

Hypnotic Discontinuation in Chronic Insomnia



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KEYWORDS

• Deprescribing • Discontinuation • Hypnotic • Benzodiazepines • Insomnia • Sleep disorder

KEY POINTS

- Patients with chronic insomnia are commonly prescribed hypnotic medications but discontinuation of these medications is difficult to achieve.
- A gradual taper is preferred over abrupt cessation to avoid rebound insomnia and withdrawal symptoms.
- Written information provided to the patient about medication discontinuation may be helpful.
- Cognitive behavioral therapy or behavioral therapies alone can improve hypnotic discontinuation outcomes.
- There is limited evidence for adjunct medications to assist in hypnotic cessation for insomnia.

INTRODUCTION

Insomnia disorder is common in adults and children. The estimated prevalence ranges from 9% to 15% in the general population, with higher prevalence in certain subpopulations.^{1–6} Hypnotic medications are those that tend to produce sleep and are frequently used to treat insomnia.⁷ Commonly used hypnotics in adults include benzodiazepines (BZDs), BZD receptor agonists (BzRAs), antihistamines, antidepressants, melatonin receptor agonists, orexin receptor antagonists, and antipsychotics. Although there are currently no medications for pediatric insomnia approved by the US Food and Drug Administration, commonly used medications include antihistamines, alpha agonists, antidepressants, BZDs, BzRAs, and antipsychotics.^{8,9} The long-term health consequences of using hypnotics are not well described, and current guidelines recommend medication tapering and discontinuation when possible.¹⁰ However, hypnotic discontinuation is difficult and often

unsuccessful.¹¹ This article discusses strategies to discontinue hypnotics and evidence supporting their use.

HYPNOTIC TAPER STRATEGIES

Abrupt Hypnotic Cessation

Rapid drug cessation is an option for many medications. However, rebound insomnia and withdrawal symptoms may accompany abrupt hypnotic discontinuation. Rebound insomnia is generally defined as insomnia that is worse relative to baseline. This was first described with the discontinuation of triazolam¹² and has since been reported with several other BZDs^{13,14}; sedating antidepressants, including amitriptyline¹⁵ and trazodone¹⁶; and BzRAs, though with conflicting reports.^{14,17–19} Additionally, withdrawal symptoms, largely defined as the emergence of previously absent symptoms, are frequently reported with abrupt discontinuation of BZDs.²⁰ Consequently, tapering hypnotics is generally preferred to abrupt cessation.

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Tapering Hypnotics

Reported tapering strategies vary widely, with no consensus on the optimal tapering protocol. A frequently described approach is a dose reduction of 25% every 1 to 2 weeks until discontinued completely.^{21–25} Complete discontinuation rates ranged from 24% to 61% in these studies but there is variability in the frequency of office visits and the follow-up period in these reports. Withdrawal symptoms were commonly reported. A slightly slower wean was used by Lopez-Peig and colleagues.²⁶ Subjects all took BZDs, and were instructed to reduce their dose by 25% every 2 to 4 weeks. At the end of the taper period, 80.4% had successfully discontinued their BZD, and 64% remained BZD-free at 12 months. Another study weaned subjects from various BZDs by 10% to 25% every 2 to 3 weeks, with an approximately 40% hypnotic abstinence rate maintained at 36 months, without significant sleep dissatisfaction compared with a control group.²⁷ Drake²⁸ weaned subjects from temazepam by cutting doses roughly in half every 2 weeks, from 10 mg to 5 mg to 2 mg. Of the subjects, 59% successfully completed the taper, with 52% remaining hypnotic-free at follow-up 12 to 35 weeks later. Lemoine and colleagues²⁹ reported a similar taper with 2 BzRAs, zopiclone and zolpidem. In that study, subjects were weaned from zolpidem 10 mg to 5 mg for a week, followed by a placebo. Similarly, subjects were weaned from zopiclone 7.5 mg to 3.75 mg for a week, followed by a placebo. This regimen was associated with significantly higher withdrawal symptoms than the control group that was not weaned. In contrast, Raju and Meagher³⁰ used a more flexible taper protocol, in which subjects were able to control the rate of withdrawal. Given control over the weaning pace, some subjects rapidly discontinued hypnotic use (19 of 68), whereas others preferred a prolonged, yet complete, taper (13 of 68). The remainder did not completely discontinue medication use. To the authors' knowledge, there are no studies specifically comparing the success of different taper strategies. However, a clinical trial is currently underway that will compare different taper strategies among hypnotic-dependent subjects.³¹

Many practitioners find it helpful to switch from a short-acting to a long-acting BZD before initiating a taper.^{27,32} This is done by switching to an equivalent dose of a long-acting BZD, commonly diazepam (**Table 1**). It is notable that a Cochrane Review published in 2006 noted higher dropout rates when tapering short half-life compounds compared with long-acting BZDs.³³ However,

Table 1
Approximate equivalent doses of benzodiazepines to 5 mg diazepam

BZD	Equivalent Dose (mg)
Alprazolam	0.25–0.5
Bromazepam	3–6
Lorazepam	0.5–1
Nitrazepam	5
Oxazepam	15
Temazepam	10
Triazolam	0.25

there was no difference in withdrawal symptoms between the groups, so switching from a short-acting to a long-acting BZD before a gradual taper was not supported. The authors are unaware of any studies specifically comparing the practice of switching to a long-acting BZD before gradual withdrawal versus a gradual withdrawal directly from a short-acting BZD.

ADJUNCT THERAPIES

Regardless of the taper strategy, several adjunct therapies have been studied to assist in hypnotic discontinuation. These include various degrees of patient education, psychological therapies, and medications.

Written Patient Education

There is some evidence that simply providing written information to patients can lead to hypnotic discontinuation. In 1 study, chronic BZD users were randomized to receive either routine care or advice during a single consultation supplemented by a self-help booklet.³⁴ The intervention resulted in a significant reduction in BDZ prescriptions compared with routine care alone (18% vs 5%). Several other studies used a letter sent to BZD users encouraging BZD reduction, with complete BZD cessation rates ranging from 14% to 27%.^{23,24,35–37}

Psychological Therapies

Many studies have used psychological therapies to aid in medication discontinuation. A brief description of the different types of therapy is provided in **Table 2**.

Sleep hygiene education

Sleep hygiene education is routinely provided to patients with insomnia. However, there is insufficient evidence to recommend sleep hygiene as a

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