

TITLE 1: “Word from the Doctors”

TITLE 2: “Polytherapy and Rotating Therapy”

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- Better treatment
- Non-pharmaceutical treatment
- Pharmaceutical treatment

ABSTRACT OVERVIEW: Two doctors present differing viewpoints on polytherapy and rotating therapy.

COPY OF ARTICLE:

[Editor’s Note: In the last issue of NightWalkers, we published an article by Christopher Earley, MD, PhD, on this subject. Comments of other members of our Medical Advisory Board follow.]

I also use rotating and polytherapy for patients with RLS. I almost always alternate Sinemet (carbidopa/levodopa) with something else (usually gabapentin) to reduce the chances of the patient developing rebound, augmentation, or both. In this situation, I use a week of one medication, and a week of the other. Many patients get “some” but not total relief with initial therapy (usually a dopamine agonist). In those patients, I will add another medication, usually from the anticonvulsant group. I do not know if it is important to get to the “maximum” dose of the initial medication or not before adding a second drug. I think that rebound and augmentation are more likely to occur at higher doses of the dopamine agonists. Adding a second drug early on may have some “dopamine-sparing” effects.

I also have some RLS patients who get relief of RLS symptoms with medication but still find themselves having difficulty falling asleep or staying asleep. I suspect that these individuals have “learned” (or psychophysiologic) insomnia. For all people (not just those with RLS) anything that disturbs sleep (such as pain, loss of a loved one, hospitalization) can lead to distress and anxiety about the ability to sleep. Attention becomes focused on worrying about whether or not they will be able to sleep, and this worry and anxiety can actually prevent sleep. In this situation, short-term use of sleeping pills, excellent sleep hygiene, and perhaps sleep restriction may be of benefit.

Sleep hygiene means going to bed and getting up at the same time; caffeine reduction or (even better) elimination; a quiet, cool, dark sleeping area; no working or worrying in bed; no nicotine or alcohol; no napping; and regular exercise. Restricting the time spent in bed to the time actually spent sleeping is also important. For example, if an individual has learned that he or she can’t fall asleep until 1 AM, it might be helpful to wait to go to bed until that time but to avoid sleeping later and later in the morning or napping. Sometimes rearranging the bedroom or even moving to a different bedroom can get the individual out of the environment where he or she has learned that sleeping is hard.

Benzodiazepines such as clonazepam are acceptable treatment for RLS and are also sleep-promoting. Adding them to the rotation may also help the sleepless RLS sufferer. I think the main thing is to keep trying!

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The treatment of the RLS seems to be quite difficult in severe cases. The mild or moderate cases are not as difficult to treat in my opinion. If L-dopa fails, dopamine agonists, opioids or a combination of both can be a reasonable and long-term treatment.

In my experience, primary-care physicians are not able to provide patients with this kind of therapy in most cases, especially when they should combine various agents. Neurologists, too, often refuse to do combination treatment. These patients therefore are mainly restricted to specialized sleep centers or movement disorder centers. I myself do not have any experience with rotating therapy, but I find the concept itself very difficult to practice, even though I am experienced in treating RLS. It would mean seeing patients very often, almost weekly or twice a week for a long time, until the rotation is established. For primary care physicians or neurologists who are not experienced in treating RLS, I would not recommend this treatment at all.

Furthermore, I think we should first do some studies and see if rotating therapy works or if we get more placebo effects than the real effects of rotating treatment. Having no combination treatment studies, we will get into trouble recommending rotation therapy. In my RLS population there are some severe cases, but it would not justify recommending rotation therapy which I have never tried for RLS in general.

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