

Hypnotic Overuse

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Story from the Front Lines:

A 63-year-old gentleman who, a year prior, developed difficulty initiating and maintaining sleep visited his primary care clinic. He described being unable to quiet his mind and “just drift off!” This had begun to impact his daily function in the form of excessive daytime sleepiness, and he felt his work and personal life suffered because of his insomnia.

His physician completed his history; performed the necessary physical; and pursued basic lab work to rule-out organic etiologies for the patient’s insomnia, such as thyroid dysfunction, anemia, heart failure, substance abuse, or psychiatric illness. Satisfied that there was no somatic or psychiatric pathology responsible and that the patient was free of significant comorbidity, primary insomnia was diagnosed. The patient was prescribed a month’s worth of zolpidem.

Three weeks later, the patient walked through his plate-glass sliding door separating his kitchen and patio. He sustained lacerations of his face and forearms, requiring twelve hours in the local emergency department having his wounds repaired. No recommendation was made to stop zolpidem during that visit. The following week, the patient returned to clinic for follow-up. His physician was shocked to hear what had happened and stopped his sleep aid immediately.

Teachable Moment:

It is estimated by The National Center on Sleep Disorders Research (NCSDR) that “about 70 million Americans suffer from sleep problems.”¹ The estimated cost to American society is in the billions, and the sequelae impair both quality of life, morbidity, and mortality.²

The American Academy of Sleep Medicine (AASM) recommends against the “use of hypnotics as primary therapy for chronic insomnia in adults.” It instead suggests cognitive-behavioral therapy for insomnia (CBT-I) with adjunctive pharmacologic therapy “when necessary”³ as determined by individual providers per their patients’ clinical picture. Nonetheless, the use of hypnotics in adults 20 years or older is estimated at 4% of the United States population, and one in six with a diagnosed sleep disorder are prescribed a sleep aid.⁴ This may be attributed to the relative ease of prescribing medication compared to investing in and pursuing CBT-I.

Though use of sedative hypnotic agents for sleep are common, they are not without risk of substantial harm. Specifically, a BMJ meta-analysis examining the risks and benefits of sedative hypnotics in people over 60 noted “the number needed to harm...compared to placebo is 6.”⁵ Cognitive effects, performance impairment, and even day-time sleepiness were found to be more common with hypnotic use compared to placebo. Additionally, it found “little difference in numbers of adverse events” between benzodiazepine and

nonbenzodiazepine sedative hypnotics. These risks are especially stark considering that the placebo effect is a significant contribution to the efficacy of sedative hypnotics.

Although nonpharmacological treatment for chronic primary insomnia is found to have lasting results in a majority of patients, there are barriers. It requires dedicated time of both practitioner and patient, and may have perceived inconvenience of both parties compared to a nightly pill. Nonetheless, the above-described harms of hypnotics—both novel and traditional—demand that clinicians question their prescribing habits and encourage non pharmacologic solutions to insomnia whenever practical.

Insomnia is a costly, complex, and prevalent problem. Avoiding harmful medications requires understanding of this problem, the small benefits of sedative hypnotics compared to placebo, and the serious risk of harm to patients from overuse of these medications.

References:

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