Response to Zee, P., Melatonin for the Treatment of Advanced Sleep Phase Disorder. SLEEP 2008;31:923.

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WE APPRECIATE THE COMPLIMENT, CAREFUL REVIEW AND CONSTRUCTIVE CRITICISM OF DR. ZEE.1 DR. ZEE POINTS OUT THAT BOTH THE REVIEW AND THE practice parameter emphasize that there are no outcome studies directly evaluating the effect of timed melatonin in the treatment of advanced sleep phase disorder (APSD). After careful consideration, we agree with Dr. Zee’s criticism, and we will make appropriate correction to this practice parameter.

In the task force review paper, a theoretical basis for the use of timed melatonin in APSD is presented. In our practice parameter, use of timed melatonin is listed as one among various indicated therapies for APSD, but the recommendation is given as an “Option” strength recommendation. An “Option” level recommendation is a “patient care strategy that reflects uncertain clinical use. The term option implies either inconclusive or conflicting evidence or conflicting expert opinion.” The inclusion of timed melatonin as an option for APSD was based upon committee consensus, but there was limited effort to evaluate consensus about the magnitude of risks involved in the use of timed melatonin for this specific recommendation. Although caution is advised by many regarding melatonin therapy, there has been little in the way of methodical study, and since adverse event reporting is not systematic it does not always provide reliable evidence on which to base a recommendation.2

This points out a potential weakness with the methods currently employed to develop recommendations for practice. The Standards of Practice Committee of the AASM has used an evaluation system based on the Oxford System.3,4 In this system, the strength of the supporting evidence for efficacy is the major focus. There are fewer explicit guidelines to use when weighing the strength of perceived costs or risks. The SPC strives to provide sensible, graded, evidence-based, peer-reviewed recommendations while not restricting sleep specialists from employing therapies that seem reasonable (by consensus) and have few demonstrated risks, but may not have yet been sufficiently studied.

Newer methods of assessing evidence, such as the GRADE method, strive to make risk/benefit analyses in the development of recommendations more explicit and transparent.5,6 The SPC is committed to learning and incorporating such new developments in evidence-based medicine techniques.

We agree with Dr. Zee’s criticism, and in retrospect feel that we should not have included timed melatonin as an “indicated therapy.” It would have been better to state that there was insufficient information to make a recommendation regarding timed melatonin for this application. We will place a correction of this particular recommendation on the AASM website, which will remove the recommendation for use of timed melatonin in APSD.

RESOURCES

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