

## PRACTICAL PSYCHOPHARMACOLOGY

## Insomnia in Elderly: Medicate With Care

*Many clinicians prefer nonbenzodiazepines over benzodiazepines because they carry less risk of falls.*

**M**ore than half of older adults have one or more chronic sleep complaints, according to data reported by the National Institute on Aging (Sleep 1995;18:425-32).

The reasons are multiple: medical and psychiatric illnesses and the medications used to treat them, changes in circadian rhythm, a higher prevalence of primary sleep disorders. "The point is that it is not aging per se that causes difficulties with sleep, but rather things that go along with aging that can cause sleep changes," said Sonia Ancoli-Israel, Ph.D., professor of psychiatry at the University of California, San Diego.

A thorough clinical interview should unearth most of these factors. "Get more detail about the nature of the complaint," said Dr. Gary Kennedy, director of geriatric psychiatry at Montefiore Medical Center, New York. Is the problem with initiating or maintaining sleep, or both? When did it start and how has the patient tried to cope with it? What medications is he or she taking?

The patient's family or bed partner may provide important clues to the possibility of disorders like sleep apnea, he said.

Sleep difficulties are prominent in most psychiatric disorders and may improve with effective treatment. Similarly, addressing diabetes, prostate disease, pain, difficulty breathing, or other physical illness may help, as may appropriate adjustments to medication.

Dealing with comorbidity alone, however, is unlikely to resolve the sleep complaint altogether, Dr. Ancoli-Israel said. "If a patient has depression and insomnia, they should be treated concurrently."

Pharmacotherapy has a place in insomnia treatment, but clinicians should be mindful of its limited efficacy and significant risks for older patients (BMJ 2005;331:1169). Medication should be prescribed, if at all, in the context of behavioral approaches. At the least, this means addressing sleep hygiene—correcting habits and aspects of lifestyle that interfere with sleep and encouraging those that

promote it, she said. Cognitive-behavioral therapy (CBT) is notably effective—even when compared with medication—for older as well as younger patients, Dr. Ancoli-Israel said.

The possible role of circadian rhythm should be considered before medicating insomnia, said Dr. Phyllis Zee, director of the sleep disorders center at Northwestern University, Chicago.

With age, the timing of the sleep-wake cycle generally advances, which is why many older adults get sleepy between 7 and 9 p.m. and awaken between 2 and 5 a.m. An individual who stays up later still wakes up too early.

"The complaint of early-morning awakening can be mistaken for a sign of depression, or treated like primary insomnia," Dr. Zee said. A better approach is to reset the cycle with an hour's exposure to a light box (of the sort used for seasonal affective disorder) in early evening. Dr. Ancoli-Israel suggested that outdoor light late in the day and avoidance early (with sunglasses if necessary) may help some people.

When to medicate insomnia "depends on individual assessment, but is indicated when symptoms don't improve sufficiently" with behavioral approaches, or for quicker relief and to facilitate participation in those strategies, Dr. Zee said.

Some of the most popular agents should actually be avoided, Dr. Ancoli-Israel said, citing an NIH state-of-the-science statement (NIH Consens. State Sci. Statements 2005;22:1-30). "Psychiatrists use sedating antidepressants all the time for insomnia, but these are only effective in the short term and have potentially significant adverse effects," she said. "They aren't recommended for patients who aren't depressed."

The NIH statement more strongly advises against sedating antihistamines like diphenhydramine, the ingredient in most over-the-counter sleep aids, whose side

effects in older patients include residual daytime sedation, diminished cognitive function, delirium, and anticholinergic phenomena like dry mouth and constipation, she said.

"This essentially leaves the FDA-approved drugs," Dr. Ancoli-Israel said.

Among these, many clinicians prefer the newer nonbenzodiazepines to benzodiazepine hypnotics because they carry less risk of falls and next-day cognitive impairment. "Ramelteon [Rozerem] is often my first choice," Dr. Kennedy said. The melatonin receptor agonist "is not a sedative. It reduces the alertness drive in the brain and allows natural sleep to occur. For older adults, it has [the] least risk for falls and confusion."

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**DR. ANCOLI-ISRAEL**

taken these "may want to go back to them," he said.

The choice of hypnotic should depend on the answers to two questions, Dr. Ancoli-Israel said: Is the problem falling or staying asleep? How long can the patient stay in bed after taking the medication?

"Eszopiclone [Lunesta] is indicated for both falling asleep and staying asleep, but the patient must be able to stay in bed for 8 hours. Zaleplon [Sonata] is indicated for sleep initiation, but because of its short half-life it does not improve sleep maintenance. However, its short half-life means the required time in bed is only 4 hours," she said.

