The choice of treatment for restless legs syndrome (RLS) depends upon various factors including the frequency and intensity of symptoms, and their impact on daily activities. The medical treatment choices for RLS should take into consideration the correction of any underlying causes of secondary RLS whenever possible, and also take into account the limitations imposed by the secondary condition (e.g., pregnancy, renal insufficiency). Patients with mild RLS may only need assistance with sleep, such as sedative hypnotics or behavioral treatments like circadian rhythm adjustment allowing sleep at a later time of the day.

Dopaminergic drugs have been the treatment of choice for RLS for several years now.1,2,3 Studies with these agents have reported a subjective improvement of symptoms and sleep quality, as well as a shortening of sleep latency and a reduction in periodic leg movements. The short half-life of levodopa poses a practical problem as some patients with severe RLS might require multiple doses during the day. Long-term treatment with levodopa has been investigated for periods of up to two years, and sustained efficacy has been observed in over 70% of the patients.4 The main complication during long-term treatment with levodopa is augmentation, which is an overall increase in symptom severity as a result of long-term dopaminergic treatment.

Dopamine receptor agonists are the first-line treatment choice for RLS, particularly if daily treatment is needed or the condition is severe.2,5 This is mainly due to their longer elimination half-life (which makes repeated administration during the night unnecessary), to their better tolerance and to the lower frequency of long-term complications. Several dopamine receptor agonist drugs have been studied under controlled conditions, showing efficacy for pramipexole,5,6 ropinirole,7–9 pergolide,10,11 cabergoline,12,13 rotigotine14 and bromocriptine.15 In addition, more large-scale controlled studies are currently being carried out for several new dopaminergic agonists. To date, only pramipexole and ropinirole have been approved for the treatment of RLS.

Opiates are generally used by clinicians as a second-choice option or in case of augmentation. Hitherto, all of the few opiates studied, such as acepromazine17 or propoxyphene,18 have been found to be effective.

Anticonvulsants, such as carbamazepine, valproate and, more recently, gabapentin, are also effective drugs for RLS. Some benzodiazepines, such as clonazepam, have also been reported to be effective for RLS.3,19,20 However, their therapeutic effects at the usual dosage (0.5–2 mg/day) is mild, and, if applied at higher dosages, can cause sedation and other side effects.

Furthermore, the effects of benzodiazepines might be mediated by sleep induction rather than by direct suppression of RLS symptoms.

References


