A 2023 Update on Managing Insomnia in Primary Care: Insights From an Expert Consensus Group

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ABSTRACT

Objective: To evaluate the status of management of insomnia disorder, describe gaps in current recognition and treatment, identify current guidance for optimal management, and develop up-to-date educational recommendations for primary care providers.

Participants: Four insomnia experts representing primary care, psychiatry, and clinical research were selected based on clinical expertise, educational qualifications, and research experience. A patient with insomnia was also included.

Consensus Process: The Insomnia Working Group met in March 2022 to review data on available therapies (including medications approved since publication of current guidelines) and share current best practices for evidence-based multimodal treatment of insomnia disorder.

Conclusions: Insomnia is highly prevalent but underdiagnosed and undertreated. It is increasingly recognized as a distinct disorder, not merely a symptom arising secondary to another medical or psychiatric illness. The subtypes of sleep disturbance—reports of difficulty falling or staying asleep, insufficient sleep duration, early waking—and the presence of next-day impairment and common comorbid conditions require a targeted, individualized approach to therapy. Challenges exist in treating insomnia with commonly used on- and off-label drugs, including low-dose antidepressants, benzodiazepines, and benzodiazepine receptor agonists because of the risk of adverse effects, including impaired next-day functioning. The dual orexin receptor antagonists have a novel mechanistic target and offer an alternative pharmacologic choice. Optimal outcomes for insomnia require a comprehensive approach that includes lifestyle and behavioral strategies to mitigate maladaptive thoughts and behaviors related to sleep and selection of pharmacotherapy based on individual patient complaints and characteristics.

Prim Care Companion CNS Disord 2023;25(1):22nr03385


To share: https://doi.org/10.4088/PCC.22nr03385
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Insomnia, Despite Its Myriad of Personal and Societal Consequences, Is Underrecognized in Primary Care

Insomnia disorder is a distinct chronic condition characterized by reports of difficulty initiating or maintaining sleep, which is present even when the patient has adequate opportunity and an appropriate environment in which to sleep, and has a significant impact on next-day functioning. Insomnia is underrecognized and undertreated, resulting in a significant health care burden (increased morbidity and mortality) and poorer quality of life for those who experience it. Insomnia disorder is highly prevalent in the general population, with estimates of 10% among adults, and is particularly prevalent in primary care patients, with estimates ranging from 10%-20%.

The medical, psychiatric, psychosocial, and economic burdens of insomnia disorder—and the resulting diminished quality of life—are significant. Poor sleep is not only a problem at nighttime; its impact also involves diminished daytime functioning and work performance, fatigue, and social isolation.

In the United States, the costs of insomnia are estimated to be as high as $100 billion, most of which reflect indirect costs due to lost productivity (presenteeism/absenteeism), accidents (often involving drowsy driving), and disproportionate use of health care resources. One study found that the costs of managing patients with insomnia compared to those without insomnia were 46% higher after 1 year; the costs were 80% higher if a comorbidity was present.

People who experience disturbed sleep often fail to consult their primary care clinicians about the issue. Although approximately half of patients in primary care experience insomnia, only a fraction of this group, about 25%-50%, discuss sleep issues with their primary care providers, and an even smaller percentage seek treatment for insomnia. A random population survey conducted by the National Sleep Foundation showed that although almost 50% of primary care patients experienced insomnia, only 30% of them mentioned the problem to a physician, and only 6% reported that they had sought the help of a physician for their sleep
difficulty (Figure 1). Compounding the problem, primary care clinicians appear to be remiss in asking about sleep disturbances. In another National Sleep Foundation survey (N = 1,506 US adults), 70% of respondents reported that their clinicians never asked them about their sleep.

The Importance of Comorbid Insomnia in Psychiatric and Medical Conditions

In the past decade, the definition of insomnia, as reflected in disease nosology systems and diagnostic criteria, has evolved. The result is that insomnia is regarded as a distinct disorder that has profound implications for treatment.

