Insomnia in older adults

Approaching a clinical challenge systematically

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Clinical question

How can I best manage insomnia in older patients?

Bottom line

Insomnia is one of the most common symptoms for which older patients seek medical attention. Assessment and treatment can be challenging, as insomnia in the elderly is often associated with multiple interacting psychiatric and medical comorbidities. Clinicians can find guidance in the article "Approach to insomnia in the elderly: practical considerations in primary care for complex patients" (**https://canadiangeriatrics.ca/wp-content/uploads/2020/01/Chun-_Insomnia-in-the-Elderly-Formatted.pdf**).[1]

Evidence

Population-based estimates indicate that one-third of adults report insomnia symptoms and 12% to 20% have symptoms that meet the criteria for insomnia disorder.[2,3] The prevalence of insomnia increases to up to 40% for people older than 65 years of age.[4,5]

A shorter form of cognitive-behavioural therapy for insomnia called *brief behavioural therapy for insomnia* can be delivered during 2 sessions by a nurse, and has been shown to be effective for insomnia treatment in the geriatric population, with benefits persisting even after 6 months.[6]

Benzodiazepines have been associated with adverse consequences, including an increased risk of falls, motor vehicle crashes, residual daytime sedation, anterograde amnesia, substance use disorder, and rebound insomnia.[7-9]

Approach

Clinicians should first review active medical and psychiatric conditions and medications that interfere with sleep, as outlined in **Tables 1** and **2**. Taking a patient history can include a review of the 6 *P*s: pain, paroxysmal nocturnal dyspnea, pharmaceuticals or pills, pee (ensure the patient is not taking a late-day diuretic and is restricting afternoon oral fluids), partner (with sleep issues), and physical environment not conducive to sleeping.

Older patients might not associate symptoms such as cough or pain with poor sleep without direct questions from a clinician. Many medications can affect sleep directly or indirectly by causing disruptive symptoms, and considering the effect of common medications is advised. Angiotensin-converting enzyme inhibitors, for example, might cause cough that disturbs sleep. Other medications might affect the physiology of sleep. For example, β-blockers suppress melatonin release. Asking about medication adherence (including overuse) is important, as is asking about substance use (eg, alcohol or coffee intake).

Clinicians should also consider primary sleep disorders, such as restless legs syndrome, obstructive sleep

Table 1. Partial list of medical and psychiatric conditions associated with disturbed sleep

TYPE OF DISORDER	CONDITION
Cardiovascular	Congestive heart failure, nocturnal angina
Respiratory	Chronic obstructive pulmonary disease, asthma
Endocrine	Hypothyroidism, hyperthyroidism
Gastroenterologic	Gastroesophageal reflux
Neurologic	Parkinson disease, major neurocognitive disorders
Pain	Arthritis, fibromyalgia, neuropathic pain, cancer, headache or migraine
Genitourinary	Nocturia, benign prostatic hyperplasia, urinary incontinence
Sleep	Sleep-disordered breathing (including apnea), restless legs syndrome, periodic limb movement disorder, rapid eye movement sleep behaviour disorder
Psychiatric	Mood disorders, anxiety disorders, substance use disorders

Table 2. Medications and other substances that can contribute to insomnia

CLASS	MEDICATION OR SUBSTANCE
Psychiatric	Selective serotonin reuptake inhibitors Serotonin-norepinephrine reuptake inhibitors Psychostimulants: methylphenidate, modafinil Cholinesterase inhibitors (eg, donepezil)
Cardiovascular	Angiotensin-converting enzyme inhibitors, diuretics, α-blockers, angiotensin receptor blockers, β-blockers, calcium channel blockers, statins
Respiratory	Bronchodilators (eg, salbutamol), theophylline
Neurologic	Dopaminergic agonists (eg, levodopa)
Gastrointestinal	Histamine-2 blockers: ranitidine, cimetidine
Analgesics	Opioids (chronic use)
Others	Caffeine, nicotine, alcohol, glucocorticoids

apnea, and rapid eye movement sleep behaviour disorder, as reviewed in our previous paper (**http://canadiangeriatrics.ca/wp-content/uploads/2016/11/INSOMNIA-IN-THE-ELDERLY-UPDATE-ON-ASSESSMENT-AND-MANAGEMENT.pdf**).[10] If primary sleep disorders are suspected, referral to a sleep specialist should be considered.

Implementation

Once contributing factors are identified, tailored treatment approaches can be employed. Psychological treatments for insomnia include stimulus control, sleep restriction, and cognitive-behavioural therapy for insomnia. Pharmacologic treatment is very challenging in the elderly. Data on medication use for insomnia in the elderly are limited. While benzodiazepines and *z* drugs such as zopiclone can provide some short-term benefit for insomnia, these agents can have substantial side effects and limited long-term efficacy. Thus, they are not recommended for chronic insomnia.[10-12] Other agents that can be cautiously considered for chronic insomnia complicated by medical or psychiatric factors in the elderly include $\alpha_2\delta$ drugs (eg, gabapentin), sedating antidepressants, antihistamines, melatonin, and atypical antipsychotics.

Management is challenging and complicated and a comprehensive approach to nonpharmacologic and pharmacologic treatment is reviewed in our previous article.[10]

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Competing interests
None declared

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