Sleep Article NYT -3/21/14

http://www.nytimes.com/2014/03/23/magazine/how-did-sleep-become-so-nightmarish.html?partner=rss&emc=rss&_r=0
- E. Fairbanks

In the last year or two, an obsessive fixation on getting sleep — not just any sleep, but *good* sleep — has crept into our public consciousness. In the early 2000s, the small number of New York Times articles that referred to sleep mostly instructed new mothers on how to get their babies to nod off.

Not so in 2013 and early '14, when there were articles on how insomnia makes you fat, sleep seminars, exercising for better sleep, napping for success, sleep as depression cure and an array of new, supposedly soporific devices and products, including dozens of sleep-monitoring smartphone apps, alarm clocks that won't wake you during REM stages, sleep-inducing chocolates, candles that crackle like fireplaces, technologically enhanced sleep masks that "switch off your mind," fitness bracelets that give you a sleep score ("I really want to do well in terms of sleep, I want to maintain my streak!" one user wrote) and a $12,000 sleep-enhancing mattress containing soothing seaweed and coconut husks.

There were also books, like "Effortless Sleep" and "Prime Your Mind for Sleep" and "The Secret World of Sleep"; radio specials; a Harper's symposium; and major surveys of sleep science in The Atlantic and The New Yorker. And in keeping with the times, there are endless listicles: 10 Foods to Avoid for Better Sleep, 10 Signs You May Be Sleep Deprived, 12 Simple Steps to Improve Your Sleep, the purposes of five-, 20-, 45-, versus 60-minute naps. There's even a website called Sleepyti.me, which helps users calculate an optimal bedtime or wake-up time, to avoid interrupting their 90-minute sleep cycles.

It would be easy to dismiss all this as a byproduct of aging baby boomers' collective obsession with health news and the media's willingness to indulge them, were it not for the fact that **sleep in the U.S. has become a $32 billion business, according to the health-marketing analytics firm IMS Health.** This includes the hugely lucrative Ambien-type drugs, sleep clinics and those candles that crackle like fireplaces (available from DayNa Decker for up to $75 apiece).

If this onslaught of coverage has an underlying ideology, it is this: First, that sleep is absolutely critical for high performance; and second, that you can improve your sleep — but only with intense effort.

… and –

More on Sleeping Pills and Older Adults

By PAULA SPAN JULY 30, 2014 5:00 AM
http://newoldage.blogs.nytimes.com/2014/07/30/more-on-sleeping-pills-and-the-elderly/

Call me nuts, but I want to talk more about sleeping pill use.

Hold your fire for a few paragraphs, please.

Just a week after I posted here about medical efforts to help wean older patients off sleeping pills — causing a flurry of comments, many taking exception to the whole idea as condescending or dismissive of the miseries of insomnia — researchers at the Centers for Disease Control and Prevention and Johns Hopkins published findings that reinforce concerns about these drugs.

I say "reinforce" because geriatricians and other physicians have fretted for years about the use of sedative-hypnotic medications, including benzodiazepines (like Ativan, Klonopin, Xanax and Valium) and the related "Z-drugs" (like Ambien) for treating insomnia.

"I'm not comfortable writing a prescription for these medications," said Dr. Cara Tannenbaum, the geriatrician at the University of Montreal who led the weaning study. "I haven't prescribed a sedative-hypnotic in 15 years."

In 2013, the American Geriatrics Society put sedative-hypnotics on its first Choosing Wisely campaign list of "Five Things Physicians and Patients Should Question," citing heightened fall and fracture risks and automobile accidents in older patients who took them.

Now the C.D.C. has reported that a high number of emergency room visits are associated with psychiatric medications in general, and zolpidem — Ambien — in particular. They're implicated in 90,000 adult E.R. visits annually because of adverse reactions, the study found; more than 19 percent of those visits result in hospital admissions.

Among those taking sedatives and anxiety-reducing drugs, "a lot of visits were because people were too sleepy or hard to arouse, or confused," said the lead author, Dr. Lee Hampton, a medical officer at the C.D.C. "And there were also a lot of falls."

The data also answer questions readers here raised about whether older adults were being singled out. Did doctors (or did I) consider them unable to make rational drug decisions? "Is it that older people are less important, full stop?" reader L. from New York City demanded.

The C.D.C. looked at visits by drug and by age. Older patients, it turns out, did not show up more

often in emergency rooms because of adverse reactions to sedatives and antianxiety drugs. People ages 19 to 44 have the highest number of visits in proportion to prescriptions for those medicines.

But the consequences were worse for older people. About a third of those older than 65 (32 percent) who went to E.R.s with adverse responses to sedatives were hospitalized, compared with about 13 percent of those 19 to 44 (and 27.2 percent of those 45 to 64).

The data also showed that Ambien, the use of which has soared in recent years, accounted for one in five E.R. visits among those older than 65, more than any other medication.

"I didn't expect a single drug to stand out that much," Dr. Hampton said. That may be because Medicare didn't cover benzodiazepines but did cover zolpidem from the inception of Part D in 2003 until last year, when the policy changed.

The Food and Drug Administration, concerned about "next-morning impairment" from Ambien, last year halved the recommended dose for women, to 5 milligrams from 10 milligrams, and to 6.25 milligrams from 12.5 milligrams for extended-release versions like Ambien CR.

The other particular concern for older people is falls, a leading cause of death and disability. A 2010 analysis of falls says 22 percent of "community dwelling" Medicare beneficiaries older than 65 (excluding nursing home residents) fell in a year. The C.D.C. estimates that a third of older adults fall annually. Twenty to 30 percent of those falls result in injuries that require medical attention.

"There's a constellation of risks that contribute to falls, and medications are clearly part of it," said Dr. Jerry H. Gurwitz, a geriatrician at the University of Massachusetts Medical School who has studied drug safety in older people. "And high on the list of those medications related to falls and fall-related injuries are sedative-hypnotics."

On to some other questions readers raised.

First, for those who objected to collectively referring to benzo and non-benzo sedatives and "not honoring the differences" between them, as Kathy from Hawaii said.

The Z-drugs are approved only as sleep aids. Benzodiazepines have other uses, like treating panic disorders or seizures; some people may be taking them throughout the day, not only at bedtime.

But as sleeping pills, "I wouldn't consider them distinct at all," Dr. Gurwitz said of the benzos and Z-drugs. "When you're talking about falls and fractures, it's the same effect....The risks are the same." Dr. Tannenbaum concurred.

Can patients gradually wean themselves from sedatives, using a chart like the one in the brochure Dr. Tannenbaum and colleagues sent patients? In their study, which looked only at benzodiazepine use, the brochure urged recipients to consult health care professionals before embarking on detoxification.

Of the group that attempted to gradually stop the drug, more than half succeeded, and another 22 percent reduced their dosage. Among those who didn't make the attempt, the greatest reason — get this — was discouragement from their physicians or pharmacists.

"Often in medicine, the quickest and easiest thing doctors can do is write a prescription," Dr.

Hampton said. “Things that take longer and require more conversation are used less.”

Yet those remedies — changing sleep habits, seeking cognitive behavioral therapy — have been found to be effective against insomnia. The physicians I consulted urged patients to seek a comprehensive evaluation, possibly including sleep studies, and then try nonpharmacological remedies first, turning to sleeping pills only after exhausting the alternatives. JAMA published a patient guide to treating insomnia last year.

A final caveat: Yes, older people are different. A 65-year-old speedwalker has a different risk profile from an 85-year-old with poor vision or osteoporosis.

But the physicians I consulted couldn’t countenance extended sedative use, even for the former.