The insomnia landscape fundamentally shifted with the publication in 2013 of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

In the previous version, chronic insomnia was defined as a primary condition or as secondary to another condition. Such a classification is inaccurate because regarding insomnia as secondary implies that it will resolve when the comorbidity is treated. Within that paradigm, management of insomnia is considered a lower priority in favor of treating its comorbidities first. This misperception has contributed to significant undertreatment of sleep disturbances.

In the DSM-5, however, the distinction between primary and secondary insomnia was eliminated, and the term insomnia disorder was adopted. Insomnia disorder is therefore now recognized as a condition that often coexists with, and is not merely secondary to, another condition such as depression.

Similarly, in a marked departure from earlier versions, the third edition of the International Classification of Sleep Disorders (ICSD-3) also consolidated primary and comorbid insomnia into a single entity.

The presence of insomnia in a patient with other medical or psychiatric diseases is an important consideration for the primary care clinician. Insomnia is typically seen comorbidly with a variety of medical and psychiatric conditions encountered in the primary care setting. One survey found that people with insomnia have a mean of 3.2 comorbidities; these include cardiovascular disease, hypertension, diabetes, gastrointestinal disorders, respiratory disorders (including asthma and sleep apnea), neurologic disorders, and cancer. Depression, however, is the most common comorbidity likely to occur with insomnia and has been shown to be the most common comorbidity seen in the primary care setting.

There are currently limited data regarding sleep dysfunction in patients who have been acutely diagnosed with COVID-19, whether asymptomatic or symptomatic or whether requiring hospitalization or not, and among those hospitalized, whether requiring intensive care admission due to respiratory failure or not. There is evidence that suggests the acute as well as long-term impact of COVID-19 on sleep can be profound. Various validated questionnaires and surveys have been employed to assess the frequency and severity of sleep problems associated with COVID-19. While there are inherent weaknesses in survey methodology, these data are useful. Donzella et al. reported that individuals with a positive COVID test result were more likely to report trouble sleeping 3 or more times per week since the start of the pandemic. It is unclear whether the sleep difficulties were due to the viral infection or secondary factors (anxiety, changes in social factors, or economic concerns). An international study regarding COVID and sleep problems found the rates of insomnia symptoms (36.7%) and insomnia disorder (17.4%) were very high during the first wave of the pandemic.

Insomnia is not only frequently comorbid with psychiatric conditions, but is also a risk factor for future development or exacerbation of a psychiatric disorder. Compared to individuals without insomnia, the risks that a person with insomnia will develop depression, anxiety, alcohol abuse disorder, or psychosis are 2.83, 3.23, 1.35, and 1.28 times higher, respectively. Sleep disturbance is also associated with a > 50% increased risk for Alzheimer’s disease. More than 40 studies have shown a clear relationship between insomnia and suicidal ideation, suicidal behaviors, and death. Aside from comorbidities, otherwise healthy older adults with insomnia symptoms (delayed sleep onset, poor sleep efficiency [ratio of total sleep time to time in bed]) have a mortality risk twice as high as those without insomnia.
Box 1. Clinician Take-Home Points Related to Insomnia in Patients

- Insomnia is highly prevalent in primary care.
- Patients do not report difficulty sleeping to their clinicians.
- Clinicians should ask specific insomnia-related questions in order to identify insomnia.
- Insomnia is associated with a multitude of comorbidities.
- Evidence suggests bidirectional interactions between insomnia and its comorbidities, with each exacerbating the other.
- Treating the insomnia may improve outcomes for the comorbidity.

Box 2. A 2-Question Screening Tool for Insomnia

1. Do you have trouble getting to sleep or staying asleep? (Or: Are you satisfied with the quantity and quality of your sleep?)
2. Do you feel well rested during the day?

