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August 23, 2023: Helpful approaches to insomnia

Panelists: Dr. Chris Frank, Dr. Marcia Kostenuik, Dr. Purti Papneja
Moderator: Dr. Stephanie Zhou; Co-Moderator: Dr. Nikki Bozinoff

Curated answers from CoP guests and panelists to in-session questions posed by participants.

- **There is association between sleep disorders and Alzheimer. Is insomnia a risk for development of AD, or is it a pre-symptom of later diagnosis of AD.**

Poor sleep may impact development of AD and depressive symptoms +/- sleep may be prodromal. Sleep disturbance include day-night reversal is common as part of progression.

- **I have found prazosin very effective for sleep disturbance for a lot of patients, especially bipolar and anxious patients. In our area, all doses are on backorder. What is an effective substitute, in what doses?**

Doxepin (Silenor) comes at 3mg and 6mg tablet. S/e anticholinergic. ODB covers 10mg not lower doses.

- **Can you please comment on the use of melatonin for sleep initiation issues (adults/kids) including evidence of harm?**

Melatonin is not actually indicated for treatment of insomnia. There is not good evidence to support this. Patient will report variable results. Melatonin is helpful in children when there is other neurocognitive disorder such as autism to help regulate their circadian or in older patients who are phase advanced. In terms of harm, it can impact puberty in children. No harms in adults other than if it causes excessive sedation then it can lead to falls etc.

- **What time do you have to stop consuming caffeine by in order to not affect night sleep. Same question for alcohol**

I suggest for patients with insomnia, stopping caffeine at noon. Typically, we think it takes about 8 hours for caffeine to fully eliminate from the body. Alcohol - just near bedtime. I tell patients if drinking, use it in early evening.

I will add to this that if there is daily use of alcohol, regardless of time of day, it can affect sleep.

I think for alcohol, it is very variable. Most people assume it helps them sleep so alerting people to the potential association with insomnia can help them monitor. Impact on older people of both is greater though!

- **Can you comment on a recommended dose of melatonin? Read that lower doses are better in the elderly since higher doses may end up disrupting circadian rhythm. Find practically that high doses used, especially in hospital.**

Melatonin is not well studied in terms of doses-so no evidence-based guidance on dose. It is not indicated for treatment of insomnia. It is a good drug for circadian rhythm disorder. For circadian rhythm disorder, it is suggested to use it 4-6 hours before bedtime.

- **Could you list the 6 Ps again, please?**

Pain, PND, pharm/pills, "pee", partner, physical environment (see CGS Journal of CME insomnia articles; free)

- **What's the mechanism behind CV meds affecting sleep?**

Beta blockers can affect melatonin levels apparently and are the most associated with sleep in my experience, especially more fat-soluble ones like propranolol for tremor. Diuretics- if someone has edema at bedtime and wakes with no edema, they are redistributing at night and waking to pee. Give Lasix at noon instead on AM so that it ends in evening and fluid does not have time to re-accumulate.

- **I would think a good 50% of patients in office and even higher %age with anxiety (as a symptom or dx'd GAD) would be positive on DSM criteria. Please explain value of defining Insomnia as a disease (with rather subjective criteria), the very high prevalence of sleep dissatisfaction that most patients feel is affecting their function.**

There is now evidence that if insomnia disorder when treated appropriately, actually helps with treatment and remission of psychological disorders. So I think it is still useful to make the diagnosis. Sometimes it is difficult to differentiate between if insomnia symptoms are part of mood disorder or present independently. It really depends on your clinical impression of the patient on where you want to focus treatment on -just the mood disorder first, treat insomnia first or treat them together.

The downside of making it a "disease" is it increases the pressure to prescribe which almost always lead to poor outcomes.

- **Ashwagandha use for insomnia?**

It is helpful for several things including libido, energy. Mg can be helpful at bedtime.

- **I get new elderly immigrants on benzo for a long time. Any advice on switching?**

Consideration might be given to risks vs benefits of continuation of bzo vs. taper in that particular patient. Generally, the approach is to make sure they are only on one agent (consolidate doses), then initiate a slow taper, can reduce the dose by ~10% every 4 weeks.

DeRX guideline is a good starting spot to validate you concern and provide some structured approaches.

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