Restless Legs Syndrome (RLS)
Advice for initial management in primary care

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Please note this is designed as a summary of management. Based on: The management of RLS; an updated algorithm Mayo Clin Proc. 2021;96(7):1921-1937. Please consult BNF for contraindications, cautions, side effects, pregnancy etc.

Restless Legs Syndrome
RLS is common although most people do not reach doctors; the diagnosis is clinical (see box) along with the exclusion of alternative explanations. It is diurnal, worse in the evening/night and thus disturbs sleep. It is often associated with Periodic Limb Movements of Sleep (PLMS). Some will have a family history. It may occur at any age. Mimics include peripheral neuropathy, cramps, varicose veins, akathisia, anxiety, spinal stenosis. Asking *"when you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or movement?*" is a useful single screening question.

Restless Legs Syndrome does not include hypnic jerks/involuntary movement
Other leg movements, especially hypnic jerks, are commonly misdiagnosed as RLS. Hypnic jerks are sudden jerky movements people have as they fall asleep which can be amplified in people with sleep disorders, opiates, and anxiety. They are not RLS.

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 they need investigation in primary care?
All suspected RLS should have a basic blood screen including glucose and serum ferritin.

Do they need to see a Neurologist?
Not necessarily limited (see below).

General Lifestyle Advice
Most people with RLS can be managed without medication. Good sleep hygiene is important including avoidance of stimulants in the evening. 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.

Investigations in primary care
All suspected RLS should have a basic blood screen including glucose and serum ferritin.

Treatment of RLS
Most require nothing more than reassurance and lifestyle advice as above; medication should be reserved for those with symptoms that are having a major impact on quality of life. Treatment response is often complicated by **augmentation**; this is the worsening of symptoms or manifestation earlier in the day after a period of successful treatment. The lowest possible doses should be used to avoid this.

Drug therapy for RLS is problematic. Currently only dopamine agonists and oxycodone are licensed for RLS; agonists are associated with augmentation and can cause impulse control disorders. Gabapentinoids are first line in many guidelines but not licenced for RLS. We do not have additional drug therapies in secondary care.

First Line therapies

- **Iron replacement**: If serum ferritin below 100 microgram/l or transferrin saturation <20%, replace orally (once a day is sufficient) until ferritin >100microg/l. Iron absorption is enhanced by co-administration with vitamin C (100-200 mg with each dose); absorption paradoxically becomes less as iron levels rise. Some may need intravenous iron if symptoms persist.
- Identify and manage co-existing sleep disorders
- Ensure not on medications that may cause/exacerbate RLS

Second Line therapies; consider carefully whether drug therapy required, consider using the International Restless Legs Scale to assess severity or response

- **Gabapentin** (starting dose 100-300mg nocte, range 300-1200mg) or Pregabalin (starting dose 25-50mg nocte, range up to 300mg). Neither drug is licensed for RLS.
- **Oxycodone (Targinact®)**: licensed for RLS but we do not recommend in primary care. Codeine, tramadol and others have been used in NICE* but none are licensed, we do not recommend their use in primary care.
- **Dopamine agonists**: although licensed for RLS, these drugs are no longer recommended due augmentation and impulse control disorders.

Do they need to see a Neurologist?
Not necessarily but we are happy to advise/see for diagnostic clarification or management problems. Treatment options are limited (see above).

Patient information
NICE CKS - Scenario: Management | Management | Restless legs syndrome | CKS | NICE
RLS-UK https://www.rls-uk.org/

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* *NICE CKS: https://cks.nice.org.uk/topics/restless-legs-syndrome/management/management/*