SLEEP DISORDERS IN LATE LIFE

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No financial relationships to disclose but does intend to discuss off-label uses of commercial products/devices.
SLEEP COMPLAINTS

- I can’t sleep
- I sleep too much (usually complaining of daytime sleepiness)
- My legs move and keep me from sleeping and/or bother me during the day
- My wife/husband/friend says I breathe funny/move funny/act funny while I’m sleeping
  - although oftentimes person will say “but I feel fine"
WHAT IS NORMAL SLEEP?

- Sleep divided into NREM and REM sleep
  - NREM includes stages 1, 2, 3 (also known as slow wave sleep (SWS))
    - SWS associated with growth hormone release
      - Experimental models of SWS deprivation associated with worsened insulin resistance
  - REM (Rapid Eye Movement)
    - associated with dreaming

1 Herzog et al, Psychoneuroendocrinology, 2013.
WHAT IS NORMAL SLEEP?

- Arousals from sleep are common
  - Increase in older adults without a significant increase in sleep complaints

1 Boselli et al, Sleep, 1998.
Normal Age Related Changes

- Total Sleep Time decreases modestly
  - About 7.4 hours in “normal” older person
    - Important to understand there’s a wide variation in “normal”
    - Tends to plateau around age 60 in healthy individuals
- WASO (Wake after Sleep Onset) increases
- Sleep Latency (time to fall asleep) generally unchanged
- Slow wave sleep decreases by about 50%
- Slightly decrease in REM sleep and REM latency
- May be a slight trend towards phase advance
WHAT IS NORMAL SLEEP?

- Despite age-related “worsening” sleep quality (by PSG) healthy older patients tend not to rate the sleep as any less restorative or have any greater frequency of sleep complaints.

- Some experimental evidence that older adults are better tolerant of sleep deprivation with respect to cognitive and psychomotor tasks than younger adults.

- A large population based study found that for all “Sleep Complaints” for healthy adults incidence peaked in middle ages and thereafter declines\(^1\)
  - Similar results in another study for health adults with for Insomnia symptoms\(^2\)

\(^1\)US Behavioral Risk Factor Surveillance system, Sleep, 2012
\(^2\)America Insomnia Survey, Biology of Psychiatry, 2011
Adequate sleep is critical to maintaining physiologic homeostasis.

Sleep disruption is associated with many consequences:
- Auto/Home Accidents
- Depression/Mood disorders
- Increased rates of insulin resistance/diabetes
- Weight Gain
- Effects on immune function
- Increased risk of cardiovascular disease (stroke, MI) and arrhythmia
- Higher risk of cognitive decline/dementia
The most common sleep disorders in older people are the same as younger:

- Sleep related Breathing Disorders (OSA, CSA)
- Insomnia

Less common include:

- Movement Disorders (RLS, PLMDS, REM Behavior Disorder)
- Circadian rhythm disorders
  - can present as insomnia or hypersomnia
- Hypersomnia (narcolepsy, idiopathic CNS hypersomnolence)
Sleep Complaints in general no higher in older adults

Some Sleep Disorders (notably sleep disordered breathing) do occur more frequently with otherwise healthy older adults

Almost all sleep disorders occur more frequently in patients with other chronic health conditions

- Aging adults tend to have more compromised health in general, leading to a higher incidence of sleep disorders
  - 60% older adults have 2+ chronic health conditions

INSOMNIA DEFINED

- Difficulty falling asleep or staying asleep, waking up too early or experiencing nonrestorative sleep
  - Acute complaints are common (20-40% population, perhaps higher in elderly)
  - Chronic complaints are a concern and are associated with negative health consequences
A predominant dissatisfaction with sleep quantity or quality with at least one of: difficulty initiating sleep, difficulty maintaining sleep, or early morning awakenings