A growing body of evidence demonstrates that the relationship between insomnia and some comorbidities is bidirectional, that is, the insomnia worsens the comorbidity, and the comorbidity worsens insomnia.2,21 The status of one condition affects the status of the other in many dimensions: severity, choice of treatment, and outcomes.16

Additionally, clinical trials of both medications and cognitive-behavioral therapy for insomnia (CBT-I) have demonstrated that treating insomnia in depressed patients was associated with improved outcomes in depression and insomnia,34,35 anxiety and insomnia,36 pain and insomnia,37 and suicidal ideation.38 While data demonstrating that improvement in insomnia can benefit comorbidities are generally lacking, there is mounting evidence that treating insomnia in the presence of the comorbidity may improve outcomes for not only the insomnia, but also the comorbidity. Clinicians should avoid the risk of trivializing insomnia and prioritizing other medical conditions, thus delaying an accurate diagnosis and downplaying the need for insomnia treatment.2,4 At the very least, the presence of insomnia indicates a patient at higher risk for poor health outcomes.

Finally, there is evidence that patients with insomnia and short sleep duration (<6 hours/night) are at higher risk for impaired neurocognitive functioning, increased cortisol levels, hypertension, diabetes, and death.39 Identifying these patients and treating their insomnia may help to mitigate risk. See Box 1 for clinician take-home points.

Insomnia Screening and Diagnosis

Given the high prevalence of insomnia demonstrated in their patients, primary care clinicians should consider sleep to be a vital sign and routinely screen for insomnia.40 To improve screening, it may be helpful for clinicians to ensure that their patient intake forms and electronic records are designed to routinely prompt a discussion of sleep patterns and next-day function. See Box 2 for simple questions that can highlight the possibility of insomnia and provoke further questions, if needed.

Table 1. ICD-11 Diagnostic Criteria for Chronic Insomniaa

<table>
<thead>
<tr>
<th>Diagnostic Criteria for Chronic Insomniaa</th>
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<tr>
<td>Frequent and persistent difficulty initiating or maintaining sleep</td>
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<tr>
<td>Daytime symptoms typically including fatigue, depressed mood, irritability, general malaise, and cognitive impairment</td>
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<tr>
<td>Sleep disturbance and daytime symptoms that occur at least several times per week for at least 3 months</td>
</tr>
<tr>
<td>Some individuals with chronic insomnia may show a more episodic course, with recurrent episodes of sleep/wake difficulties lasting several weeks at a time over several years</td>
</tr>
<tr>
<td>Adequate opportunity and circumstances for sleep</td>
</tr>
<tr>
<td>Daytime impairment must be present</td>
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</table>

If the insomnia is due to another sleep-wake disorder, a mental disorder, another medical condition, or a substance or medication, chronic insomnia should be diagnosed only if the insomnia is an independent focus of clinical attention.


If insomnia is suspected, further evaluation is indicated. A detailed history obtained during the interview is key to understanding the patient’s subjective experience of insomnia.4 In line with the 11th edition of the International Classification of Diseases (ICD-11) criteria, questions should explore the nature of the sleep disturbance (delayed sleep onset, trouble staying asleep, early morning awakening, nonrestorative sleep), sleep routines and potentially maladaptive habits, impaired daytime functioning, and the potential presence of contributing comorbidities.21,41 Other potentially useful sources of information include a sleep diary and an interview with the patient’s bed partner. Data from smartphone or fitness apps may be suggestive,21 but the objective accuracy of data from such devices has not been validated.

The ICD-11, approved in February 2022, defines insomnia disorder as characterized by “persistent difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity and circumstances for sleep, and results in some form of daytime impairment” (Table 1).1

Next-day impairment can involve fatigue, poor functioning, reduced alertness, and, in many cases, exacerbation of existing comorbidities such as depression, any of which can significantly reduce the affected individual’s quality of life.2,42

Polysomnography is not usually necessary, nor is it recommended for the initial objective assessment of insomnia. However, additional clinical screening tools and laboratory and sleep studies may be needed to rule out other conditions that can disrupt sleep, such as mood disorders, pain, restless leg syndrome, or obstructive sleep apnea.21

