Fatigue is reported by 70% - 97% of people with chronic kidney disease\(^1,2\) Rates in the non-dialysis population are similar to rates in the end-stage renal disease population\(^3\) Causes are usually multi-factorial. Non-pharmacological strategies are recommended for at least 2 - 4 weeks before attempting pharmacological options.

**Assessment**

- Sleep symptoms (latency, total sleep time, early and/or frequent waking, daytime impact) and duration.
- Sleep hygiene assessment.
- Medical history for exacerbating conditions. e.g., obstructive sleep apnea, restless legs, pruritus, pain, mood disorder.
- Medication history for medications that may cause insomnia.
  - Minimize or substitute offending medications* if possible (see list below)
  - Discuss caffeine, alcohol, nicotine intake or recreational drugs

**Non-pharmacological Strategies**

- Promote good sleep hygiene measures:
  - Avoid caffeine after lunch.
  - Avoid alcohol and smoking, particularly during the evening.
  - Try not to eat a large meal close to bedtime.
  - Avoid using screens that give off light before bed. e.g. tablet, smart phone, ebook.
  - Create a sleep environment that is quiet, very dark and cool.
  - Do not go to bed until feeling sleepy.
  - Develop a regular and relaxing bedtime routine.
  - Follow a regular sleep schedule (wake up at the same time every morning and avoid napping during the day).
  - For more ideas, go to https://sleepfoundation.org/ask-the-expert/sleep-hygiene.
- Promote physical activity, both aerobic and resistance exercise.
- Consider referring to cognitive-behavioral therapy.\(^5\)
- Acupressure therapy has been shown to improve sleep quality and duration.\(^5\)
- If obstructive sleep apnea possible cause, refer for assessment and treatment.
- See BCPRA patient teaching tool on “Fatigue/Insomnia”.

**Pharmacologic Options (Insomnia)**

- Consider melatonin, 3 mg po HS\(^6\).
  - Note that there is NO standardization or regulation on natural health products in Canada.
  - If fatigue/difficulty sleeping persists, refer to primary care provider for risk/benefit discussion
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re: short-term use of sleeping aids (i.e., 3 - 4 weeks). (Note: Prescription sleep aids such as trazodone, zopiclone, lorazepam, oxazepam do not require dose adjustment in CKD).

• Consider one of these sedatives:
  • Zopiclone 3.75-5 mg po HS PRN (do not exceed 5 mg dose in elderly, patients with hepatic or renal impairment or patients receiving potent cytochrome 3A4 inhibitor)
  • Trazodone 25-100 mg po HS PRN (if no orthostatic hypotension)
  • Short acting benzodiazepines: Temazepam 15-30 mg po HS PRN, Lorazepam 0.5-2 mg po HS PRN or Oxazepam 10-30 mg po HS PRN
  • For Home HD patients on nocturnal dialysis, sedatives should be avoided.
  • Go to www.bcrenalagency.ca (Health Professionals > CKD) for information on costs of medications and whether coverage may be available through BCPRA, Pharmacare or Palliative Care benefit plans.

References


This randomized, double-blind placebo controlled trial involved melatonin 3 mg vs. placebo po HS for 6 weeks in 20 hemodialysis patients. Patients reported reduced sleep latency from 44.5 to 15.5 minutes (p=0.002) and improve sleep efficiency from 67.3% to 73.1% (p=0.01) after melatonin treatment.
General References