Causes clinically significant distress or impairment

Occurs 3 or more nights weekly

Present for 3 or more more months

Occurs despite adequate opportunity for sleep

Not better explained by another disorder

Not attributable to physiologic effects of a substance

Not adequately explained by another mental disorder or medical condition

DSM-5: INSOMNIA DISORDER
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10 Code</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary insomnia</td>
<td>F51.01</td>
<td>Does not occur in the context of any other sleep disorder and is not linked to any other substance or medical condition; often has a childhood or young-adult onset</td>
</tr>
<tr>
<td>Adjustment insomnia</td>
<td>F51.02</td>
<td>Transient insomnia, usually less than 1 mo in duration</td>
</tr>
<tr>
<td>Paradoxic insomnia</td>
<td>F51.03</td>
<td>Also known as sleep-state misperception</td>
</tr>
<tr>
<td>Psychophysiological insomnia</td>
<td>F51.04</td>
<td>Chronic, conditioned insomnia</td>
</tr>
<tr>
<td>Insomnia caused by other mental disorder</td>
<td>F51.05</td>
<td>Often related to anxiety or depression</td>
</tr>
<tr>
<td>Other insomnia not caused by a substance or known physiologic condition</td>
<td>F51.09</td>
<td>Generally refers to persistent insomnia</td>
</tr>
<tr>
<td>Insomnia, unspecified</td>
<td>G47.00</td>
<td>Suspected insomnia caused by other conditions but not definitive (not otherwise specified)</td>
</tr>
<tr>
<td>Insomnia caused by medical condition</td>
<td>G47.01</td>
<td>Attempt to code the medical condition if possible</td>
</tr>
<tr>
<td>Alcohol-related insomnia</td>
<td>F10.182</td>
<td>Although alcohol has an initial soporific effect, it can increase the rate of arousals as blood alcohol levels decrease, usually after about 2 h</td>
</tr>
<tr>
<td>Drug-related insomnia</td>
<td>Multiple</td>
<td>Different ICD-10 codes depending on drug</td>
</tr>
</tbody>
</table>
INSOMNIA DISORDER IN OLDER ADULTS

- Prevalence approximately 8%
- More frequent in women (about 1.7x relative risk)
- Resolves spontaneously in approximately 50% within one year
  - Lower rate of spontaneous remission than in younger patients
    - More frequently resolves in men

Gireke et al, Sleep, 2011
CONSEQUENCES OF INSOMNIA DISORDER IN OLDER ADULTS

- Greatest evidence for mood disorders
  - 23% increase risk of depression
  - Higher risk for persistent depression
  - May be related to higher suicide risk (equivocal)
- 1.47 – 3.90 increased RR for heart disease
- Possible relationship to increased incidence of cancers
- Increased risk for cognitive impairment
  - Perhaps as much as 50% increase in risk of dementia
- Lower Quality of Life on standardized assessments

Gooneratne et al, Clinics in Geriatric Medicine, 2014
3 FACTOR MODEL OF CHRONIC INSOMNIA

Adapted from Clinics in Geriatric Medicine, 2014
FACTORS AFFECTING SLEEP

PREDISPOSING, PRECIPITATING, PERPETUATING

- Behavioral and environmental
- Psychosocial
- Psychiatric
- Physical status
- Medications or other substances
BEHAVIORAL AND ENVIRONMENTAL

- Sleep Hygiene
- Temperature
- Noise or Light
- Physical inactivity
- Hospitalization
PSYCHOSOCIAL

- Stress
- Social Isolation
- Bereavement
- Depression
- Anxiety
- Bipolar
- Psychosis/Schizophrenia
- Delirium/Dementia

PSYCHIATRIC
MEDICATIONS AND SUBSTANCES

- Alcohol
- Caffeine
- Nicotine
- Stimulants
- Beta blockers
- Calcium channel blockers
- Decongestants
- Bronchodilators
- Steroids
- Anticholinergic drugs
- Antidepressants
- And more
CLINICAL EVALUATION OF PATIENT WITH INSOMNIA

- Take a careful history
  - Diagnosis based on history – no objective test to rely on
- Consider other comorbid sleep disorders
  - OSA/CSA
  - RLS
  - Circadian rhythm disturbances
2 week sleep diary very useful in evaluating possible causes

- Free version can be downloaded from National Sleep Foundation
- May include: Bedtime, Sleep latency, # awakenings, WASO, total sleep time, awakening time, sleep medication and other medications, naps, caffeine and alcohol, other sleep hygiene factors
### Complete in Morning

<table>
<thead>
<tr>
<th>Day of week:</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>I went to bed last night at:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PM / AM</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I got out of bed this morning at:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AM / PM</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last night I fell asleep:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Easily</td>
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</tr>
<tr>
<td>After some time</td>
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<td></td>
</tr>
<tr>
<td>With difficulty</td>
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</tr>
<tr>
<td>I woke up during the night:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td># of times</td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td># of minutes</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last night I slept a total of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Complete at the End of Day

