Insomnia

Assessment, referral criteria, sleep hygiene, and treatm



Background

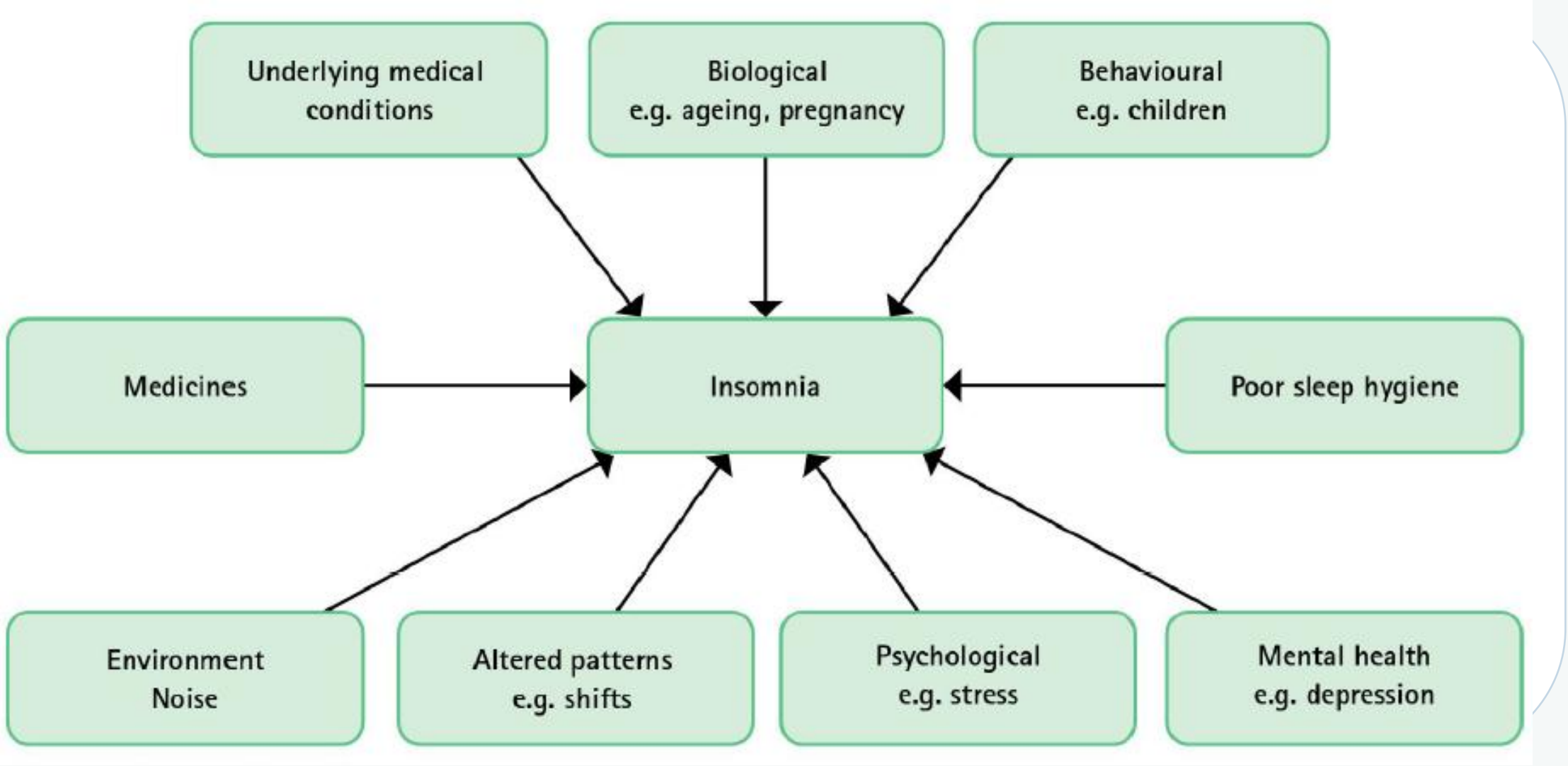
Sleep needs vary and usually decrease with age. People over 80 commonly sleep less than 6 h/day (1).

Features: difficulty falling asleep, staying asleep, early waking, or poor-quality/nonrestorative sleep (2).

Lecture classification: transient (days), short term (up to 4 weeks), chronic (>4 weeks). Refer all chronic cases (3).

Short-term insomnia often follows acute stress: exams, bereavement, job loss, marriage or moving home (1).

Causes of insomnia



Patient assessment: Age and duration

Older adults usually sleep less deeply and for fewer hours, with more night waking. They may still seek sleep medication (3).

Daytime naps reduce night-time sleep needs and may be mistaken for insomnia (1).

Refer patients under 16 years (3).

Refer insomnia lasting >4 weeks (3).



