The Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea

Sidebar 1. Clinical Features of OSA and Chronic Insomnia Disorder

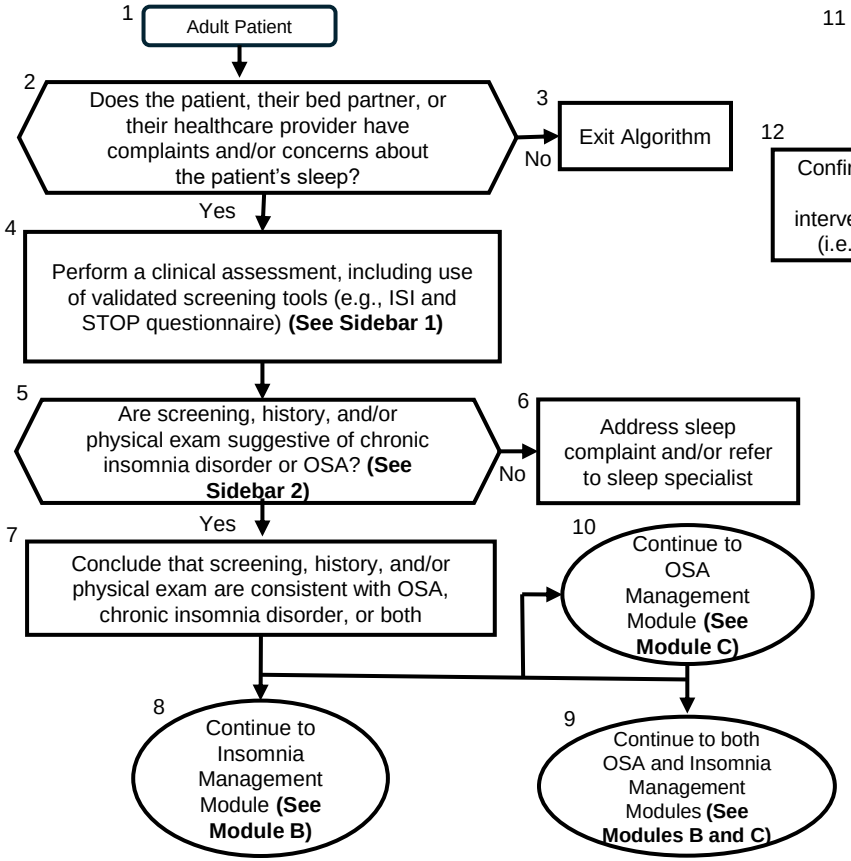
OSA (**See Appendix F**) in the full CPG for detailed ICSD-3-TR Diagnostic Criteria):

- Sleepiness
- Loud, bothersome snoring
- Witnessed apneas
- Nightly gasping/choking
- Obesity (BMI > 30 kg/m²)
- Treatment resistant hypertension