Validated tools are available to help clinicians assess the severity of insomnia disorder and monitor the response to treatment. Perhaps most useful is the brief Insomnia Severity Index (ISI),43 a 7-item patient self-reported questionnaire that reliably assesses both nighttime and daytime aspects of sleep disturbance occurring within the past month. Questions use a 5-point scale (from “no problem” to “very severe problem”) to evaluate patterns of sleep onset, sleep maintenance, and early awakening; difficulties with daytime functioning; whether the sleep problems are noticed by others; and the degree of distress resulting from insomnia. Results classify insomnia as not present, mild, moderate, or severe.43

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The Emerging Science of Sleep and Consequences for Treatment Selection

Research continues to reveal the complex neurophysiologic processes involved in the regulation of sleep and wakefulness. A basic awareness of these mechanisms can help clinicians better understand how different drugs target various neurotransmitter pathways to improve the symptoms of insomnia.17 Different brain structures and their associated neurotransmitters play various complementary roles at different stages in the sleep process (Figure 2).17 Neurons in the thalamus, hypothalamus, hippocampus, basal ganglia, and brain stem produce γ-aminobutyric acid (GABA), a widespread inhibitory neurotransmitter that reduces arousal. Within the hypothalamus, the suprachiasmatic nucleus receives information about light exposure that regulates the circadian rhythms that govern the sleep/wake cycle and triggers production or suppression of melatonin. During rapid eye movement sleep, the brain stem reduces muscle activity, while the thalamus relays sensory information for processing by the cerebral cortex.

The act of falling asleep involves 2 separate but complementary (and equally necessary) neurochemical processes: decreasing wakefulness-promoting activity and increasing sleep-promoting activity. Inhibiting wakefulness results from activity by such factors as adenosine, nitric oxide, and GABAergic neurons in the hypothalamus.44 At the end of the night, the process reverses: sleep-promoting activity diminishes, and wakefulness is triggered and maintained by a group of neurotransmitters (glutamate, norepinephrine, dopamine, serotonin, acetylcholine, histamine, and orexin A and B).45–47 Many of these neurotransmitters and neurotransmitter pathways may serve as potential therapeutic targets for managing various forms of sleep disturbance in individual patients.

Treating Insomnia: Nonpharmacologic Approaches

Optimal management of insomnia disorder calls for a multimodal strategy that reduces time to sleep onset (sleep latency), reduces awakening during the night, increases sleep duration, and allows wakefulness after adequate sleep duration. The goal of treating insomnia disorder is thus 2-fold: to restore the duration and quality of sleep, while alleviating the daytime impairment caused by the disorder.48 To achieve optimal outcomes, clinicians should adopt an approach incorporating lifestyle changes, improved sleep hygiene, cognitive-behavioral techniques, and the safe, judicious use of appropriately selected medications. Guidelines urge a shared decision-making approach when designing a treatment strategy, which involves discussing the
Insomnia is a common and often disabling condition characterized by difficulty falling or staying asleep, or not getting quality sleep. It affects millions of people worldwide and can have significant impacts on daily functioning, mood, and overall health. In this article, we discuss the causes of insomnia, its management, and the role of healthcare providers in addressing this common issue.

### Causes of Insomnia

Insomnia can be caused by a variety of factors, including lifestyle habits, medical conditions, and psychological issues. Common causes include:

- **Lifestyle factors**: These include irregular sleep patterns, lack of physical activity, and exposure to electronic screens before bedtime.
- **Medical conditions**: Conditions such as anxiety, depression, and sleep disorders like restless leg syndrome and sleep apnea can contribute to insomnia.
- **Psychological factors**: Stress, anxiety, and mood disorders can also disrupt sleep.

