnotic - close monitoring required here.

Using hypnotics

- When?
- What dose?
- What is Rebound Insomnia?
- What else do I have to do?

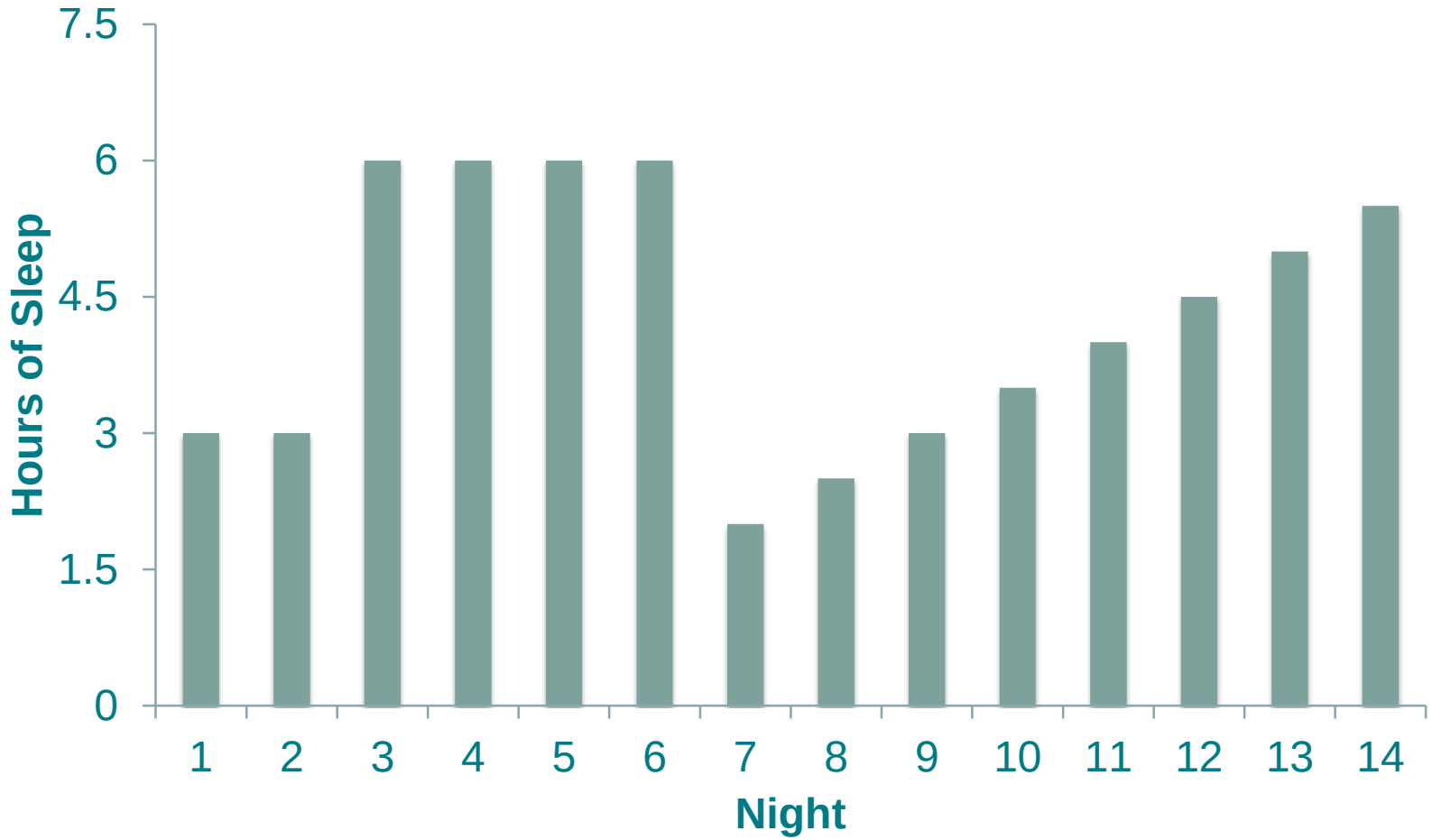
When?

- Taken immediately before going to bed.
- If used on a PRN basis, unlikely to be any issues (monitoring frequency of repeat prescriptions will alert if any issues arise).
- If used nightly, monitor for dose increases.
- If used nightly, drug holidays can be used to minimise tolerance; but n.b. to warn the patient about Rebound Insomnia.

What dose?

- Start at the lowest ***effective*** dose.
- If tolerance develops - switch to another drug rather than escalating the dose (Wilson et al; 2010).
- Tolerance tends to develop quickly with Promethazine, Diphenhydramine (e.g. Nytol, Unisom, Sominex, Benadryl), and Amitriptyline. All have a very poor evidence base in the treatment of insomnia, and are associated with pronounced anti-cholinergic side-effects.

Rebound Insomnia



What else do I need to do?

- These are hypnotics - not general anaesthetics!
- They only form ***one part*** of the treatment of insomnia.
- Doctor and patient need to address other approaches i.e. Cognitive Behavioural Therapy for Insomnia (CBT-I).

CBT-I resources

https://gps.camdenccg.nhs.uk/education/video/insomnia-in-10-minutes-one-of-our-favourite-videos

Stopping Hypnotics

- Why are you stopping?
- When to stop.
- How to stop.

Why are you stopping?

- There was a clear precipitant which has now resolved.
- The patient is no longer deriving benefit, has intolerable side-effects, or has developed tolerance.
- The hypnotic is being used for other reasons.
- Be mindful of stopping a hypnotic when it is effective - insomnia poses significant risks to quality of life, functioning, and mental health. It is often a long term condition, which needs a long term treatment.

When to stop?

- Choose the time carefully - for both the patient and you!
- It can be very stressful for the patient, and you may need to provide extra supervision/support.
- Tell the patient what to expect.
- If the hypnotic is effective, be sure to have an alternate strategy to replace it with before stopping.

How to stop

- With written or verbal physician advice - 14-28% stop (Voshaar 2003; Gorgels 2005).
- Using a systematic taper - 48% stop, but when combined with CBT-I, 85% stop.
- Most studies use a regime of tapering the dose by 25% every 1-2 weeks.

Practical tips on stopping

- Be sure it's the right thing to do, at the right time for that particular patient.
- If you're removing an effective hypnotic, need to replace it with an alternate drug or CBT-I.
- Prescribe the smallest denominations of the drug to make tapering off easier e.g. if a patient is taking Zolpidem 10mg, prescribe 2 x 5mg.
- Agree a flexible tapering regime - e.g. 25% every 1-2 weeks.
- When on the lowest dose, either stop, or reduce the frequency.
- Educate about Rebound Insomnia.
- Don't be afraid to stop the reduction or reverse if the patient's insomnia becomes too difficult to manage.