Choosing Wisely®

An initiative of the ABIM Foundation

American Academy of Sleep Medicine

Five Things Physicians and Patients Should Question

1 Avoid polysomnography in chronic insomnia patients unless symptoms suggest a comorbid sleep disorder.

Chronic insomnia is diagnosed by a clinical evaluation that includes a thorough sleep history along with a medical, substance and psychiatric history. Some instruments can be helpful at the clinical encounter: these include self-administered questionnaires, sleep logs completed at home and symptom checklists. Although polysomnography (PSG) may confirm self-reported symptoms of chronic insomnia, it does not provide additional information necessary for diagnosis of chronic insomnia. However, PSG is indicated in some specific circumstances, for example when sleep apnea or sleep-related movement disorders are suspected, the initial diagnosis is uncertain, behavioral or pharmacologic treatment fails, or sudden arousals occur with violent or injurious behavior.

2 Avoid use of hypnotics as primary therapy for chronic insomnia in adults; instead offer cognitive-behavioral therapy, and reserve medication for adjunctive treatment when necessary.

Cognitive-behavioral therapy (CBT) for chronic insomnia involves a combination of behavioral modification, such as stimulus control and sleep restriction, and cognitive strategies, such as replacement of unrealistic fears about sleep with more positive expectations. In clinical trials, CBT is generally as effective as or more effective than hypnotics at improving sleep, and can be effective over an extended period of time without side-effects associated with hypnotics. Some patients may benefit from a limited course of hypnotics while CBT for chronic insomnia is initiated. Patients who have successfully used hypnotics for extended periods and are reluctant to discontinue their current treatment regimen may be reasonable candidates for continued pharmacologic treatment.

3 Don't prescribe medication to treat childhood insomnia, which usually arises from parent-child interactions and responds to behavioral intervention.

No medications are approved by the US Food and Drug Administration for the treatment of pediatric insomnia. As childhood insomnia usually arises due to parent-child interactions, treatment should involve efforts to improve relevant parent and child behavior, establish better sleep hygiene and manage expectations. Basic environmental, scheduling, sleep practice, and physiological features should be optimized before hypnotic use is considered for children. When necessary, hypnotics should be used short term, with caution and close monitoring for efficacy and side effects. Some children with significant developmental delay or cognitive impairment may not respond to behavioral management and may benefit from judicious use of hypnotics.

4 Don't use polysomnography to diagnose restless legs syndrome, except rarely when the clinical history is ambiguous and documentation of periodic leg movements is necessary.

Restless Legs Syndrome (RLS) is a neurologic disorder that can be diagnosed based on a patient's description of symptoms and additional clinical history. Polysomnography (PSG) generally does not provide additional information necessary to make the diagnosis. If a patient's clinical history for RLS is ambiguous, PSG to assess for periodic leg movements may be useful to help confirm an RLS diagnosis.

5 Don't perform positive airway pressure re-titration studies in asymptomatic, adherent sleep apnea patients with stable weight.

Re-titration of positive airway pressure (PAP) is not indicated for adult obstructive sleep apnea patients with stable weight whose symptoms are well controlled by their current PAP treatment. Follow-up PSG or re-titration is indicated for adult patients who are again symptomatic despite the continued, proper use of PAP, especially if they have gained substantial weight (e.g. 10% of original weight) since the last titration study. A new diagnostic PSG or re-titration may be indicated for patients who have lost substantial weight, to determine whether PAP treatment is still necessary.

Released December 2, 2014

How This List Was Created

The Executive Committee of the American Academy of Sleep Medicine developed 21 candidate recommendations for ways in which medical waste could be minimized while care for patients with sleep disorders is improved. Members of the Executive Committee then voted to assign priorities to each, and the top five were selected. Final wording of the five statements were approved by the full Board of Directors of the American Academy of Sleep Medicine. The Secretary/Treasurer and research staff of the American Academy of Sleep Medicine developed rationale and references for each recommendation. The final statements, explanations and citations were approved by a final vote of the Board of Directors.

The AASM disclosure and conflict of interest policy can be found at aasmnet.org.

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About the AASM

The American Academy of Sleep Medicine (AASM) is the only professional society dedicated exclusively to the medical subspecialty of sleep medicine. As the leading voice in the sleep field, the AASM sets standards and promotes excellence in health care, education and research. Established in 1975 as the Association of Sleep Disorders Centers, the AASM has a combined membership of nearly 11,000 accredited member sleep centers and individual members, including physicians, scientists and other health care professionals.

To learn more about the AASM, visit www.aasmnet.org.

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