

## Sleepless On Firm C

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You finally have the opportunity to rest. You've been up since 6:00 am and have gone from rounds to noon lecture, back to the ward to face the afternoon commotion before taking new admissions for your long call. You do 5 Firm C admissions. Your head is swimming with comorbidities and medication lists that are the length of your arm. Of course, you kindly help out with cross coverage, too. Now that it's midnight, things have settled a bit. The on-call room resembles Ritz-like accommodations to your dreary eyes. As your head hits the pillow your super-reliable beeper goes off again for that all-too-common call, "Mrs. Smith needs a sleeping pill."

Insomnia is common in older adults and roughly half of the geriatric population is taking some form of sleeping medication. Age-related changes in sleep occur in older adults and affect all phases of sleep, especially after age 75. These changes include taking longer to fall asleep, decreased REM sleep, and frequent awakenings. There are several factors associated with aging that make older adults more prone to insomnia. Symptoms from comorbidities such as neuropathy, arthritis or COPD can disrupt sleep. The older adult has an average of 3 comorbidities and therefore is at risk for polypharmacy. Certain drug-drug interactions may cause symptoms other than those that are being treated leading to adding even more drugs to the medication list which may cause insomnia. Certain psychiatric disorders can disrupt sleep as well. One condition, which is not uncommon among older adults, and has a very significant association with insomnia, is depression.

Being an inpatient may also result in sleepless nights. Patients may sleep poorly due to the anxiety of being in unfamiliar surroundings. In addition, patients may not sleep at night in the hospital because they sleep during the day. Patients are usually restricted to their hospital beds so why not nap? There are also those dependable, sometimes hourly interruptions that don't create a healthy sleep environment either. No wonder sleep improves at home for all age groups!

So what are we to do? Certainly it would be nice if we could avoid medication use altogether for insomnia. Convincing evidence for effective non-pharmacologic treatment of insomnia is lacking (Pallesen), although certain strategies may be worth trying. For some people, simply avoiding daytime naps often does wonders. Bright light exposure during the day, elimination of stimulating medications, and of course treatment of medical illnesses that contribute to insomnia are examples of helpful interventions. But sometimes, that hospitalized octogenarian just wants to get a good night's sleep. What about sleeping pills? Trazodone as a hypnotic is a favorite among geriatricians. At doses of 25-50 mg before bedtime, it has very few side effects besides morning drowsiness and priapism, which is very rare. While there are no randomized controlled trials showing its benefit over other agents in older adults, several small studies have shown efficacy in younger healthy patients and in patients with depression on other antidepressants (Schwartz, Nierenberg). What about benzodiazepines, the drugs that were invented for sleep and anxiety disorders? Undoubtedly they can cause dependence and adversely affect both cognition

and gait. Common side effects are lightheadedness, confusion, impaired reaction time, and residual daytime sleepiness all of which increase fall risk. However, low-dose intermediate-acting benzos, such as lorazepam (Ativan 0.25-1.0 mg), are quite effective. Short acting benzos such as oxazepam (Serax 10-15 mg), or alprazolam (Xanax 0.25-0.5 mg) may be preferable as they are less likely to result in morning lethargy. In addition, the older adult often responds well to zolpidem (Ambien 5-10 mg). Remember, **START LOW, GO SLOW** when dosing.

**Never give long-acting benzodiazepines such as diazepam (Valium) or high doses of the shorter acting benzodiazepines for insomnia as they may cause daytime sleepiness and diminished performance the following day, not to mention prolonged hospitalizations!** Diphenhydramine (Benadryl) should **rarely if ever** be used in older patients. Its anticholinergic side effects such as confusion, dizziness, dry mouth, constipation and urinary retention far outweigh its hypnotic benefits in older adults.

Whenever treating insomnia it is best to use pharmacologic agents, if needed, as a temporary measure to avoid dependence and adding to your patient's polypharmacy. Remember sleep improves following discharge when patients return to familiar surroundings.

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