# Restless Legs Syndrome (RLS )

**– advice for initial management in primary care**

Centre for Sustainable Delivery NHS SCOTLAND

## Introduction

This Fact Sheet provides information on how to treat patients for the management of Restless Leg Syndrome (RLS) with different symptoms, situations and circumstances.

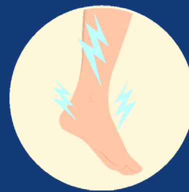
## Restless Legs Syndrome (RLS)

RLS is a common condition, although most people do not seek medical attention. The diagnosis is clinical (see box below) along with the exclusion of alternative explanations and is diurnal, which means it can be constant day and night, but is generally worse in the evening/night, affecting sleep. It is often associated with Periodic Limb Movements of Sleep (PLMS). Some will have a family history and it may occur at any age. Symptomatic mimics include peripheral neuropathy, cramps, varicose veins, akathisia, anxiety and spinal stenosis.

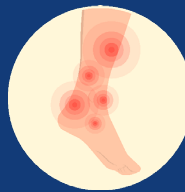
## Restless Legs Syndrome does not include hypnic jerks/involuntary movement

Other leg movements, especially involuntary hypnic jerks, are commonly misdiagnosed as RLS. Hypnic jerks are sudden jerky movements people have normally as they fall off to sleep, which can be amplified in people with sleep disorders, on opiates and with anxiety. They are not RLS and should not be treated with the medications below.

**Diagnostic features:**

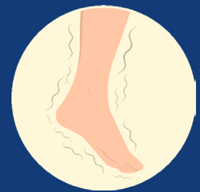


**Urge to move legs often with uncomfortable /unpleasant sensations**



**Symptoms begin/ worsen during rest or inactivity**

**Symptoms relieved by movement (walking or stretching)**



**Symptoms occur/ worsen in evening/ night**

## Do patients need investigation in primary care?

All with suspected RLS should have a basic blood screen, including glucose and serum ferritin.

## Do patients need to see a Neurologist?

Not necessarily, but this is an option for further advice/appointments for diagnostic clarification or management problems.

# Restless Legs Syndrome (RLS )

**– advice for initial management in primary care**

Centre for Sustainable Delivery

NHS SCOTLAND

## General lifestyle advice

Most people with RLS can be managed with resorting to drugs. Good sleep hygiene is important including avoidance of stimulants in the evening. Cognitive Behaviour Therapy (CBT) for insomnia may be effective. Relaxation therapy, walking or stretching before bedtime, warm evening bath and/ or massage may be helpful. Some drugs, notably Tricyclic antidepressants such as amitriptyline, may worsen symptoms.

## Treatment of RLS

Most will require nothing more than reassurance and sensible lifestyle advice, as above. Drug therapy should be reserved for the most distressing cases. Treatment responses are often accompanied by augmentation - this is the worsening of symptoms or manifestation earlier in the day after a period of successful dopaminergic treatment. The lowest possible doses should be used to try and avoid this effect.

## 1 First Line Therapies

**Iron replacement:** if serum ferritin is low/low normal, then replace orally.

## 2 Second Line Therapies

- Consider additional dose later at night if breakthrough symptoms.
- **Dopamine agonists** oral ropinirole 0.25mg-4mg, pramipexole up to 0.75mg base (i.e. 0.088 tablets salt x 3) or rotigotine patch 1mg-3mg/day. Counsel for possibility of impulse control disorders (e.g.excessive gambling, shopping, hypersexuality, binge eating). **1–11; http://dx.doi.org/10.1016/j.sleep.2016.01.017**.
- **Levo-dopa (co-careldopa or co-beneldopa).**
- **Gabapentin** (starting dose 300mg nocte, range 300-1200mg) or **Pregabalin** (starting dose 50-75mg nocte, range up to 300mg).

**Patient information:**
**RLS-UK https://www.rls-uk.org**

**Reference:**
Based on Trenkwalder C et al. Comorbidities, treatment and pathophysiology in restless legs syndrome. Lancet Neurol 2018;17:994-1005