### Management of Insomnia

 effective strategies for managing insomnia include:

- **Lifestyle changes**: These include maintaining a regular sleep schedule, creating a comfortable sleep environment, and limiting caffeine and screen time before bedtime.
- **Nonpharmacologic treatments**: These include cognitive behavioral therapy for insomnia (CBT-I), relaxation techniques, and relaxation exercises.
- **Pharmacologic treatments**: This includes the use of medications such as sedating antidepressants and benzodiazepines.

### CBT-I

CBT-I is a first-line approach to treating insomnia and involves the use of skills and techniques to improve sleep patterns. It includes several components:

- **Sleep restriction therapy**: This involves gradually reducing the time spent in bed while maintaining the same bedtime and wake-up times.
- **Cognitive restructuring**: This involves identifying and challenging negative thoughts about sleep.
- **Relaxation techniques**: These include deep breathing, progressive muscle relaxation, and meditation.

### Medications for Insomnia

Prescription medications for insomnia are typically used when lifestyle changes and nonpharmacologic treatments are ineffective. Common medications include:

- **Sedating antidepressants**: Such as trazodone and mirtazapine.
- **Benzodiazepines**: These include zolpidem and zaleplon.
- **Nonbenzodiazepine sedative-hypnotics**: Examples include eszopiclone and zaleplon.

### Emerging Treatments

There is ongoing research into new treatments for insomnia, including:

- **CBT-I combined with medications**: This combines the benefits of both approaches.
- **Wake-promoting agents (WA)**: These agents include modafinil and armodafinil, which are used to improve daytime alertness.

### Patient Education

It is important for healthcare providers to educate patients about the risks and benefits of treatment options. Patients should be informed about the potential side effects of medications and the importance of maintaining a healthy lifestyle to improve sleep.

### Conclusion

Insomnia is a complex and multifaceted condition that requires a comprehensive approach to management. Healthcare providers play a crucial role in helping patients achieve good sleep hygiene and optimal sleep outcomes. Further research is needed to identify effective and safe treatment options for insomnia.
setting, with 34% more prescriptions than the next most commonly prescribed FDA-approved hypnotic. However, it is not FDA approved for insomnia, and clinical trial data are lacking to support the safety and efficacy of trazodone for insomnia. Importantly, although GABAergic agents such as benzodiazepines and BzRAs are widely prescribed, they can be associated with significant adverse effects that include diminished sleep maintenance. Adverse effects include sleep paralysis, hypnagogic hallucinations, cataplexy, and suicidal ideation.

Because they sometimes have shorter half-lives and possibly somewhat different mechanisms than conventional benzodiazepines, the BzRAs (eszopiclone, zaleplon, zolpidem), the first of which was approved in 1992, initially offered hope for greater safety. These drugs carry a boxed warning on their safety and efficacy were not available at the time current AASM insomnia guidelines were developed. However, a recent meta-analysis comparing the various classes of insomnia agents that included suvorexant, zolpidem (immediate release and extended release), zopiclone, eszopiclone, trazodone, flunitrazepam, estazolam, triazolam, brotizolam, temazepam, and ramelteon showed that lemborexant had the highest probability of being the best treatment on 3 of 4 outcome measures: sleep efficiency, sleep-onset latency, and total sleep time. This meta-analysis did not include daridorexant, as it was conducted prior to the drug's approval. Lemborexant also effectively reduces wakefulness after sleep onset. Importantly, lemborexant was approved in 2019; data on its safety and efficacy were not available at the time current AASM insomnia guidelines were developed. However, a recent meta-analysis comparing the various classes of insomnia agents that included suvorexant, zolpidem (immediate release and extended release), zopiclone, eszopiclone, trazodone, flunitrazepam, estazolam, triazolam, brotizolam, temazepam, and ramelteon showed that lemborexant had the highest probability of being the best treatment on 3 of 4 outcome measures: sleep efficiency, sleep-onset latency, and total sleep time. This meta-analysis did not include daridorexant, as it was conducted prior to the drug's approval. Lemborexant also effectively reduces wakefulness after sleep onset. Importantly, lemborexant was approved in 2019; data on its safety and efficacy were not available at the time current AASM insomnia guidelines were developed. However, a recent meta-analysis comparing the various classes of insomnia agents that included suvorexant, zolpidem (immediate release and extended release), zopiclone, eszopiclone, trazodone, flunitrazepam, estazolam, triazolam, brotizolam, temazepam, and ramelteon showed that lemborexant had the highest probability of being the best treatment on 3 of 4 outcome measures: sleep efficiency, sleep-onset latency, and total sleep time. This meta-analysis did not include daridorexant, as it was conducted prior to the drug's approval. Lemborexant also effectively reduces wakefulness after sleep onset. Importantly, lemborexant was associated with significantly less risk of dizziness and postural instability compared to the BzRAs, and it was not associated with clinically meaningful residual morning sleepiness or reduced next-day morning sleepiness or reduced next-day sleep.
Choosing the Right Drug for the Right Patient: What the Evidence Shows