<table>
<thead>
<tr>
<th>Day of week:</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>I consumed caffeinated drinks in the:</td>
<td>Morning</td>
<td>Afternoon</td>
<td>Evening</td>
<td>(NA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M / A / E / NA</td>
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</tr>
<tr>
<td>How many?</td>
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</tr>
<tr>
<td>I exercised at least 20 minutes in the:</td>
<td>Morning</td>
<td>Afternoon</td>
<td>Evening</td>
<td>(NA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications I took today:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took a nap?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>(circle one)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, for how long?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>During the day, how likely was I to doze off while performing daily activities:</td>
<td>No chance</td>
<td>Slight chance</td>
<td>Moderate chance</td>
<td>High chance</td>
<td></td>
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</tr>
<tr>
<td>Throughout the day, my mood was:</td>
<td></td>
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</tr>
<tr>
<td>Very pleasant</td>
<td>Pleasant</td>
<td>Unpleasant</td>
<td>Very unpleasant</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Approximately 2-3 hours before going to bed, I consumed:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A heavy meal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the hour before going to sleep, my bedtime routine included:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Treat or modify related conditions
- Set reasonable expectations
  - Probably not going to make sleep "normal"
- Nonpharmacologic & Pharmacologic options
  - Nonpharmacologic preferred
  - Can be combined
- **Sleep Hygiene**
  - While important, sleep hygiene alone is ineffective.

- **Cognitive-Behavioral Therapy for Insomnia (CBT-I)**
  - Sessions with trained therapist that address counterproductive behaviors and cognitive beliefs that perpetuate insomnia.
    - Shown to be effective in older adults across multiple studies.
    - Shown to be effective even in those with cognitive impairment.
    - Internet-based therapy effective.

1. Gooneratne et al, Clinics in Geriatric Medicine, 2014
Box 2
Sleep hygiene interventions for insomnia

Create a stable sleep pattern

1. Maintain a regular sleep/wake schedule. It is most important to keep the same rise time every day; bedtime is also important but it can be more difficult for patients to have a consistent bedtime because of day-to-day demands of work/family. Advise patients to set their alarm to get up at the same time each morning, regardless of how much sleep they got during the night, in order to maintain a consistent sleep/wake schedule.

2. Do not attempt to make up for lost sleep on weekends or holidays.

3. Refrain from taking naps during the day.

Encourage a nondisruptive sleep environment

4. Keep the bedroom dark and at a temperature that is comfortable.

5. Block out noises that can disturb sleep with sponge earplugs or white noise made by fans, air conditioners, or a white noise machine.

Reduce presleep tension

6. Do not watch the alarm clock and worry about the time or lost sleep.

7. Develop a sleep ritual. Do the same things each evening before retiring for the night to give your body cues (signals) that it is time to settle down.

8. Plan evening activities that promote relaxation. Before going to the bedroom, make a list of things to deal with tomorrow and make a list of things to do before bedtime.

Dietary/Lifestyle modifications

9. Maintain a healthy diet. Going to bed hungry or eating a large meal before bedtime can worsen sleep. If hungry at bedtime, eat a light snack. Eat meals at approximately the same time each day, every day.

10. Avoid or minimize the use of caffeine. It is recommended not to drink coffee, tea, or soda after lunch. If patients continue to have difficulty falling asleep, avoid drinking caffeinated beverages after breakfast.

11. Avoid alcohol. Although it may temporarily lead to somnolence, for most people it causes awakenings as well as poor sleep later in the night. Alcohol can make snoring and sleep apnea worse.

12. Maintain a regular exercise schedule. Walking is an excellent form of exercise. The best time is in the late morning or midday (9 AM–1 PM). For some people, strenuous exercise before bedtime can be too stimulating and may prevent them from falling asleep. Light stretching can be done on rainy days.
Components of CBT-I

Address maladaptive sleep cognitions: Patients with insomnia may have exaggerated perceptions of how sleep impacts their life and how much sleep they need. These inaccurate beliefs lead to increased worry and unrealistic expectations.

Sleep hygiene: Promote regular sleep-wake patterns and minimize nocturnal disruptions.

Stimulus control therapy: Chronic insomnia can condition negative associations between the bed and sleep such that patients find it difficult to relax in bed; stimulus control therapy seeks to reassociate the bed with sleep. Patient instructions include avoiding sleep-incompatible behaviors (do not use the bed as a place to read, watch television, or catch up on work), go to bed only when sleepy, and get out of the bed if unable to sleep and patients are beginning to feel anxious.

Sleep restriction therapy: Many patients with insomnia attempt to overcompensate for their insomnia by spending excessive time in bed. Although seeming counterintuitive, sleep restriction induces partial sleep deprivation, which in turn increases the likelihood that patients with insomnia will actually sleep when they are in bed. The ultimate goal is to break the cycle of insomnia.

