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SNORE AUSTRALIA

Information for Patients

RESTLESS LEGS SYNDROME (RLS)

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Restless legs syndrome (RLS) was first described in 1685 by Thomas Willis. It occurs sporadically or can be familial. According to the May 2003 NEJM, the prevalence of RLS in the general population is between 2.5% and 15%. Its prevalence increases with age although it can occur in children. It is more common in women (especially during pregnancy) than men. It has a strong co-morbidity with Periodic Leg Movement Disorder (PLMD) and Nocturnal Myoclonus. The symptoms of RLS are brought on with rest. They usually occur towards the end of the day when affected patients sit and relax or lie down to rest. The more comfortable the patient becomes, the more likely it is that RLS will occur (and vice versa).

Patients commonly describe:

- A distressing, irritable urge to move the legs
- Feelings of crawling, creeping, pulling and tingling in the legs; some patients even describe pain or aching
- Muscular tension or twitching in the legs with sitting still or lying down
- Immediate relief with movement and ongoing relief with continued movement (such as walking); if patients stop moving their legs, the symptoms return.

For a positive diagnosis, alternative neurological and psychiatric explanations must be excluded.

RLS is usually associated with semirhythmic leg movements during sleep, known as Periodic Limb Movements of sleep (PLMS). RLS and PLMS typically disturb the sleep of the patient and their partner. For the patient, RLS and PLMS may have profound negative effects on sleep. Insomnia and fatigue may be symptoms initially reported, often with reduced concentration and memory, decreased motivation and drive, depression and anxiety. Since rest often brings on RLS, patients often avoid activities that require prolonged sitting, such as travelling long distances or going to movies.

Cause

The cause of RLS remains unknown. Iron deficiency may be correlated, and brain iron-deficiency may be a critical factor in the pathology. RLS occurs in 20% to 60% of patients undergoing renal dialysis. It is also associated with small-fibre peripheral neuropathy.

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Diagnosis
The key to diagnosis lies in maintaining a high index of suspicion, and then excluding other explanations such as vague limb-discomfort with sitting for long periods, limb pain due to neuropathy or arthritis, and restlessness associated with insomnia. Particularly when the diagnosis of PLMD is suspected, overnight polysomnography helps to distinguish the intermittent limb movements which often occur with Obstructive Sleep Apnoea (OSA) - such movements usually settle when the patient's OSA is treated.

Treatment
There is currently no cure for RLS. Initial management of the disorder involves the confirmation of normal neurological findings and the exclusion of iron-deficiency anaemia or abnormal renal function.
Treatment usually involves evaluation at a Sleep Centre and the prescription of medications. Temporary relief can be obtained by rubbing, massage, standing or walking but medications are usually required when the symptoms are severe.

Natural History and Prognosis
The severity of RLS and PLMD fluctuates from time to time but both conditions tend to be chronic and to become more severe with time. The symptoms may eventually become so distressing that patients become distraught to the stage of being suicidal.

Newly diagnosed patients should be reassured that RLS and PLMD are benign conditions which do not normally reflect chronic or severe, latent illness.

Family Dynamics
Patients with RLS often feel compelled to leave their bed and pace about the house during the night in order to obtain relief from their symptoms. This can disturb their partner's sleep and sometimes prevents the patient's partner from sleeping in the same bed. As with all serious sleep problems, family dynamics, education and support are very important.