Drugs used in insomnia produce different effects on distinct types of sleep disturbance. The choice of agent should be individualized depending on various factors such as the patient's age and gender, as well as the presence of comorbidities, the risk for adverse effects, and patient preference (Table 3).16,42,47,60

As discussed previously, clinicians who identify insomnia in a patient should be alert for the presence of a psychiatric disorder and, conversely, should always assess for insomnia in a patient with a psychiatric disorder. The choice of treatment should also take the presence of comorbidities into account. For example, a BzRA may be an appropriate choice for a patient with comorbid insomnia and depression or anxiety, while an atypical antipsychotic might be indicated for a patient with comorbid insomnia and schizophrenia. DORAs may be a better choice for patients with a substance abuse disorder since orexin mediates the reward and arousal effects of drugs of abuse, including opioids. Use of such substances can often result in disrupted sleep, while use of orexin antagonists can block arousal and reward, thus offering a potential 2-fold benefit for patients with comorbid substance abuse disorder and insomnia.47

Insomnia is also associated with an increased risk of cardiovascular disease, possibly because it is a risk factor for hypertension.21 Therapy that effectively controls blood pressure may contribute to improved sleep, and, conversely, insomnia agents that down-regulate the arousal and stress systems (such as trazodone, doxepin, or the DORAs) may contribute to lower blood pressure.71

The patient’s gender is also a consideration when designing therapy for insomnia. For example, prescribing information for zolpidem notes that women should receive the lower starting dose (5 mg).72 For pregnant or breastfeeding women, a nonpharmacologic therapy such as CBT-I may be a better option than any insomnia medication.10

Like doxepin73,74 and ramelteon,75,76 DORAs appear to be a viable choice for older adults. A prespecified subgroup analysis of pooled data from 2 efficacy and 3 safety randomized, double-blind, placebo-controlled, parallel-group trials showed that suvorexant improved sleep maintenance and onset over 3 months of nightly treatment with few safety concerns.77 A 1-month randomized,

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**Table 3. How to Match Insomnia Treatments to Patient Presentation**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Patient Presentation</th>
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<tbody>
<tr>
<td>Cognitive-behavioral therapy for insomnia</td>
<td>Increased arousal</td>
</tr>
<tr>
<td>Benzodiazepines or benzodiazepine receptor agonists</td>
<td>Decreased homeostatic drive</td>
</tr>
<tr>
<td>Dual orexin receptor antagonists</td>
<td>Sleep-onset insomnia, last quarter of the night</td>
</tr>
<tr>
<td>Dorexanin</td>
<td>Patient needs to wake up and function in the night</td>
</tr>
<tr>
<td>Ramelteon</td>
<td>Vulnerability to substance use disorder</td>
</tr>
<tr>
<td>Off-label treatments</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Treatment-resistant insomnia</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Comorbid depression, anxiety, or pain</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Treatment-resistant insomnia</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Comorbid depression or psychosis</td>
</tr>
</tbody>
</table>

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16 Adapted from Rosenberg and Krystal and Valentino and Volkow.47

