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Clinical – Observations for Consultations

A practical guide to the diagnosis and management of insomnia in a general practice consultation

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Case history

A 43 year old woman presents with difficulty sleeping for five weeks and still feeling very tired when she wakes up. This has been adversely affecting her work performance. Additionally, she has recently had relationship problems with her husband. She burst into tears at work three days ago, which she has never done before and this has finally prompted her to come and see you.

History, examination and differential diagnosis

- Is this actually insomnia? Explore her beliefs about how many hours sleep she feels she requires. A commonly held belief is that everyone, irrespective of age, needs eight hours sleep every night. However, reduced physical activity levels and physiological changes with increasing age result in decreasing sleep requirement with age.
- General exploration. What are her ideas about her insomnia? Listen carefully, be empathic and take this problem seriously to encourage her to fully disclose any underlying (embarrassing) psychological or physical problems. Provide reassurance of normality, when possible.

Is the insomnia due to psycho-social, environmental or physical causes?

- **Psycho-social causes**. Identify any potential psychological cause (which accounts for over 50% of insomnia cases). Find out more about the relationship problems she is having with her husband. Also, is there work stress, financial pressure or recent life events? Is there difficulty getting to sleep/staying asleep and early morning waking (suggesting possible underlying anxiety or depression)?
- **Environmental causes**. Ask about excessive light, cold or noise in her bedroom. Does she have irregular sleeping patterns? What are her current work shift-patterns? Does she have physical or mental stimulation approaching bed-time, which could exacerbate the problem? Does she have any daytime 'napping' or late 'lie-ins' affecting her sleep-wake circadian rhythms?
- **Physical causes**. Does she experience any night-time symptoms – such as a persistent cough, dyspnoea, dyspepsia, pain, nocturia, sweating or hot flushes? Is there daytime somnolence and/or headaches (suggestive of sleep apnoea)? These types of questions will help exclude organic pathology.

Physical examination

If you suspect a physical cause, do an appropriate physical examination, including looking for pallor, lymphadenopathy, thyroid disease or cardio-respiratory disease.

Management

1st line

Psycho-social

- If there is underlying anxiety or depression, this needs to be appropriately managed. Ask about her general mood, appetite and enjoyment of life. Does she have a history of depression?
- Counselling may be helpful for her relationship problems
- Psychotherapy or cognitive behavioural therapy may be useful, if available, if there are deeper problems which would benefit from more specialised help.
- Whatever the nature of the psychological problem, follow-up is essential to ensure the situation is not deteriorating.

Environmental

- Management will depend on the specific problem she has, but simple measures which may alleviate her symptoms can be suggested, including:
- Sleep hygiene advice may be helpful, including: changing bedroom curtains/blinds to avoid excessive light; ear plugs (to counteract noise); controlling stimuli close to bed-time (such as avoid working or using the computer); avoiding large meals, caffeine, smoking and alcohol; relaxation exercises (using CDs), moderate daytime physical activity to promote night-time sleepiness. Advise getting up at the same time each day and developing night-time routines – a bath, decaffeinated herbal drinks, aromatherapy and light-reading.
- If these fail, a sleep diary for two weeks, detailing evening activities, including meal-times, time she retires to bed and wakes up can be helpful. This provides a baseline indicator of her sleep-wake patterns, lifestyle and behaviour for her and you. It also highlights underlying problems.

Physical causes

- Specific physical symptoms will need to be addressed appropriately. For example, adequate analgesia to control pain. Sleep apnoea can present with daytime tiredness and fatigue and can easily be overlooked as a possible diagnosis, when a patient presents with a history initially suggestive of insomnia.
- Consider possible underlying medical conditions (Fig 1) and if an underlying medical condition is found, remember that physical causes can cause anxiety and depression

