

FAST FACTS AND CONCEPTS #101
INSOMNIA: PATIENT ASSESSMENT**Robert Arnold MD, Michael Miller, and Rohtesh Mehta MD MPH**

Background Sleep disorders are common in the general population, the elderly, and the terminally ill. Sleep deprivation causes reduced tolerance to pain and increased fatigue that prevents patients from participating in meaningful daytime activities and decreasing their quality of life. This *Fast Fact* focuses on the assessment of insomnia; it is the first of a series of three *Fast Facts* about insomnia (see #104, 105).

Definitions

- **Primary Insomnia:** difficulty initiating or maintaining sleep, or non-restorative sleep, for at least 1 month; does not occur exclusively during another mental disorder; is not due to the direct physiological effects of a substance/medication or a general medical condition; and significantly impairs functional/social quality of life. [*DSM-IV-TR Diagnostic Criteria 307.42*]. The International Classification of Sleep Disorders (ICSD-2) classifies insomnias into various categories:
 - i. **Acute/Adjustment Insomnia:** Usually related to an acute physical/psycho-social stressor, change in environment; is short-term, expected to resolve when stressor disappears, usually lasts less than 3 months.
 - ii. **Idiopathic Insomnia/Life-Long Insomnia:** Begins during infancy or childhood, etiology is unknown; patients may have learning disabilities.
 - iii. **Psychological Insomnia/Conditioned/Learned Insomnia:** Caused by an acute event such as a significant life stress, pain, or illness; the individual no longer associates the bed with sleeping.
 - iv. **Paradoxical Insomnia/Pseudo-insomnia/Sleep Hypochondriasis:** Subjective feeling of insomnia, with no polysomnographic evidence of a sleep disorder.
 - v. **Inadequate Sleep Hygiene:** Related to irregular sleep schedule, consumption of caffeinated beverages, nicotine or alcohol, or exercise before bed-time.
 - vi. **Circadian Rhythm Sleep Disorders:** Jet lag and shift-work.
- **Parasomnia:** a disruptive physical act that occurs during sleep or during sleep–wake transitions which may cause awakening or other disturbance in sleep. It includes nightmare disorder, sleep terror disorder, sleepwalking disorder and other parasomnias.
- **Sleep Apnea:** short periods of breathing cessation during sleep; can be obstructive or central in origin.
- **Restless Legs Syndrome (RLS):** paresthesias and dysesthesias of the legs that typically occur in the evening or at night and may be relieved by movement (see *Fast Fact #217*).
- **Periodic Limb Movement Syndrome (PLMS):** involuntary, rhythmic twitches, typically ankle dorsiflexion, occurring every 20–40 seconds, leading to brief arousals and accidental kicking of bedmates. In contrast to RLS, PLMS occurs during sleep and patients often are not aware of it.
- **Narcolepsy:** a disorder of excessive daytime fatigue associated with abnormalities in rapid-eye-movement sleep.

Sleep History Obtain a focused sleep history from the patient and bed partner. If needed, the patient should be asked to record their daily sleep patterns in a sleep log for one week; see <http://www.webmd.com/sleep-disorders/guide/how-to-use-a-sleep-diary>.

- **Sleep hygiene.** Has the patient altered their bedtime routine (e.g. change in bedtime, use of sleep aids, lying in bed watching TV prior to sleep)?
- **Sleep chronology.** Evaluate the onset, pattern and duration of sleep and whether the insomnia is transient, intermittent or persistent. A persistent problem usually is a consequence of a medical, neurologic or psychiatric disorder. Ask if the patient has difficulty initiating sleep, staying asleep, or both. Sleep apnea rarely causes disorders in initiating sleep. Nightmares (see *Fast Fact #88*) cause difficulty staying asleep and may reflect spiritual suffering. Ask about multiple nocturnal or early morning awakenings. Frequent awakening is often due to medicine and early awakening is classically due to depression.
- **Sleep environment.** Are any environmental factors (e.g. noise, light, odors) preventing sleep? This may be particularly important in the hospital or a situation where a patient has moved into an unfamiliar setting (e.g. children's house).

- **Physical symptoms.** Are there physical symptoms interfering with sleep (e.g. cough, pain, dyspnea)? Symptoms occurring just prior to sleep may reflect primary sleep disorders.
- **Medical conditions.** Are there co-morbid medical conditions that are associated with insomnia?
 - Worsening of chronic medical conditions (e.g. CHF, COPD).
 - New onset or worsening depression and/or anxiety.
 - Drugs (e.g. steroids, beta blockers, psychostimulants); use of alcohol and caffeine, especially in the evening.
 - Restless leg syndrome or periodic limb movements in sleep (see above).
- **Spiritual concerns.** Fears about dying may cause a patient to be afraid of falling asleep or to not want to turn off the lights; this is especially common in patients with dyspnea. This is in contradistinction to more typical insomnia where the patient is bothered by the lack of sleep.

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