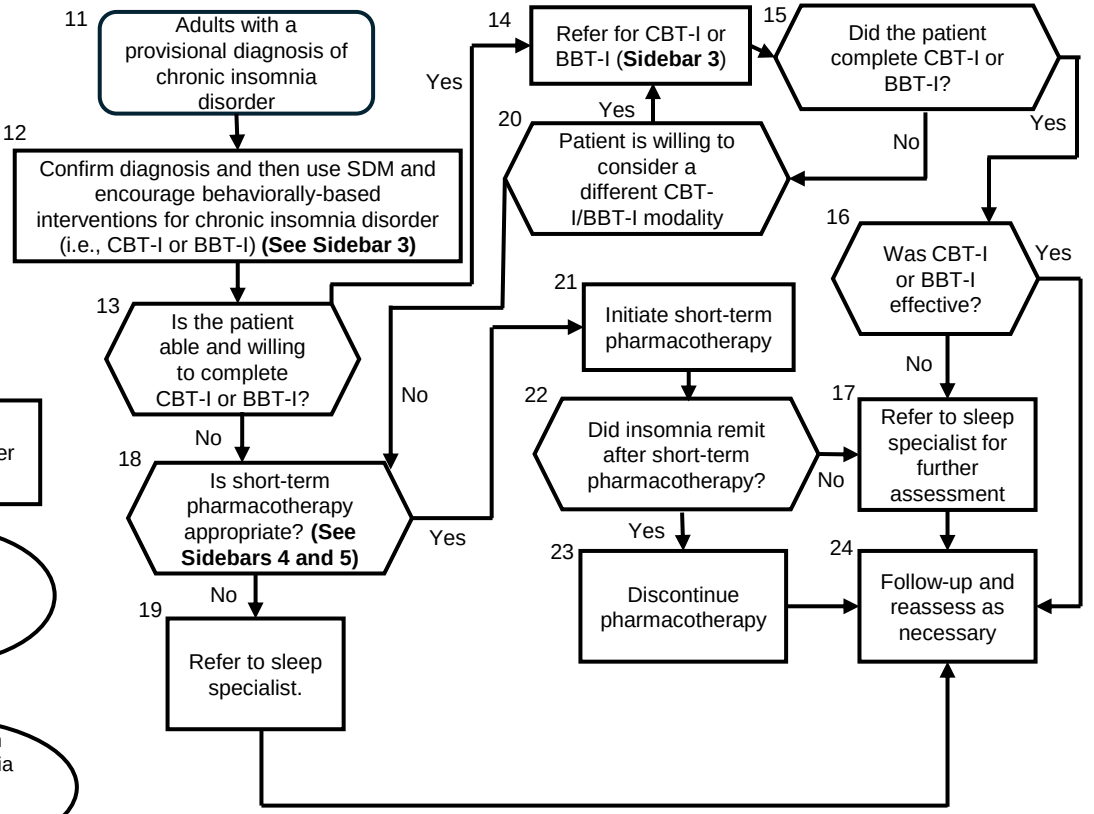
Chronic Insomnia Disorder (**See Appendix F**) in the full CPG for detailed ICSD-3 TR Diagnostic Criteria):

- Difficulty initiating sleep, difficulty maintaining sleep, or early-morning awakenings
- The sleep disturbance causes clinically significant distress or impairment in important areas of functioning
- The sleep difficulty occurs at least 3 nights per week
- The sleep difficulty has been present for at least 3 months

Module A: Screening for Sleep Disorders



Module B: Management of Chronic Insomnia Disorder



Sidebar 3. Components of Sleep Education, Overview of Behavioral Interventions, and Contraindications

Patient education and Shared Decision Making (SDM):

- General information on chronic insomnia disorder
- Education about available behavioral and psychological treatment options and available modalities
- Discussion of risks, benefits, preferences and alternatives to treatment options

Components of behavioral and psychological treatment (CBT - I and BBT - I):

- Sleep Restriction Therapy: Limits time in bed to actual sleep duration to increase sleep drive; time in bed extended across treatment
- Stimulus Control: Strengthens bed as a cue for sleep rather than wakefulness
- Arousal reduction techniques: introduction of calming bedtime routine, relaxation techniques to reduce physiological arousal such as diaphragmatic breathing, body scan or grounding exercises
- Sleep Hygiene Education (optional): Planned changes in target behaviors and environmental factors that negatively impact sleep including light/noise exposure, eating/drinking near bedtime and at night, caffeine/nicotine/alcohol use **(See Recommendation 7)**
- Cognitive Restructuring (CBT-I only): Addresses cognitive arousal (busy or racing mind) and inaccurate sleep-related thoughts by challenging unhelpful thoughts and beliefs about sleep

Conditions requiring adaptations or delay of CBT-I/BBT-I:

- Medically unstable (delay)
- Active alcohol or drug use disorder (delay)
- Excessive daytime sleepiness (adapt/delay)
- Nighttime fall risk or inability to transfer in/out of bed (adapt)
- Engaged in exposure - based PTSD treatment (delay)
- Uncontrolled seizure disorder (delay)
- Bipolar disorder (adapt)
- Current acute mental health symptoms (delay)
- Pregnancy and postpartum insomnia (adapt)

a In cases where the patient requires immediate intervention, providers may exercise clinical judgment to determine if pharmacotherapy may be safely initiated.

b CBT-I and BBT-I are not equivalent, and there is more robust evidence for CBT-I. While this algorithm uses CBT-I and BBT-I similarly, providers referring patients for these treatments should consider availability of the treatment, the complexity and comorbidities of the patient, and the training of the provider.

