cause many of these cases simply reflect the growing numbers of older adults, in whom kidney function appears to wane naturally.

“Even if we identify people with chronic kidney disease, we’re not really sure what the prognosis will be—this is a fairly robust debate within the kidney community,” Eggers said.

Richard J. Glassock, MD, an emeritus professor of medicine at the David Geffen School of Medicine at the University of California, Los Angeles, attributes the apparent increasing numbers to the adoption in 2002 of guidelines that stratified kidney disease into 5 stages that are based partly on estimated glomerular filtration rates (eGFRs) that do not take into account aging and gender; healthy older individuals have lower eGFRs than younger persons, and eGFRs of women are lower than those of men (Glassock RJ and Winearls C. Nephrol Dial Transplant. 2008;23[4]:1117-1121).

As a result, “we’re overestimating chronic kidney disease by 50%,” Glassock said. “By using absolute thresholds of eGFR for older patients and women, we’re causing unnecessary anxiety, depression and referral.”

Coresh, who debated Glassock in print (Coresh J et al. Nephrol Dial Transplant. 2008;23[4]:1122-1125), acknowledges the arguments but counters with the example of hypertension. “Hypertension is nearly universal as people get older, but that doesn’t mean you should not treat it,” Coresh said.

Despite Effectiveness, Behavioral Therapy for Chronic Insomnia Still Underused

Lynne Lamberg

Studies show that cognitive behavioral therapy for insomnia (CBT-I) works as well as, or better than, hypnotic medications to alleviate chronic insomnia, and its benefits also continue after active treatment ends. While US physicians treating patients with insomnia more often prescribe medications than behavioral strategies, sleep specialists are stepping up CBT-I training. They also are working to improve CBT-I delivery in primary care settings, where three-fourths of people with insomnia receive their treatment.

Developed over the past 2 decades, CBT-I uses 2 main behavioral strategies to combat insomnia: sleep restriction to consolidate sleep by initially reducing time in bed to match actual sleep time, and stimulus control to regularize the sleep-wake schedule and promote bedroom routines that foster sleep. It also includes relaxation techniques to reduce tension at bedtime. In the cognitive arena, CBT-I aims to correct common dysfunctional beliefs about sleep, such as the exaggerated fear that sleep loss will cause catastrophic harm.

An estimated 10% to 15% of adults in the United States report having slept poorly most nights or every night for at least a month, often for years. These individuals find it hard to fall asleep or stay asleep, often waking hours earlier than desired. They report that nonrestorative sleep disrupts daytime concentration, memory, and mood, undermining quality of life.

Perhaps only 5% of people with chronic insomnia have no other detectable major health problem, thus qualifying for a diagnosis of primary insomnia. Causes of primary insomnia remain elusive; some people report lifelong poor sleep. Chronic insomnia most often accompanies other chronic illnesses, including depression; cardiovascular, pulmonary, and gastrointestinal disorders; cancers; pain syndromes; and other sleep disorders.

Until recently, illness-related or secondary insomnia was regarded as simply a symptom of an underlying disorder. In 2005, however, panelists at a National Institutes of Health state-of-the-science conference on insomnia noted that chronic insomnia often takes on a life of its own and needs specific treatment. Cognitive behavioral therapies have demonstrated efficacy, the panel said (http://consensus.nih.gov/2005/2005InsomniaSOS26html.htm).
The standards of practice committee of the American Academy of Sleep Medicine (AASM) recommends CBT-I as first-line treatment for people with both primary and secondary chronic insomnia, including chronic hypnotic users (Morgenthaler T et al. Sleep. 2006;29[11]:1415-1419).

CBT-I usually reduces symptoms of chronic insomnia by 50%, according to Michael Perlis, PhD, associate professor of psychiatry at the University of Pennsylvania School of Medicine, Philadelphia, and director of its behavioral sleep medicine program.