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No significant drug interactions were reported, suggesting that lemborexant may be safer to use in older patients than the BzRAs.67 However, given the potential risk of next-morning driving impairment, individuals who are more sensitive to the effects of lemborexant should be prescribed a lower dose.10

A third DORA, daridorexant, was approved in January 2022. Daridorexant is FDA approved in doses of 25 mg and 50 mg.68 In the pivotal trials, doses of 25 mg and 50 mg showed a statistically significant improvement in sleep parameters compared to placebo at both months 1 and 3.69 Daridorexant improves both sleep and daytime functioning with a favorable safety profile in adult patients, including the elderly.10,69 In a randomized trial, the 50 mg dose of daridorexant significantly reduced daytime sleepiness at 1 and 3 months (a secondary endpoint) as measured by the sleepiness domain score on the Insomnia Daytime Symptoms and Impacts Questionnaire.70 Daridorexant has the shortest half-life of the available DORAs (8 hours compared to 12 hours for suvorexant and 17–19 hours for lemborexant). Whether that short half-life contributes to reduced risk for impaired next-day functioning is not yet known.

Another agent in the pipeline is seltorexant, which is selective for the OXR2 receptor and is being evaluated for potential use in major depressive disorder and insomnia.10 Seltorexant has a very short half-life (2 to 3 hours). Whether selectivity for one type of orexin receptor offers better efficacy and safety than dual inhibition is yet to be established.
double-blind, placebo-controlled study" of lemborexant in adults aged ≥55 years with insomnia (N = 1,006) showed that lemborexant 5 mg and 10 mg significantly improved sleep latency, sleep efficiency, and wake time to sleep onset compared to placebo. Lemborexant 5 mg did not differ from placebo on cognitive performance testing, and both lemborexant doses caused less postural instability than zolpidem.

DORAs also appear to be a viable option for patients with Alzheimer’s disease who typically demonstrate reduced total sleep time and early awakening. A recent controlled trial found that, compared to placebo, treatment with suvorexant in patients with Alzheimer’s disease resulted in significantly longer sleep times and reduced awakening after sleep onset.22

The appropriate management strategy for sleep disturbance comorbid with COVID-19 remains unclear. Well-controlled randomized double-blind studies with this population have not been conducted with either older or more recently approved drugs to treat insomnia disorder. Use of CBT-I or newer orexin antagonists could be considered and expected to be as effective as with other insomnia comorbid medical disorders.

Regardless of the choice of therapy, patients should be monitored frequently to assess treatment efficacy and identify potential adverse effects.59 If results are unsatisfactory, the drug dosage may need to be adjusted, or a switch to another drug within the class with a different half-life or to a drug with a different mechanism may be needed. Patients should also be counseled not to stop taking prescription sleep aids abruptly, especially benzodiazepines and BzRAs, due to the risk for rebound insomnia or withdrawal symptoms such as anxiety.2,42,59

CONCLUSIONS

Insomnia disorder is not just a problem at night. It has a profound negative effect on daytime functioning and overall health and is often underreported in the primary care setting. Primary care clinicians should proactively screen for evidence of insomnia, especially in patients presenting with medical or psychiatric illnesses. There is evidence that insomnia may contribute to worse outcomes in comorbid conditions and that treating the insomnia can result in improvements in the comorbid illness and quality of life. Effective treatment combines pharmacologic and nonpharmacologic strategies aimed at reducing time to sleep onset, maintaining sleep for an adequate duration, and preventing early awakening, while improving daytime function. A new class of drugs, the DORAs, improves sleep parameters through a novel mechanism that targets the wakefulness system, in contrast to commonly used hypnotics that cause sedation by increasing GABA transmission. A personalized approach to insomnia management should consider whether the patient has difficulty falling or staying asleep, comorbidities, and patient preferences.


16. Rosenberg RP, Krystal AD. Diagnosing and treating insomnia in adults and older adults.

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Prim Care Companion CNS Disord 2023;25(1):22nr03385
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