Relaxation techniques: These techniques include progressive muscle relaxation or guided imagery.
PHARMACOLOGIC TREATMENTS

- Benzodiazepines
- Nonbenzodiazepine Benzodiazepine Receptor Agonists
  - Ambien, Lunesta, Sonata “Z-drugs”
- Melatonin Receptor Agonists
- Orexin Receptor Antagonists
- Antidepressants
- Antihistamines
- Naturopathic products (melatonin, etc)
Glass et al, 2005 metanalysis in BMJ
- 24 studies, >2400 patients over 60, Benzos or BRA
  - Small improvements in sleep quality and overall time (25 minutes)
  - 4.8x risk of cognitive impairment
  - 2.6x risk of psychomotor events (dizziness, balance, falls, accidents)
  - 3.8x risk of complaints of daytime fatigue/hangover
- NNT for improved sleep quality 13, NNT for harm was 6
Evidence-based recommendations for insomnia evaluation and treatment


<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Quality of Evidence</th>
<th>Strength of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>A sleep diary is an essential component of an insomnia evaluation.</td>
<td>III</td>
<td>A</td>
</tr>
<tr>
<td>Polysomnography is not routinely required for insomnia evaluation.</td>
<td>III</td>
<td>A</td>
</tr>
<tr>
<td>CBT-I is effective in older adults and is associated with minimal side effects.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Nonbenzodiazepine hypnotics can improve insomnia symptoms but can be associated with side effects, such as tolerance and neurocognitive effects.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Melatonin-receptor agonists can improve sleep-onset insomnia symptoms.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td>Concurrent CBT-I and pharmacotherapy can be efficacious.</td>
<td>II</td>
<td>A</td>
</tr>
<tr>
<td>Doxepin at subantidepressant doses can be efficacious.</td>
<td>I</td>
<td>B</td>
</tr>
<tr>
<td>Antihistamines, anticonvulsants, and antipsychotics are not recommended for the chronic treatment of insomnia.</td>
<td>II</td>
<td>B</td>
</tr>
<tr>
<td>Exercise and bright-light therapy may improve sleep.</td>
<td>II</td>
<td>B</td>
</tr>
</tbody>
</table>

Quality of evidence: I: at least one properly designed randomized controlled trial; II: substantial evidence from nonrandomized trials; III: expert committee reports.
Strength of evidence: A: good evidence to support the use of a recommendation; B: moderate evidence; C: poor evidence (clinicians may elect to not follow the recommendation).

Abbreviation: CBT-I, cognitive-behavioral therapy for insomnia.
Carefully weigh risks
Screen carefully for adverse effects and discontinue if present or if not clinically effective
  - It doesn’t matter if patient sleeps more if they don’t feel/function better!
Use for the shortest duration necessary
  - Frequently consider tapering off
Don’t use to the exclusion of nonpharmacologic treatments
Little to no data on safety and effectiveness in chronic cognitive impaired and high risk for adverse effects
Can be Obstructive (OSA) or Central (CSA)
  - OSA more common than CSA in all age groups, including elderly
Incidence unclear given widely varying definitions
  - What AHI (>5, >15, >30)?
  - How is AHI defined (3% or 4% desaturation rule)?
15% incidence rate in males, 5% females (US adults)
  - AHI > 15 or AHI >5 with symptoms
- 1.7x higher risk in adults over 60\(^1\) (Using AHI cutoff 15)
  - Rates in men/women nearly equal after menopause
- Significantly higher rates in those with comorbidities
  - Rates may be 50-80%
    - Cardiovascular disease (CHF or ASCAD)
    - Atrial fibrillation
    - Prior stroke
    - Diabetes 2 (even among those without increased BMI)
    - Dementia

\(^1\)Sleep Heart Health Study, 2002.
Higher all-cause mortality
  - Equivocal relationship in adults over 60

Stroke
  - Convincing benefit of treatment even in older adults

CAD
  - Less clear association >70

HTN
  - Association diminishes with age

Heart Failure
  - Relationship persists after age 70

UNTREATED OSA EFFECTS IN ADULTS

¹Osorio et al, Neurology, 2015
Cognitive dysfunction

- Strong association in older adults
- CPAP may delay onset and progression of cognitive decline\(^1\)
  - One study suggested 85% higher risk of developing dementia in untreated severe disease
  - Particularly strong relationship to degree of oxygen desaturation
- Higher rates of postoperative delirium
SIGNS/SYMPTOMS OF SLEEP APNEA IN OLDER ADULTS