Patients who stick with CBT-I tactics—usually taught in 4 to 8 weekly individual or group sessions—often see symptoms fade by another 25% over the next few months. Treatment gains also last at least 2 years, said Perlis, who conducted a 3-day course to train physicians, psychologists, nurses, and others in CBT-I in Arlington, Va, in October. The University of Rochester Medical Center sponsored the event.

One hurdle to broad use of CBT-I is the still small population of trained practitioners. To date, 136 doctoral-level US sleep specialists, including 42 physicians, have received AASM’s certification in behavioral sleep medicine, demonstrating knowledge and skill in CBT-I and other behavioral therapies. The AASM will start certifying master’s level practitioners in psychology, nursing, and other health-related fields in CBT-I in 2010 (http://www.aasmnet.org/BSM.aspx). The nearly 1600 AASM-accredited sleep centers are required to have behavioral services available.

Because CBT-I is time intensive for both clinician and patient, some sleep specialists are exploring shorter variants that, if effective, would be more practical in primary care settings. One such approach is a brief behavioral treatment for insomnia devised by researchers at the University of Pittsburgh School of Medicine. It consists of a 45-minute session in the primary care office, plus a booster session 2 weeks later. A master’s level nurse practitioner reviews sleep diaries, suggests ways to regularize daily schedules, advises patients to limit time in bed to time spent asleep, and provides a workbook with further instructions. Sleep quality and efficiency improved significantly more in 17 older adults receiving such help than in a matched control group receiving routine sleep habit advice (Germain A et al. J Clin Sleep Med. 2006;2[4]:403-406). Self-directed computerized or Web-based CBT-I programs also are under evaluation, but Perlis remains skeptical about their utility. “CBT-I uses evidence-based methods, delivered in a way the patient finds compelling,” he said, “with a coach to follow up and foster compliance.”

“Asking every patient, ‘How are you sleeping?’” he said, “elicits an excellent indicator of overall health. Some patients with insomnia can be managed medically, and some need referral to a sleep specialist. Proper treatment will reduce subsequent morbidity and health care utilization.”

Findings From South Korea Provide Insight Into XDR-TB

Rebecca Voelker

A NEW STUDY OF TUBERCULOSIS PATIENTS in South Korea is filling in some of the blanks about extensively drug-resistant tuberculosis (XDR-TB), showing just how much more deadly and difficult to treat it is than TB caused by less-resistant strains (Kim DH et al. Am J Respir Crit Care Med. 2008;178[10]:1075-1082).

The new findings are based on a review of medical records from 1407 patients who were newly diagnosed or retreated for multidrug-resistant tuberculosis (MDR-TB), which is caused by isolates resistant to the 2 most effective first-line drugs, isoniazid and rifampin. Only 1.5% of patients were also infected with HIV.

Researchers found that 5.3% of the patients had XDR-TB at the start of treatment. (In addition to resistance to isoniazid and rifampin, XDR-TB isolates are resistant to fluoroquinolones and at least 1 of 3 injectable drugs—amikacin, kanamycin, or capreomycin.)

All of the patients were followed up for 3 to 7 years after their treatment began. Among the patients with XDR-TB, treatment was successful in 29.3% compared with a 46.2% success rate among patients with MDR-TB. During the follow-up period, 49.3% of patients with XDR-TB died of any cause compared with 19.4% of those with MDR-TB. In patients with XDR-TB, 41.3% of deaths were from TB-related causes compared with 11.8% of deaths in patients with MDR-TB. According to the study investigators, the death rate for the South Korean patients with XDR-TB was similar to that of patients in South India with untreated TB.

An accompanying editorial (Migliori GB et al. Am J Respir Crit Care Med. 2008;178[10]:1000-1001) noted that no new anti-TB drugs have been developed in decades, adding that further research to understand and quantify the impact of resistant strains of TB is needed to prevent MDR-TB and XDR-TB from becoming pandemic health crises.