Sidebar 4. Pharmacotherapy Considerations for Chronic Insomnia Disorder

Before starting short-term pharmacotherapy, review sleep history, reproductive status, and evaluate contraindications for pharmacotherapy:

- Evaluate for other sleep disorders (e.g., apnea, NREM parasomnias), daytime sleepiness, respiratory impairment, cognitive impairment, substance abuse history, and medication interactions

Encourage non-pharmacologic approaches (e.g., CBT-I or BBT-I) When short-term pharmacotherapy is appropriate, consider the following agents and discuss deprescribing plan:

- Low-dose doxepin; or
- Dual orexin receptor antagonists; or
- Non-benzodiazepine benzodiazepine receptor agonists (all patients offered treatment with a non-benzodiazepine benzodiazepine receptor agonist should be specifically counseled regarding the risk of complex sleep-related behaviors) **(See Recommendation 9)**

The use of antipsychotic agents, benzodiazepines, diphenhydramine, and trazodone are NOT suggested for treatment of chronic insomnia disorder (See Recommendation 10).

Consider sleep specialist referral in patients who do not respond to pharmacotherapy.

Sidebar 6. Risk of Obstructive Sleep Apnea (OSA)

Consider using STOP questionnaire for risk stratification:

1. Snoring loudly
2. Tired, fatigue, sleepy in daytime
3. Observed to stop breathing
4. Hypertension

High risk of OSA: greater than ≥2 items are answered "yes"

Low risk of OSA: less than <2 items are answered "yes"

STOP questionnaire should not replace clinical judgment; clinical assessment should include BMI >30 kg/m2, age >50, menopausal status, neck circumference, family history, and crowded oropharynx

Sidebar 8. AHI 5 to <15 on HSAT

1. Treatment for OSA is recommended for symptomatic patients with an AHI or REI of 5 to <15 events per hour
2. For patients who will have limitations to their work and/or lifestyle, definitive testing with an in-lab PSG is recommended
3. For the general population without such restrictions, an AHI of 5 to <15 events per hour on HSAT should be treated as OSA

Sidebar 7. Appropriateness for HSAT

In-laboratory polysomnography is preferred over HSAT in the following groups:

1. Significant comorbid conditions

Advanced heart failure

- Established or suspected hypoventilation/hypoxic conditions
- Neuromuscular dysfunction
- Advanced primary neurological conditions
- Medication related (opioid, sedative and hypnotics)
- Advanced respiratory comorbidities.