- Similar presentation to that of younger adults
  - Daytime sleepiness / Unrefreshing sleep
  - Nighttime arousals (not necessarily because of breathing)
    - Frequent nocturia can be symptom esp if not reporting diurnal urinary sx
  - Concentration or memory problems
  - Observed breathing pauses by bed partner or family
  - Snoring
    - Association decreases after age 60
  - More frequently associated with obesity
    - Association decreases after age 60
  - Edentulous states significantly increase incidence
    - True for younger and older adults but may occur more frequently in older adults
TESTING FOR SLEEP APNEA IN OLDER ADULTS

- Polysomnography
  - Home tests acceptable choice in those without significant cardiopulmonary comorbidities
  - Need face to face evaluation documented prior to PSG with clinical symptoms justifying the order in order to assure Medicare will cover
- Medicare covers treatment for AHI >15, or >5 with symptoms or comorbidities
TREATING SLEEP APNEA IN OLDER ADULTS

- CPAP most effective
  - AutoPAP good option for OSA without cardiopulmonary conditions
- Dental Appliances acceptable for mild to moderate disease
  - Need dentition in order to be an option
- Surgical options 3rd line
  - Hypoglossal nerve stimulation effective and well tolerated in older adults
Similar rates of adherence as younger patients

Similar rates of effectiveness

Can be used effectively even in those with cognitive impairment

For Medicare to pay

- 75% use >4 hours nightly in first 3 months (for any 30 day period)
- Face to face in 31-90 days documenting "use and benefit from PAP"
OTHER SLEEP DISORDERS IN OLDER ADULTS

- RLS / PLMDS
- REM Behavior Disorder
- Narcolepsy/Hypersomnia
- Insufficient Sleep Syndrome
Uncomfortable (but not painful) urge to move the legs, relieved by movement, often occurring in the evening around bedtime which interferes with the ability to sleep. Relieved by movement.

- Restless legs common
- Restless Legs Syndrome less so (perhaps 10-15%, similar to other adults)
- Strong hereditary link
- May be more common in dementia and may be associated with higher rates of nocturnal agitation
- Strongly associated with low ferratin levels and with ESRD
  - Improves with iron replacement
- Often associated with PLMDS (frequent nighttime leg movements associated with arousals, although rarely PLMDS can present without RLS)

RESTLESS LEG SYNDROME IN OLDER ADULTS
Treatment

- Dopaminergic agents commonly used
  - Pramipexole, ropinirole
  - More effective in severe disease
  - Problems with tolerance and augmentation

- Alpha-2-delta calcium channel ligands (gabapentin, pregabalin)
  - Less risk of augmentation
  - May have higher rates of psychomotor effects in older patients

- Benzodiazepines and narcotics options for refractory cases, but with much higher risk of adverse effects
OTHER TREATMENTS FOR RLS IN OLDER ADULTS

- Daily HD may help in ESRD
- Avoid sleep deprivation
- Treat comorbid sleep disorders (esp OSA)
- Moderate daily exercise
- Look for offending medications
  - Antihistamines
  - Antidepressants
Patients act out their dreams due to absence of physiologic atonia in REM sleep

- Rare, but increasing incidence with age
- Injury to patient or bed partner indication for treatment
- Higher dose melatonin or low dose benzodiazepines effective
- Strongly associated (perhaps 90%) with subsequent onset of Parkinson’s and/or other neurodegenerative conditions
Onset of Narcolepsy in older adult extremely unusual
  - Consider CNS imaging

Hypersomnia not uncommon after stroke, TBI
  - Rule-out other causes
  - Stimulants can help manage symptoms but come with risks

NARCOLEPSY / HYPERSOMNIA DISORDERS IN OLDER ADULTS
Most common sleep disorder in US adults causing complaints of sleepiness

Incidence in older adults unknown
  - Take a good history

INSUFFICIENT SLEEP SYNDROME
The sleep disorders that affect older adults are largely the same as those that affect younger adults.

Healthy older adults tend to sleep nearly as well as younger adults.

Complaints about sleep disruption or sleepiness are not “normal” in older adults and should prompt a thorough evaluation.
Chronic sleep disorders, untreated, have negative health consequences, and adverse outcomes can be reduced with treatment.

CBT-I is preferred and effective therapy for older adults with Insomnia disorders, although medications can be used with caution and proper supervision.

Take a good history and maintain vigilance for sleep disorders. They are significantly underdiagnosed and you often won't find them if you're not looking for them.
QUESTIONS?