

**TITLE 1:** “Ask the Doctor”

**TITLE 2:**

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**AUTHOR/S:** Bruce Ehrenberg, M.D., Wayne A. Hening, M.D., Ph.D. & Claudia Trenkwalder, M.D.

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- Sleep
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**ABSTRACT OVERVIEW:** Three different doctors tackle a question from a reader about whether the drug he is taking, primarily Mirapex, is safe for him to use while piloting an aircraft.

**COPY OF ARTICLE:**

**Ask the Doctor**

*Q. I was diagnosed with RLS about a year ago, and initially given clonazepam (three 1 mg tablets every night). This worked for awhile, but the medication made me feel absolutely awful during the day. Recently, a specialist prescribed Mirapex, and began to wean me off the clonazepam. I'm now taking only one tablet of 1 mg at night. It's not an easy drug to stop taking!*



*My question is this: I hold an airline pilot's license, and since all this started I've been told not to fly. Do you know whether taking Mirapex also affects my ability to be licensed as a professional pilot? No one has given me any indication as to whether I will always have to take medication for my RLS, or whether it will “go away” just as strangely as it suddenly appeared. Any help you can give me would be greatly appreciated, as this condition is “obviously” affecting my life in a serious way.*

*Three physicians have provided input in answering this question.*

**A.** Clonazepam can be very difficult to withdraw from. Yet even when used regularly, it does not cover all the symptoms as well the dopamine agonists, such as pramipexole or ropinirole. I see no impediment to returning to regular flights once you are sleeping well and feeling well rested. In the interim, I suspect it is the destroyed sleep pattern that is holding you back the most. My best way of dealing with this is to stay with the lowdose of pramipexole, taking half the dose at 5pm and the other half at bedtime (10-11pm, preferably), and adding gabapentin at bedtime in a very low dose to ease the transition into sleep. However, since this drug was initially released as an anti-epileptic drug and that is still its primary indication, you may well not be allowed to take it, especially as an “off-label” treatment for insomnia. Another drug to try for sleep is the anti-hypertensive clonidine. Not as strongly sedating as clonazepam, its side effects are easier to deal with. Because it works by modulating the brain-stem's autonomic centers, it may provide an extra margin of safety against the more dangerous side effects known to occur during withdrawal from clonazepam. I am hoping that pramipexole is allowed for pilots, since its official indication is for Parkinson's disease. Use of this drug should not by itself be a cause for grounding someone, since patients with RLS (if not in the advanced stages) are normal when taking adequate medication, and the only issue is the sleepiness problem, which is thought to be caused more by the poor sleep patterns from the illness than from the medication, and is best dealt with by getting optimal sleep. There is some very slow progression of RLS with age but not in all patients and not equally in those who do progress.

*Bruce Ehrenberg, M.D.*

*Tufts University, Medford, MA*

A. I suggest that you check with the licensing authorities. It would be important to determine which drugs are proscribed or whether it is the plausible or demonstrated effects that are proscribed. Having this information would allow the patient's physician to tailor his treatment, since a wide variety of drugs are useful in RLS, and some are probably not proscribed. Of the drugs Dr. Ehrenberg mentioned, I think clonidine is the least likely to be proscribed — it is a standard antihypertensive. However, our study in the 1990s (Wagner et al) showed that it mostly helped sleep-onset insomnia, and had little impact on sleep. Most of the other drugs, including pramipexole, gabapentin, opioids, and sedatives may be excluded because of their sedative effects. There is some suggestion that beta blockers may help. Tramadol might slip under the net, since it is mostly categorized as a serotonergic drug. As to whether RLS can go away, I think there is some evidence that this may occur. In the Walters/Wilson study (1996), 15% of patients reported remissions lasting more than a month. Clinically, we have seen patients who do get better. In the Hopkins family study, a number of individuals reported their symptoms stable or decreasing with age, or even going away completely. However, once patients are on medication, they are not likely to stop, since stopping usually means a transient increase in symptoms, and the only way to see if the condition has improved is to decrease or stop medications.

*Wayne A. Hening, M.D., Ph.D.*

*Baltimore, MD*

A. I once treated a pilot who had the same problem, and we tried figure out an appropriate regimen for him. The health administration of pilots told us that the pilot would not be allowed to take any drug that might affect his alertness during the flight. Therefore we elected to treat him with L-dopa, but only on the return flight, not on his flight on duty. We had to prove that the half-life of the drug was short enough not to affect his next flight. I do not think that any dopamine agonist can be proven to be eliminated as quickly, and clonazepam not at all. I got the impression that the pilot health administration was quite strict in their rules and unwilling to compromise. Gabapentin could be another solution, but if anything pertaining to alertness is written in the patient's record, the administration will not allow it.

*Claudia Trenkwalder, M.D.*

*University of Göttingen, Germany*