

# Use Caution When Prescribing for Insomnia

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MINNEAPOLIS — Metabolic changes and comorbid conditions are just a few of the factors that challenge clinicians when they treat insomnia in older adults.

“The predictability of your giving drug X to patient A and knowing what is going to happen goes way down. That’s the bottom line,” said Dr. Daniel Buysse, a professor of psychiatry and the director of the

Clinical Neuroscience Research Center at the University of Pittsburgh.

The physiologic changes that occur with aging affect how the body absorbs medication, he said at the annual meeting of the Associated Professional Sleep Societies.

“As we get older, our lean body mass decreases and our adipose tissue increases,” he noted. Because the drugs used to treat insomnia are lipid soluble, older adults who have a greater proportion of adipose tissue will store the drug longer before

processing it through the body, Dr. Buysse explained. Consequently, older patients may have more residual sleepiness the next day after taking a sleep medication the previous night, and their dosages may need adjustment.

Hypnotics have shown effectiveness in treating insomnia in adults, but be aware that the measured blood concentrations of drugs are much more variable in an older population, Dr. Buysse said. In addition, some studies have shown that hypnotics

are associated with cognitive and psychomotor problems in older patients.

Antidepressants such as trazodone may be helpful for some patients; but be aware of the risks of dizziness, which could lead to falls, and the risk of oversedation because of older adults’ slower metabolisms.

Choosing insomnia medications for older adults is tricky, said Dr. Alon Avidan, a neurologist at the University of California, Los Angeles. Drugs have their risks, but untreated insomnia can be just as risky, because it has been linked to an increased risk of falls in older adults. Elderly people

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**References:** 1. Dauvilliers Y, Arnulf I, Mignot E. Narcolepsy with cataplexy. *Lancet*. 2007;369:499-511. 2. Thorpy M. Current concepts in the etiology, diagnosis and treatment of narcolepsy. *Sleep Med*. 2001;2:5-17. 3. Thorpy M. Therapeutic advances in narcolepsy. *Sleep Med*. 2007;8:427-440. 4. American Academy of Sleep Medicine. *The International Classification of Sleep Disorders: Diagnostic and Coding Manual*. 2nd ed. Westchester, Ill: American Academy of Sleep Medicine; 2005. 5. Green PM, Stillman MJ. Narcolepsy: signs, symptoms, differential diagnosis, and management. *Arch Fam Med*. 1998;7:472-478.

Because many disorders have symptoms resembling those of narcolepsy—excessive daytime sleepiness, cataplexy, disturbed nocturnal sleep, hypnagogic and hypnopompic hallucinations, sleep paralysis—a differential diagnosis including narcolepsy is often required.<sup>2-4</sup>

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The measured blood concentrations of drugs might be more variable in older populations.

DR. BUYSSE

who wake up at night are likely to get out of bed, which means that they are at greater risk for falls than older adults who are able to sleep longer.

In fact, hypnotics may be protective in preventing falls in older adults with insomnia, Dr. Avidan said, based on data from his study of more than 34,000 nursing home residents with an average age of 84 years (*J. Am. Geriatr. Soc.* 2005;53:955-62).

The patients with untreated insomnia were 30% more likely to fall, compared with those who were treated with hypnotics. But treating insomnia had no measurable effect on the patients’ risk for hip fractures, Dr. Avidan noted.

Dr. Buysse shared his top clinical considerations when choosing drug therapies for elderly patients with insomnia.

First, keep expectations realistic, he advised. “The fact that older adults have comorbidities may limit how well we can do with our treatments,” he noted.

Second, remind patients that insomnia medication is not a general anesthesia. “Some older adults look at sleep as a behavioral alternative when they run out of things to do,” Dr. Buysse said.

In addition, remember that no evidence-based treatment guidelines exist to direct treatment of insomnia in older adults.

“We have not the least idea how to match a particular treatment to a patient, and we don’t really know what constitutes a clinically significant response,” Dr. Buysse said. Findings from a recent meta-analysis suggest that many of the drugs currently available for treating insomnia have not shown consistent effectiveness in improving sleep in older adults (*Ann. Clin. Psychiatry* 2006;18:49-56).

Dr. Buysse recommended starting with a benzodiazepine receptor agonist, and then switching to a sedating antidepressant if the benzodiazepine doesn’t help. “When people still don’t improve, you could start moving to other methods such as behavioral therapy,” he said.

More research is needed to understand how to combine drug therapy with behavior therapy to treat insomnia in older adults, he added. ■