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

Dept Clinical Neurosciences, NHS Lothian. Jan 2020.

Please note this is only designed as a brief summary of management

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

Please consult BNF for contraindications, cautions, side effects, pregnancy etc.

More information at www.refhelp.scot.nhs.uk/

Restless Legs Syndrome

RLS is a common condition 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 affects sleep. It is often associated with Periodic Limb Movements of Sleep (PLMS). Some will have a family history. It may occur at any age. Symptomatic mimics include peripheral neuropathy, cramps, varicose veins, akathisia, anxiety, 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 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 they need investigation in primary care?

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

Do they need to see a Neurologist?

Not necessarily but we are happy to advise/see for diagnostic clarification or management problems.

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. 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 such be used to try and avoid this effect.

First Line therapies

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

Second Line therapies (consider carefully whether drug therapy required)

- **Dopamine agonists (only licensed drugs for RLS)**: oral ropinirole 0.25-4mg, pramipexole up to 0.75 base (i.e. 0.088 tablets salt x 3) or rotigotine patch 1-3mg/day. Counsel for possibility of impulse control disorders (e.g. excessive gambling, shopping, hypersexuality etc).
- **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/

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