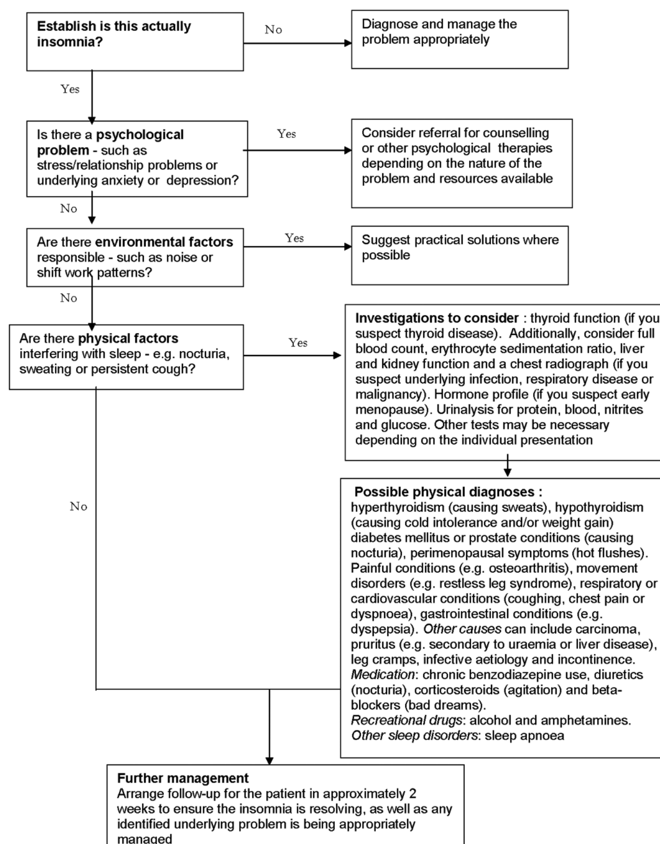

Figure 1 Algorithm for the investigation of insomnia

2nd line

Prescribing sleeping tablets/hypnotics as an adjunct for severe insomnia

- If non-pharmacological management has failed and the insomnia is severely affecting her daily functioning, a short-acting hypnotic could be offered in the first or subsequent consultation. Many patients develop tolerance to the effects of hypnotics so that higher doses are required – which can potentially occur as quickly as over 3–14 days. Additionally, many patients can become dependent on hypnotics (physically and psychologically), so they should only be prescribed for severe insomnia and for the shortest possible duration.
- Benzodiazepines (such as temazepam or lormetazepam) are the first-line treatment. The Committee on the Safety of Medicines advises benzodiazepines for short-term use (maximum 2–4 weeks) at the lowest possible dose and only in severe, debilitating cases.
- Non-benzodiazepine hypnotics (the 'z drugs') e.g. zopiclone and zalepion are an alternative to benzodiazepines, though the National Institute for Health and Clinical Excellence (2004) reported there is lack of evidence to support prescribing 'z-drugs' over traditional benzodiazepines.
- You can advise taking the sleeping tablets alternate or once every three nights to avoid dependence
- If you prescribe a benzodiazepine or a z-drug, warn her that they can cause drowsiness the following day and can impair driving and daytime tasks. Concomitant alcohol should be avoided. (Although not relevant in this case, prescribing hypnotics for the frail and elderly can be particularly dangerous. Hypnotics can cause drowsiness, decreased coordination and dizziness, particularly if they interact with other medication; this can subsequently increase the tendency to falls and subsequent fractured neck of femur and/or fractures at other sites in the elderly).

Investigations/referral

Investigate (Fig 1) and/or refer if you suspect an underlying physical or serious psychological problem or drug dependence.

Follow up

Regular follow-up until the problem is resolved, particularly if there is anxiety/depression. This can also help prevent missing underlying diagnoses.

USEFUL READING

For clinicians:

NICE guidelines. Insomnia. Newer hypnotic drugs: guidance 2004 (updated 2007) www.nice.org.uk/guidance/index.jsp?action=download&o =32845

Simon GE and VonKorff M. Prevalence, burden and treatment of insomnia in primary care. *American Journal of Psychiatry* 1997: 154(10):1417–23. http://ajp.psychiatryonline.org/cgi/reprint/154/10/1417

Prodigy guidelines on insomnia.www.cks.library.nhs.uk/insomnia

For patients:

NICE guidelines. *Insomnia – newer hypnotic drugs : information for the public* www.nice.org.uk/guidance/index.jsp?action=download&o=32847

NHS prodigy guidelines. Patient information leaflet. www.cks.library.nhs.uk/patient_information_leaflet/insomnia

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