When to refer

Referral criteria
❑ Suspected depression or a regular pattern of anxiety (3).
❑ Chronic problem (longer than 4 weeks' duration) (3).
❑ Children under 16 years (3).
❑ Snoring, apnea, restless legs (3).
❑ Associated physical conditions (3).
❑ Suspected alcohol dependency (3).
❑ If prescribed medication is suspected to be the cause (3).
❑ Taking prescribed medication for mental health problem (3).

Recent travel and symptoms

Time-zone changes disturb sleep. Normal patterns may take several days to return (1).

Distinguish the sleep pattern:

1-Difficulty falling asleep: often worry/anxiety, e.g. before an exam. Refer if this becomes a regular pattern (3).

2-Early waking with unhappiness, hopelessness or worthlessness may indicate depression. Refer (3).

3-Night waking/poor-quality sleep: consider snoring, sleep apnoea or restless legs (3).

Consider heart disease, COPD/asthma, neurological disease (Alzheimer's/Parkinson's), hyperthyroidism, joint/muscle or chronic pain, and nocturia (3). Contact the prescriber to discuss medication changes when these may help (1).

Medical problems and treatment timescale

Some drug can cause or contribute to insomnia (**Table 6-2**) [1].
There should be an improvement within days; **refer after 1 week if the problem is not resolved** [3].

Table 6-2: Medication that may cause insomnia [1]

Medication	Comments
Stimulants	Caffeine, theophylline, sympathomimetics amines (e.g., pseudoephedrine), monoamine oxidase inhibitor, especially in early treatment
Antiepileptics	Carbamazepine, phenytoin
Alcohol	Low to moderate amounts can promote sleep but when taken in excess or over a long period can disturb sleep
Beta blockers	Can cause nightmares, especially propranolol; limit by swapping to a beta blocker that does not readily cross the blood–brain barrier
Selective serotonin reuptake inhibitors	Especially fluoxetine
Calcium channel blockers	Can cause somnolence
Diuretics	Ensure that doses should not be taken after midday to stop the need to urinate at night
Cholinesterase inhibitors	Donepezil (abnormal dreams and nightmares) Galantamine
Alpha-blockers	

Management: Sleep hygiene

Key steps to good sleep hygiene

Keep fixed daily bedtimes and waking times (3).

Keep the bedroom comfortable, quiet and dark (3).

Relax before bed (3).

Try a warm bath (3).



Management: Sleep hygiene

Use the bedroom only for sleep (3).

Avoid daytime naps, or limit them to 20–30 min (3, 4).

Avoid caffeine after midday. Avoid nicotine, alcohol and large meals within 2 h of bed. Do not use alcohol as a sleep aid (3).

Exercise earlier in the day, avoiding the 4 h before bed (3).

Avoid TV, phones, tablets and computers for 2 h before bed (3).

Go to bed when sleepy (3).

If unable to sleep, get up and return when sleepy (1).



Pharmacological treatment

Antihistamine: diphenhydramine and promethazine: can be recommended for adults and children over 16 years in UK (1) (older than 12 years of age in USA) (4).

1-They reduce sleep latency (time taken to fall asleep) and also reduce nocturnal waking (3).

2-Diphenhydramine should be taken 20 minutes before bedtime (1). The dose is 50 mg (1, 3).

3-Promethazine: 20 or 25 mg taken an hour before bedtime (1).

Tolerance to their effects can develop, and they should not be used for longer than 7–10 consecutive nights (3).

4-Diphenhydramine and promethazine should not be recommended for pregnant or breastfeeding women (3).

5-Summaries of practical points are listed in (Table 6-4) (1).

Melatonin

1-Melatonin is an endogenous hormone produced by the body's pineal gland during darkness and is thought to regulate sleep. It is widely used in the United States to treat insomnia, where it is regarded as a nutritional supplement rather than a medicine (3).

Melatonin is advocated for sleep disturbance, particularly associated with jet lag (1).

2-The timing of the dose is critical. It has to be taken close to the target bedtime at destination (1) (30–60 min before bedtime) (5). Doses between 0.5 mg and 5.0 mg appear equally effective (1).

References – Insomnia

1-Paul Rutter. Community Pharmacy. Symptoms, Diagnosis and Treatment. 6th edition. 2026.

2-W. Steven Pray. Insomnia and Its Treatment with Nonprescription Products. US Pharm. 2009; 34(4)(OTC suppl):8-11.

3-Alison Blenkinsopp, Paul Paxton and John Blenkinsopp. Symptoms in the pharmacy. A guide to the managements of common illness. 10th edition. 2025.

4-American pharmacists association. Handbook of Non-prescription drugs: An Interactive Approach to Self-Care. 20th edition. 2020.

5-Canadian pharmacists association (CPhA). CTMA: Compendium of Therapeutics for Minor Ailments. 2018.