

Sleep Medicine Strives to Unite Multiple Disciplines

BY HEIDI SPLETE
Senior Writer

MINNEAPOLIS — The need to unite sleep specialists from multiple academic departments challenges the field of sleep medicine, Dr. Ronald D. Chervin said at the annual meeting of the Associated Professional Sleep Societies.

“Because sleep is relevant to so many different departments, there is not always good integration across campus,” said Dr. Chervin, a professor of sleep medicine at the University of Michigan, Ann Arbor. Dr. Chervin is also a professor of neurology and the director of the university’s sleep disorders center.

For example, a sleep scientist may not rub elbows daily with a pulmonologist or ENT specialist, he said.

The structural challenges that persist at many research universities can make interdisciplinary integration difficult, even though such integration may be the way to provide the best patient care, Dr. Chervin noted.

But the tug-of-war persists between clinician desires to provide good multidisciplinary care versus departmental concerns for the bottom line.

Most sleep specialists agree that patients receive the best care when they see clinicians from a variety of medical fields, Dr. Chervin said. But sharing human resources is not always a priority for any given academic department, and it is not always easy to give up billing opportunities to another department in order to serve a higher goal and allow faculty to pursue diverse interests, he explained.

The role of sleep medicine can be difficult to explain to administrators and faculty outside the field, in part because there often is inadequate investment in sleep medicine specifically.

For example, even at the University of Michigan, which has a large and successful sleep disorders center, there is no administrator dedicated to sleep medicine to help the director manage budgets and financial spreadsheets, “which we are not trained in medical school to do,” Dr. Chervin said. Also, billing and hiring issues still create interdepartmental friction.

“I’m proud of our faculty here at Michigan, but we have lost some opportunities to hire qualified personnel because of these departmental issues,” he said.

One strategy that the university has used to overcome some of the interdepartmental barriers has been the creation of an “Alternatives to CPAP” clinic.

“We can see patients shoulder to shoulder with an ENT specialist, maxillofacial surgeon, and dentist. It serves the patients’ interests and is wonderful for education,” he said. “And we managed to satisfy all the departments in terms of billing.” The university has developed two

other clinics that follow the CPAP program model—a multidisciplinary pediatric sleep and behavior clinic and another behavioral sleep medicine clinic for adults.

What does the future hold for sleep medicine? Dr. Chervin said he

believes that creating comprehensive sleep centers at universities would improve patient care and promote the basic scientific research that continues to drive advances in sleep medicine.

Ideally, a “center for sleep science” would unite sleep specialists on campus, at least for joint grand rounds, for training, and for promoting grant submissions that could cross department boundaries, he said.

In his view, sleep centers should uphold a tripartite mission that includes research, education, and patient care and provide both clinical and preclinical programs.

Sleep centers need their own physical space and dedicated funding, in part to allow them to bill for clinical and laboratory services and then reimburse other departments for faculty effort, Dr. Chervin said. And sleep centers should have a greater say in hiring decisions, he added.

As more data emerge to support the impact of sleep and sleep problems on a range of medical conditions, support for interdisciplinary work in sleep medicine and the establishment of sleep centers may gain traction. “How does a new interdisciplinary field fit within a traditional, department-based academic medical center?” Dr. Chervin asked. “It’s like trying to put a square peg in a round hole.” ■

CBT for Insomnia May Reduce Osteoarthritis Pain

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Cognitive-behavioral therapy for comorbid insomnia in patients with osteoarthritis not only improved sleep but also reduced self-reported pain in a randomized, controlled pilot study of 51 patients, reported Michael V. Vitiello, Ph.D.

The improvements in both sleep and pain levels persisted at 1-year follow-up. This is the first study to demonstrate such a duration of benefit from cognitive-behavioral therapy for insomnia in patients with comorbid chronic medical illness of any kind, Dr. Vitiello and his associates reported in a poster presentation at the annual meeting of the Gerontological Society of America.