Zolpidem (Ambien) is indicated primarily for falling asleep, and the extended-release formulation can both initiate and maintain sleep. With either, the patient should stay in bed for 7 hours. "Ramelteon isn't sedating, so there's no minimum time patients need to be in bed. It's primarily good for initiating sleep," Dr. Ancoli-Israel said.

Dr. Marc Baltzan, a sleep specialist at the Mt. Sinai Hospital Center, Montreal, commonly prescribes a generic short-acting ben-

zodiazepine, such as oxazepam, when medication cost is a factor. He cited a review (BMJ 2005;331:1169) that found the risk-benefit ratio comparable with benzodiazepine and nonbenzodiazepine hypnotics.

Regardless of the drug, "it's always preferable to prescribe for intermittent use, to make sure it's not the only tool the patient is using for insomnia, and to maintain efficacy long term," Dr. Baltzan said.

As is generally the case with older patients, these medications should be started low (half the standard adult dose, Dr. Zee suggests) and increased cautiously.

Dr. Kennedy observed that drug metabolism varies more widely with age. "Some patients are exquisitely sensitive. I had one who tried Sonata and felt sedated the next day."

Ramelteon is an exception: the single dose in which it is available (8 mg) is appropriate for all patients, Dr. Zee said.

Clinicians should be alert for primary sleep disorders besides insomnia, such as sleep apnea, movement disorders of sleep, and REM behavior disorder.

The prevalence of restless leg syndrome (RLS) and periodic limb movements of sleep in those 65 years and older has been reported at 20% and 45% respectively (J. Clin. Psychiatry 2005;66[suppl. 9]:24-30). The dopamine agonists ropinirole (Requip) and pramipexole (Mirapex) have been approved for these disorders.

Dr. Baltzan suggested that supplementation may resolve RLS in iron-deficient patients, and that a benzodiazepine may be sufficient for intermittent symptoms.

The prevalence of REM behavior disorder is uncertain but is largely seen in older men. Clonazepam is the standard treatment; dopamine agonists like pramipexole also may be effective, Dr. Baltzan suggested. Dr. Zee observed that melatonin has also been used successfully for this disorder.

Sleep apnea may affect as many as 45%-62% of older adults. When it is suspected, patients should be referred to a sleep specialist for a full evaluation. Most sedating drugs can worsen sleep apnea and should be avoided, and the newer nonbenzodiazepines and ramelteon have no apparent effect on it, Dr. Ancoli-Israel said. ■

By Carl Sherman, contributing writer



## Suicides High Among Rochester, N.Y., Home Care Seniors

BY ALICIA AULT

Associate Editor, Practice Trends

**NEW ORLEANS** — Rates of suicide are highest, proportionately, among the elderly, and seem to be very high among seniors who receive home care in the Rochester, N.Y., area, according to a poster presented at the annual meeting of the American Association for Geriatric Psychiatry.

Thomas Richardson, P.A., and his coinvestigator, Dr. Yeates Conwell, both of the University

of Rochester, were looking for precursors of suicide in an attempt to determine how to prevent it.

They randomly selected and interviewed clients receiving home care through the Aging Services Network of Rochester. Overall, 211 patients were selected. Most were white (88%) and female (69%), and 101 patients (48%) lived alone. The mean age was 77 years, with a range of 60-102. This also was a fairly low-income group, with al-

most 45% of the patients having an income of less than \$1,250 a month.

They were evaluated using the Paykel Suicide Scale, the physical activities of daily living and instrumental activities of daily living scales, a modified version of the Louisville Older Persons Events Scale, Lubben Social Network Scale, and the Multidimensional Scale of Perceived Social Support.

Of the 211 patients, 65 admitted to feeling that life was not

worth living in the past year, 44 said they had wished they were dead, 21 thought of taking their own life, and 8 seriously considered taking their own life, they wrote.

Some of the patients had these thoughts before. Seven percent, or 14 patients, admitted to at least one lifetime suicide attempt and 2 had tried in the past year.

Patients with lower functional status, more stressful life events, and less social support were at higher risk for suicidal ideation.

Mr. Richardson said the rates were surprising to him, despite the high numbers of suicides nationally each year. He and Dr. Conwell are hoping to build a network of providers who can reach out to these home-based patients and provide suicide prevention and treatment. They have received a 5-year grant from the National Institute of Mental Health to develop a system in which social workers would treat home care patients for depression and interface with physicians. ■