Journal of Sleep Disorders & Therapy
ISSN: 2167-0277

Radek, J Sleep Disorders Ther 2013, 2:7
DOI: 10.4172/2167-0277.1000e122

Editorial Open Access

Insomnia Symptom Presentation and Sleep Aids

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In a recent poll conducted by the National Sleep Foundation, forty-eight percent of Americans report symptoms of Insomnia on a nightly basis. With this, females more so than males, report insomnia symptoms [1]. Adults over sixty-six years were two times more likely to report insomnia symptoms as compared to young adult respondents to the National Sleep Foundation survey. An examination of the responses summarized the impact of poor sleep quality reported on healthcare costs; $14 billion directly and $28 billion indirectly costs are incurred from healthcare services/hospital/nursing home and transportation to services/lost wages, respectfully[1]. Overall, the Center for Disease Control, reported that 8.6 million people or 4% or the general population of Adults use sleep medications [2]. Further, researchers have reported the high co-occurrence of sleep and psychiatric prescriptions with depression and physical disability as the most common reasons [3,4].

Insomnia is the most prevalent sleep disturbances reported [1]. The treatment pathway indicates the use of sleep hygiene, then cognitive behavioral therapy then short term medication treatment for Insomnia symptoms of difficulties of both falling asleep and staying asleep. The duration and severity of the Insomnia symptoms dictate the entry point and length of time using treatment techniques on this pathway (i.e., transient = 1-3 days; Short-term=no more than 3 weeks; Chronic=3 nights/week for one month or longer) [2]. It is estimated that nearly 25% of all Americans have transient insomnia symptoms and approximately 10% have chronic symptoms of Insomnia [2].

Non-benzodiazepine Hypnotics are the first line of medication intervention. This category includes Zolpidem, Zaleplon, Eszopiclone and Ramelteon. This group of medications is commonly used and is reported as effective. Possible side effects include: drowsiness, dizziness, fatigue, headache, and diarrhea. The drowsiness side effect has been the most commonly reported and clear warning by the Prescribing Care Provider is be given with the educational explanation of the reasoning for the use of the medication for their care. The benzodiazepine category of medications is in second place of common use because of their potential dependence and side effects profiles. Long acting benzodiazepines Flurazepam, Clonazepam and Quazepam along with medium acting benzodiazepines of triazolam, lorazepam, alprazolam and temazepam are used in Insomnia treatment. Also, antidepressant medications such as trazodone, doxepin, amitriptyline and mirtazapine are commonly used with an hour of sleep designation. Last, the herbal supplements, while economical and available without prescription have not been empirically vetted for clinical use. Valarian root, Kava and Tryptophan have been popular for use to self-treat Insomnia. Melatonin has had some empirical study and when monitored and prescribed correctly, is useful [5].

Responsible examination of the prevalence figures reported suggests an unmet need. Further, the treatment pathways do not suggest an association between treatment and symptom presentation. Sensible approaches suggest the use of self-help and cognitive behavioral methods for transient, short-term and moderate levels of chronic Insomnia. However, data indicating that this is the case is unknown. Such figures would provide both valuable information about the utility of the treatment as well as the specific symptom/treatment need that is to be addressed.

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Received October 06, 2013; **Accepted** October 10, 2013; **Published** October 15, 2013

Citation: Radek KS (2013) Insomnia Symptom Presentation and Sleep Aids. J Sleep Disorders Ther 2: e122. doi:10.4172/2167-0277.1000e122