This preliminary study suggests that improving sleep can be “analgesic” in patients with osteoarthritis, said Dr. Vitiello, professor of psychiatry and behavioral sciences at the University of Washington, Seattle. “Techniques to improve sleep should be considered for addition to treatment programs for pain management in osteoarthritis and possibly other pain states,” he added.

More than half of older adults develop osteoarthritis, and a majority of these develop significant sleep disturbance. The pain initiates and exacerbates the sleep disturbance, and the disturbed sleep then seems to maintain and exacerbate pain by lowering pain thresholds and amplifying transmission of pain signals, he said.

The study randomized 23 patients (18 women and 5 men) to cognitive-behavioral therapy for insomnia and 28 patients (27 women, 1 man) to a control group that received an intervention focused on attention control, stress management, and wellness. Neither group specifically addressed pain control. Each group met 2 hours per week for 8 weeks for the intervention.

Several measures of insomnia im-

proved significantly in the treatment group but not in the control group. Sleep latency (the time it takes to fall asleep) decreased from a mean of 40 minutes before therapy to 24 minutes, and nighttime wakefulness decreased from 62 to 25 minutes. Sleep efficiency (the proportion of time in bed spent asleep) improved from 71% to 84%.

Self-reported pain on the Short Form-36 pain scale improved from a score of 56 before cognitive-behavioral therapy to 66 afterward (with a higher score indicating less pain), but did not change significantly in the control group. There was a nonsignificant trend toward reduced pain in the treatment group as measured by the McGill Pain Questionnaire.

After posttreatment results were assessed, 10 patients in the control group crossed over to receive CBT for insomnia. Results of 1-year follow-up in 19 patients from the original cognitive-behavioral therapy group plus the 10 crossovers were nearly identical to the results of the after-treatment assessments, showing duration of the improvements over time, Dr. Vitiello said.

CBT for insomnia is “not the kind of thing that a physician can do in an office visit, but it can be done by trained health care professionals in relatively quick fashion in group settings,” he said.

The intervention consisted of a fairly standard series of behavioral manipulations, such as sleep restriction (teaching patients to somewhat curtail their time in bed), stimulus control (telling them not to go to bed unless sleepy), sleep hygiene (teaching them how to nap appropriately), and other techniques.

“What we’re learning, really, is that sleep is interactive with illness, and it is not simply a symptom,” Dr. Vitiello said.

The study was limited by its small size and the lack of 1-year follow-up in the control group, among other factors, he said. ■

Women, Families With Children Need Sleep Education

BY SHARON WORCESTER
Southeast Bureau

NEW ORLEANS — Mothers of young children aren’t likely to be surprised by a recent study showing that they are more sleep deprived than are their male partners and women without children, but the findings are important because they underscore the need for sleep education in families with children, the investigators said.

Dr. Daniel P. Chapman and his colleagues at the Centers for Disease Control and Prevention in Atlanta used data from the 2002 Behavioral Risk Factor Surveillance System (BRFSS) for the study, which included 72,576 adult participants from the ongoing, state-based, random-dialing survey of community-based adults.

Married women with children were significantly more likely than were married men to report insufficient sleep (34% vs. 27%), and both married women and married men with children were more likely than were their married, gender-matched counterparts without children to report insufficient sleep (34% vs. 21%, and 27% vs. 16%, respectively).

The same was true among unmarried women with and without children (36% vs. 27%), and for unmarried men with and without children (31% vs. 25%), Dr. Chapman reported in a poster at the American Psychiatric Association’s Institute on Psychiatric Services.

Of note, married women without children reported significantly more sleep insufficiency than did married men without children (21% vs. 16%), but the same did

not hold true for unmarried women and men, who reported similar rates of sleep insufficiency (27% and 25%, respectively).

The findings indicate that sleep insufficiency is more prevalent in households with children and among women with children, compared with their partners, Dr. Chapman noted. “These findings suggest the need for sleep education among families with children—particularly for mothers—and corroborate the importance of sleep as a facet of women’s health,” he concluded.

Respondents in this study were considered to have insufficient sleep if they reported feeling that they did not get enough sleep on 14 or more of the 30 days prior to the survey. The survey was conducted in 18 states and the District of Columbia. ■