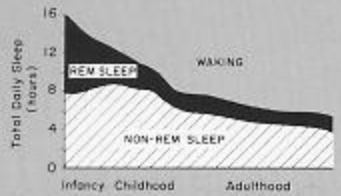
YOUR GENTLE TOUCH may be all she needs at bedtime

For many nursing home residents, bedtime is a lonely time. A moment or two with the nurse or aide can be reassuring, even if a sleeping pill is not given. Personal contact and a simple program of sleep-promoting routines (see other side) may help bring on rest without the risk of drug "hangover" or other adverse effects.

LONGER LIFE, LESS SLEEP. . .



As the human being moves from infancy to old age, the total amount of time spent in sleep drops from 16 hours to less than six.[1]

As people age, their bodies seem to require fewer hours of sleep. Studies indicate that although young adults sleep an average of about eight hours a night, the average for the very old is less than six hours per night.[1] Brief awakenings during the night are common and normal for many elderly people.[2,3]

Elderly patients are more likely than younger patients to experience complications from sleeping medications.[4] Some commonly used sleep medications can cause memory loss, confusion, falls, daytime drowsiness, incontinence, and unsteadiness.[5] Patients with any of these side-effects are less safe, require more supervision, and are less able to care for themselves.

Surprisingly, there is very little good evidence that the commonly used benzodiazepine sleep medications continue to work in many patients beyond several weeks of use.[6]

ARE THERE ANY ALTERNATIVES?

A simple program of sleep-promoting routines can help:

- **Avoid caffeine after 2 pm** (coffee, tea, colas – except decaffinated).
- **Increase exercise and mobility as much as possible.**
- **Discourage daytime napping.** It may be a side-effect of the sleep medication, and only makes matters worse.[7]
- **Keep bedtimes regular and sensible.** An 85-year-old who needs only 6 hours of sleep and is put to bed at 9 pm will be up by 3 am!
- **Help elderly residents to have realistic expectations of sleep.**
- An analgesic at bedtime, such as an aspirin product or acetaminophen (Tylenol) will help patients with chronic pain to fall asleep. It will also comfort those who feel dependent on the idea of a pill at bedtime.
- Take the time for a brief "tucking in" even if no medication is dispensed. **It's a major active ingredient of any sleep program.**

In many cases, a careful program of this sort will enable the elderly patient to sleep well – and safely. Those who have developed a habituation to their medications may require a gradual taper of their drug, reducing the dose by half each week for two or three weeks.

IF A DRUG MUST BE USED OCCASIONALLY: PRESCRIBE IT ONLY WHEN NEEDED . . . NOT EVERY NIGHT.[3]

DRUG	HALF-LIFE (hours)	ANTI-CHOLINERGIC PROBLEMS	GERIATRIC DOSE	COMMENT
oxazepam (Serax)	SHORT 4-8	NONE	10 mg	ok for occasional use
lorazepam (Ativan)	MODERATE 10-20	NONE	0.5-2 mg	ok for occasional use
chloral hydrate	SHORT 4-6	NONE	250-500 mg	ok, but g.i. irritation can occur
temazepam (Restoril)	MODERATE 8-20	NONE	15 mg	ok for occasional use
triazolam (Halcion)	SHORT 2-4	NONE	0.125 mg	elderly may experience hallucinations, amnesia
diphenhydramine (Benadryl)	MODERATE 4-8	**SEVERE**	not recommended	can cause frequent anti-cholinergic Sx
flurazepam (Dalmane)	**VERY LONG** 50-100	NONE	not recommended	duration of effect too long

Shorter-acting benzodiazepines such as oxazepam (Serax) are preferable to longer-acting drugs. It is advisable to cut standard doses in half for older patients.[1] Diphenhydramine (Benadryl) can cause anticholinergic side-effects not found with benzodiazepines and is not recommended.[1]

Anti-psychotic medications such a thioridazine (Mellaril) and haloperidol (Haldol) should not be used merely to induce sleep, since they can cause major side-effects and better choices are available.

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