

Depression and Hypersomnia A Complex Association

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KEYWORDS

• Hypersomnolence • Sleepiness • Hypersomnia • Mood • Depression

KEY POINTS

- Hypersomnolence in depression is commonly considered a consequence of the disorder, in line with disturbances in monoamine activity. However, associated factors may contribute to hypersomnolence in patients with depression.
- Depressive symptoms and hypersomnolence are often associated with complex and often bidirectional interactions.
- Although depressive symptoms are common in patients with central hypersomnia, the formal diagnosis of a major depressive episode requires a structured evaluation to avoid frequent clinical overlap between the 2 conditions.
- Ideally, the management of both depressive symptoms in central hypersomnias and hypersomnolence in depressive disorders requires a collaboration between sleep specialists and psychiatrists.

INTRODUCTION

Depression and hypersomnia are 2 conditions linked in a complex and bidirectional manner. Excessive daytime sleepiness (EDS) is a common complaint among patients suffering from depression. On the other hand, patients with central hypersomnia, such as narcolepsy type 1 (NT1) or type 2 (NT2), and idiopathic hypersomnia (IH), often present depressive symptoms, probably due to their chronic and disabling condition, but also potentially due to an intrinsic predisposition in NT1. The aims of this review are to focus on the following: (1) the definition and prevalence of hypersomnolence as a pathologic condition; (2) the frequency, pathophysiology, and practical assessment of depression in central hypersomnia

disorders; and (3) hypersomnolence in depressive disorders.

EPIDEMIOLOGY AND NOSOGRAPHIC CONSIDERATION

The definition of hypersomnolence and its frequency remain problematic. The terms “hypersomnia,” “hypersomnolence,” “somnolence,” “excessive somnolence,” and “excessive daytime sleepiness” (EDS) were often used interchangeably in literature, leading to high heterogeneity in the results with thus potential for bias.¹

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) recently introduced the concept of “hypersomnolence disorder,” a syndrome that associates excessive daytime or

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nighttime sleep, impaired vigilance, and/or sleep inertia, not due to narcolepsy, disturbed nighttime sleep, circadian rhythm disorder, or a substance that can be associated, but not entirely explained, by a medical or mental disorder.² The diagnostic criteria of the hypersomnolence disorder may overlap with those of IH in the third edition of the International Classification of Sleep Disorders, third edition.³ In this latter classification, the terms “hypersomnia” and “central disorders of hypersomnolence” are used to label specific sleep disorders such as narcolepsy but also when associated or due to various medical, psychiatric, or environmental (insufficient sleep, substance use) conditions. In the DSM-5, the term “hypersomnia” was also used, in reference to a symptom, for example, a symptom criteria for mood disorders.²

Hypersomnolence needs currently to be defined as a clinical syndrome characterized by the occurrence of 3 major symptoms, being potentially associated, with large variability regarding severity among patients: (1) an excessive quantity of nighttime and/or daytime sleep; (2) an alteration in the quality of arousal defined by an incapacity to maintain a satisfactory level of vigilance during the day; and (3) sleep inertia,⁴ defined by major difficulties in waking up in the morning or after a nap with frequent reentries in sleep, reduced vigilance, and impaired performance, lasting few minutes to hours.

The frequency of an excessive duration of nighttime sleep (>9 hours) is 8.4% in the general population, with a higher prevalence in women than in men (9.2% vs 7.6%), and with a large age effect (decreasing until 65 years of age and increasing thereafter).^{5,6} Excessive nighttime sleep is associated with significant daytime consequences in 1.6%.⁶ In addition, some studies highlighted its association with increased risk of developing cardiovascular,^{7,8} neurodegenerative disorders, and even with a higher risk of mortality.⁹ The inability to maintain satisfactory alertness during the day, or having at least 2 sleep attacks 3 days per week, for at least 3 months is seen in 4.7% of the general population.⁶ Because of the lack of standardized definition of sleep inertia,⁴ there are no robust data on its prevalence; however, a large recent study reported a nonrestorative prolonged sleep episode in 1.2% of the general population.⁶ The latter 3 symptoms were often associated together, and with numerous medical and psychiatric disorders, and the use of psychotropic medication. After the exclusion of these comorbid conditions, the prevalence of the hypersomnolence disorder is estimated at 1.5%.⁶

To avoid potential confusion in terminology in this review, the terms “central hypersomnia” refers to a specific sleep disorder and “hypersomnolence”

refers to the complaints of either excessive nighttime or daytime sleep, unsatisfactory alertness, and sleep inertia that can be associated with environmental, medical, or psychiatric conditions.

DEPRESSIVE SYMPTOMS IN CENTRAL HYPERSOMNIAS

Central hypersomnias are rare and disabling sleep abnormalities that include NT1, NT2, and IH. NT1 is characterized by hypersomnolence and cataplexy, frequently associated with hypnagogic hallucinations, sleep paralysis, and disturbed nighttime sleep.^{10,11} IH and NT2 are 2 other central hypersomnias mainly characterized by hypersomnolence, but without pathognomonic symptom, with unclear prevalence and often unstable disease course.^{12,13}

Assessing Depressive Symptoms in Central Hypersomnias

The assessment of depressive symptoms in central hypersomnias warrants specific clinical considerations. According to the DSM-5, the diagnosis of major depression requires sad mood and/or anhedonia plus 4 of the following symptoms: suicidal ideation, fatigue, weight or appetite change, psychomotor agitation or slowing, feelings of excessive guilt, cognitive and sleep complaints.² Accordingly, hypersomnolence could be one of the symptom criteria for major depression. Furthermore, central hypersomnias are frequently associated with fatigue, cognitive alterations such as inattention and risk-taking behavior, with feelings of being lazy, slow, or with motor hyperactivity,^{14–17} and with increased weight gain and appetite, especially in NT1.¹⁸ Overall, 5 out of 9 symptom criteria for major depression are shared with central hypersomnia, resulting in a clinical overlap between the 2 conditions. Then, screening questionnaires for depression, such as the Beck Depression Inventory,¹⁹ being largely administered in patients with central hypersomnia, should be used with caution because of the risk of false positive results. For example, one case-control study found depressive symptoms in one-third of narcolepsy patients, whereas no significant difference was found between patients and controls regarding the formal mood disorder diagnosis.²⁰ To date, no questionnaire has been validated to assess the presence or the severity of depressive symptoms in patients with central hypersomnia specifically. Instead, a structured clinical interview remains essential to conduct an optimal evaluation of depressive symptoms in these conditions. Another challenging issue concerns depression as an exclusion criterion for the diagnosis of IH.

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