Sleep Disturbance Management Tips for Health Care Professionals

Guiding Principles: A common and multifactorial problem.

Step 1. Top underlying treatable causes and diagnosis:
- Both cancer treatments and cancer-related symptoms can contribute to insomnia (difficulty falling asleep, maintaining sleep, wakening too early or poor sleep quality, and impaired daytime functioning)
- Identify contributing causes:
  - Unrelated to cancer / therapy: e.g. sleep apnea, restless leg syndrome
  - Depression (see depression tip), anxiety (see anxiety tip), existential spiritual distress or other psychiatric/ psychological disorders have a higher prevalence in cancer palliative population
  - Drugs: e.g. corticosteroids, stimulants, diuretics
  - Poor symptom control: pain, dyspnea, pruritus, sweating, diarrhea, tenesmus

Step 2a. Non-pharmacological management:
- Address contributing causes (if able)
- Sleep Hygiene (stimulus control treatment, regular schedule and bedtime routine, only go to sleep when sleepy, get up / read etc. if sleep latency >30 min, avoiding daytime naps)
- Dark room, reduce ambient noise
- Avoid caffeine
- Cognitive Behavioral Therapy
- Relaxation, exercise (if able), mindfulness meditation
- Exercise/physical activity during the day as able
- Warm milk (releases tryptophan which is a natural sleep aid)
- A warm bath a few hours before bed (allows the body core to initially heat up and then gradually cool down in the hours prior to going to bed – mimicking what normally happens when we sleep)
- Warm blanket from the dryer wrapped around the core when first going to bed (not a heating blanket as you want the blanket temperature to decrease over time)

Step 2b. Pharmacological options:
Mild symptom:
- Many of the non-sedative hypnotics have a lower evidence of efficacy for sleep initiation and maintenance but are suggested to trial first due to a lower adverse effect profile. This is especially applicable in the elderly population
- Tailor selection to patient co-morbidities, concurrent medication interactions and side-effects
- Note: Limited evidence for most medications
- Melatonin 2-4 mg po qhs (least side-effects)
• Mirtazapine 7.5 mg po qhs (sedating at <15 mg, i.e. no need to titrate up if ineffective at lower doses)
• Trazadone 50 mg po qhs (Caution: avoid in dementia patients)
• Doxepin 3-6 mg po qhs

Moderate to severe symptoms (refractory to above):
• Non-benzodiazepine receptor agonists like analogues (Zopiclone 3.75-7.5 mg po qhs (Elderly or frail: maximum of 5 mg)) can be tried for a short term in conjunction with non-pharmacological therapies and reassessed for efficacy and tolerability
• Short-Acting Benzodiazepines (Lorazepam 0.5-1.0 mg) (avoid in elderly)
• Limited evidence: Low dose sedating antipsychotic (Quetiapine 12.5-25 mg po qhs) may be tried if there is no history of Parkinsons disease or extra-pyramidal symptoms with neuroleptics and not elderly. Antipsychotic may be useful if other coexisting symptoms may also be beneficially treated (nausea, delirium with marked aggression/agitation and vivid dreams)

Step 3. When to refer to specialists:
• If insomnia symptoms worsening despite above treatments
• Psychosocial Oncology: concomitant depression or anxiety
• Palliative Care:
  ○ Concomitant physical symptoms (e.g. pain, nausea) that are difficult to control and contributing to insomnia.
  ○ Existential distress requiring involvement of multidisciplinary team

For more detailed information on Sleep Disturbance visit:
A Pan-Canadian Practice Guideline: Prevention, Screening, Assessment and Treatment of Sleep Disturbances in Adults with Cancer, Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology, December 2012. https://www.cancercareontario.ca/sites/ccocancercare/files/assets/CCOSleepGuideline.pdf

End of Life Considerations:
In EOL, pharmacotherapy with sedative hypnotics may have a higher adverse effect profile (e.g. delirium, daytime sedation and fatigue, fall risks etc.).

Choosing a medication that achieves both nighttime sedation and treats the other prevailing symptoms may help reduce polypharmacy (e.g. if also neuropathic pain, use Gabapentin or nortriptyline).

NOTE: Guidelines do not replace individualized care and clinical expertise.
Guideline Summary for Health Professionals
Sleep Disturbance (Insomnia)
Effective Date: January 1, 2019
Last Updated: February 7, 2019

References:


