

key points

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The prevalence of sleep complaints in adults in a primary care setting is > 10%. The most frequently seen condition by far is that of primary insomnia, which affects 10% of adults on a chronic basis. In contrast to primary insomnia, in which most patients report tiredness and fatigue during the day but are unable to sleep during the day either, the second most frequent sleep disorder encountered, obstructive sleep apnoea, is typified by excessive daytime sleepiness.

Sleepiness is defined as the inability to maintain wakefulness or alertness during daytime wake periods. Patients with primary insomnia or fatigue syndromes typically will score low on the Epworth Sleepiness Scale (ESS < 3) whereas those with organic sleep pathologies or sleep restriction will score higher. A score > 10 is seen as 'pathological', with a mean ESS in the population of 5-6.

The most common cause of sleepiness in the adult population is that of behaviourally induced insufficient sleep syndrome, affecting up to one third of adults. This can be severe enough to mimic a condition such as narcolepsy both clinically and on diagnostic testing. Anyone with a sleep opportunity of less than seven hours per night, or undertaking shift work, should be given sleep hygiene advice to optimise sleep duration, before other potential causes are investigated, unless there are clear pointers.

Restless legs syndrome affects 5-15% of the adult population as well as some children. The syndrome is characterised by the urge to move the legs, or other body parts (such as the arms, trunk, face and even genitals) usually accompanied by a range of unpleasant sensations. These features are typically worse in the evening or night, are transiently or partially relieved by movement, and are worsened by immobility. In addition to the motor restlessness, 80-90% of sufferers also experience frank leg movements, which usually arise in sleep but can also occur in wakefulness. These leg movements are involuntary, and typically involve periodic flexion of the hip and knee, dorsiflexion of the foot and extension of the hallux. These movements may be unilateral, alternating or bilateral, and occur at intervals of between 5 and 90 seconds. The duration of individual leg movements is longer than in myoclonus, of the order of 0.5-5 seconds.

Narcolepsy has a prevalence of 1 in 3,000. Peak onset is in the mid-teens and mid-thirties, although it can occur at any age, and the diagnosis is lifelong. The major and only mandatory diagnostic feature is of excessive daytime sleepiness, which can manifest as persistent sleepiness, or discrete sleep attacks. The most dramatic feature is cataplexy, the sudden loss of muscle tone, sometimes spontaneously but usually precipitated by strong emotions such as laughter, surprise, anger or fear. It is important to remember to counsel these patients regarding driving, and they have a legal duty to inform the DVLA about this diagnosis.