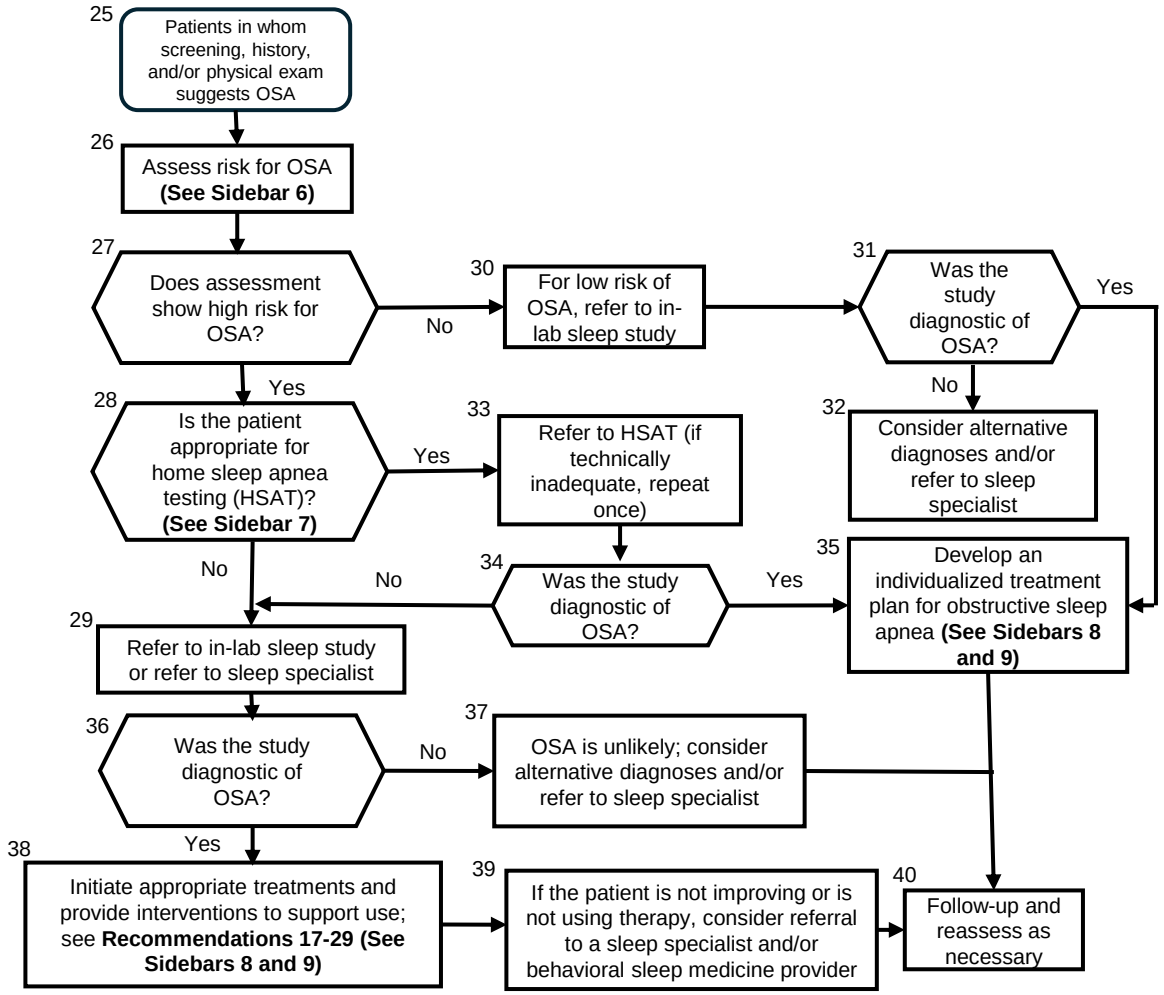
Stroke

2. Patients with significant sleep disruption (e.g. due to chronic insomnia disorder)
3. Physical, sensory and cognitive impairment
4. Chain of custody concerns
5. Low pretest probability for obstructive sleep apnea

Sidebar 9. Treatment of Obstructive Sleep Apnea (OSA)

1. Prescribe PAP as first line therapy for patient with severe OSA (i.e., AHI >30 events per hour)
2. Prescribe PAP or MAD for other OSA severity (i.e., AHI 5 to <30 events per hour), based on clinical evaluation, comorbidities, and patient preference.
3. Offer educational, behavioral therapy, and supportive interventions to improve PAP adoption and use
   - Consider a two-week course of eszopiclone to improve PAP adoption
   - Consider referral to behavioral sleep medicine provider to enhance PAP adoption and use
4. Encourage weight loss and a comprehensive lifestyle intervention program in patients with OSA who are overweight or obese.
5. Refer patients for follow up to a sleep medicine specialist:
   - Who do not adopt/use PAP and/or MAD therapy
   - With persistent symptoms despite adequate therapy

Module C: Management of Obstructive Sleep Apnea



Abbreviations: AHI: apnea - hypopnea index; BMI: body mass index; BBT - I: brief behavioral therapy for insomnia; CBT - I: cognitive behavioral therapy for insomnia; CIH: complementary and integrative health; CNS: central nervous system; GOLD: Global Initiative for Chronic Obstructive Lung Disease; HSAT: home sleep apnea testing; ICSD - 3: International Classification of Sleep Disorders, 3rd edition; ISI: Insomnia Severity Index; kg/m2: kilograms per meter squared; MAD: mandibular advancement device; NREM: non - rapid eye movement; OSA: obstructive sleep apnea; PAP: positive airway pressure; PSG: polysomnogram; PTSD: posttraumatic stress disorder; REI: respiratory event index; REM: rapid eye movement; SDM: shared decision making; STOP: Snoring, Tiredness, Observed apnea, and high blood Pressure

Recommendations can be accessed in the full guideline. Available at: https://www.healthquality.va.gov/.