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Clinical Protocol: Sleep

Preamble

- Practical / empirical approach
- Consider sleep disorders (e.g., OSA, Restless Leg Syndrome)
- Promote sleep hygiene and patient education
- Some medications used for pain can improve sleep or sleep architecture
    - TCA
    - Gabapentinoids
    - Cannabinoids
- May need to reduce dose of sleeping meds if patients are on these
- Base medical treatment on sleep problem(s)
    - Un-refreshing sleep
    - Sleep initiation
    - Sleep maintenance
    - Nightmares
- Watch for "hang-over" effect
- Patients with ME/CFS may need to be titrated more slowly, and may not tolerate higher doses of medications
- The treatments described below may occur one-on-one or in a group setting depending on resources
- Provide patient with information/dose adjustment handout
- It is expected that physicians would educate themselves about these drugs beyond the outline provided below

1. Patient Education & Sleep Hygiene

- Incorporated into multiple offerings (e.g., handouts, web-based resources)
    - Sleep Patient Resources
- Offered in group setting and individual sessions with nursing
- Incorporated into core group: Living with Complex Chronic Diseases
- "Family and Friends" evening session

2. Physical activity

- Offered in group setting and individual sessions with PT and OT
- Tai-Chi and mild Yoga
    - Suggested
    - Offerings in community rather than CCDP

3. Psychological and behavioural therapies

- Incorporated in core group: Living with Complex Chronic Diseases
  - Combines Education, Pacing, CBT &, Mindfulness
  - 10 weeks
- Incorporated into other groups

4. Alternative and Complementary Therapies

4.1 Melatonin

- Usually starting dose: 1-3 mg at bedtime
- Max: 5 – 10 mg at bedtime
- Dosing 2 – 3 hrs before bedtime may be most effective
- Sustained-release preparations may be better for improving sleep maintenance (if patient wakes up < 4 hours after falling asleep)
- Immediate-release preparations might be more beneficial for decreasing time to falling asleep (sleep latency)

5. Medication

5.1 Un-refreshing Sleep

- Tend not to treat this directly
- Pain meds may help (see FM and Central Pain protocol)
  - Tricyclic antidepressants (TCA)
  - Gabapentin or pregabalin (Lyrica)
  - Nabilone

5.2 Sleep Initiation

5.2 A. Trazodone

- Good general agent for sleep initiation and maintenance
- If sleep initiation and or maintenance remain a problem, these two issues may need to be treated separately
- Least likely sleep aid to lose its effectiveness
- Watch for: dizziness/postural hypotension, blurred vision, dry mouth
- Starting dose 12.5 – 25 mg qhs
- Usual dose range 25 – 150 mg qhs
- Higher doses may be needed in some individuals (up to 300 mg)
- Off label use

5.2 B. Zopiclone

- Not first line choice
- Better for sleep initiation
- Last for only about 3 – 4 hours
- May need to add a sleep maintenance agent
- Watch for: metallic taste, rebound insomnia; next day impairment
- May need to rotate with other agent (loss of efficacy)
- Available as 5 mg or 7.5 mg tablets
- Starting dose 2.5 mg - 3.75 mg qhs (Health Canada notice to decrease starting dose)
- Usual dose range 2.5 mg to 7.5 mg PO qhs
- Maximum dose 5 mg in elderly patients, pts with renal/hepatic impairment or those on potent CP450 inhibitors (Health Canada notice)
- Higher doses may be needed in some individuals (15 mg)

5.2 C. Zolpidem

- Not first line choice
- Better for sleep initiation
- Last for only about 3 – 4 hours
- May need to add a sleep maintenance agent
- Watch for: headaches, dizziness; next day impairment
- Available as 5 mg or 10 mg orally disintegrating tablets
- Starting dose: women 5 mg SL qhs; men 5-10 mg SL qhs
- Maximum dose 10 mg qhs; 5 mg SL qhs for patients > 65 years old

5.2 D. Quetiapine

- Helpful with comorbid anxiety
- Helps with both sleep imitation and sleep maintenance
- Watch for: dry mouth, dizziness, weight gain (higher doses)
- Starting dose 6.25 – 50 mg qhs
- Usual dose range 25 – 100 mg qhs
- Higher doses may be needed in some individuals
- Off label use

5.2 E. Benzodiazepines

- Generally avoided
- Interfere with sleep architecture

- Use as agent of last resort
- Long term use can lead to complete loss of hypnotic activity, tolerance and rebound insomnia
- Temazepam – 15 mg PO at bedtime
- Lorazepam – 0.5 mg PO at bedtime
- Oxazepam – 10-15 mg PO at bedtime

5.3 Sleep Maintenance

5.3 A. Trazodone

- Good general agent for sleep initiation and maintenance
- If sleep initiation and or maintenance remain a problem, these may need to be treated separately
- See above for dosing

5.3 B. Nozinan (methotrimeprazine)

- Very effective for sleep maintenance
- Need to watch for hang-over effect
- Should be taken 2 hrs before bed or 10 – 12 hrs before getting up
- Watch for: orthostatic hypotension, dry mouth, dizziness, constipation, weight gain (higher doses)
- Available as 2 mg, 5 mg, and 25 mg tablets
- Starting dose 2 mg – 2.5 mg PO 2 hrs before bed
- Usual dose range 2 – 25 mg
- Higher doses may be needed in some individuals (50 mg)

5.3 C. Doxepin

- Old TCA; do not add if patient already taking another TCA (e.g., amitriptyline, nortriptyline)
- Also very effective for sleep maintenance
- Watch for: dry mouth, dizziness; orthostatic hypotension
- 3 mg, 6 mg and 10 mg tablets
- Starting dose 3 mg PO 2 hrs before bed
- Usual range 3 mg – 10 mg PO qhs

5.4 Phase Shifting /Day-Night Inversion

- Very difficult to treat as individuals are often not motivated to change

- Sleep Hygiene is key
- Better to shift forward than backwards
- Light therapy (10,000 lux SAD lamp) in the morning can help
- Melatonin 4 hours before bed time
- Sleep initiation / maintenance agents may be added

5.5 Nightmares

5.5 A. Clonidine

- Very effective against nightmares
- May also benefit night sweats associated with Central Sensitivity Syndromes
- Usually well tolerated
- Some reported side effects include: dizziness, lightheadedness, hypotension
- Usual dose: 0.1 mg – 0.2 mg PO qhs

5.5 B. Prazosin

- In rare instances where clonidine is not tolerated for nightmares
- Usual dose: 1 mg– 2 mg PO qhs

Resources for patients

http://www.bcwomens.ca/health-info/living-with-illness/living-with-complex-chronic-disease