apnoea, circadian disorders, narcolepsy, and idiopathic hypersomnia), medications, or other medical or psychiatric conditions. These disorders also commonly co-occur. Accordingly, the assessment of hypersomnolence requires a rigorous clinical approach, completed by use of self-reported questionnaires and neurophysiological measures, depending on clinical context.[2] This thorough assessment ensures proper diagnosis and personalised therapy. However, the mean and median diagnostic delay of patients with narcolepsy in different European countries over the past three decades was about 9·7 and 5·3 years, respectively.[3]

We also concur in the need for joint work between sleep medicine specialists and primary care doctors for a comprehensive and successful identification, assessment, and management of these patients. The aim of the Sleep Series was to bring to attention to the wider clinical audience some of the most common issues within sleep medicine encountered in routine clinical practice. Hopefully, by increasing the awareness of the nature and impact of sleep conditions, medical training and continued professional development programmes will be shaped to provide appropriate understanding of sleep medicine among physicians, with the goal to deliver the best possible quality of care (including diagnosis and management) to patients.

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Deprescribing benzodiazepine receptor agonists for insomnia in older adults

The Series paper on insomnia by Michael Perlis and colleagues[1] summarises evidence on the diagnosis and management of insomnia, but overlooks important considerations on the management of insomnia in older adults.

Although the authors highlight that evidence on the efficacy of pharmacological approaches in older people, including benzodiazepine receptor agonists (BZRAs), is of low quality, they also emphasise that BZRAs are an appropriate option when cognitive behavioural therapy for insomnia is not effective or available. This statement should be reconsidered when it comes to older adults. First, the use of BZRAs is associated with major risks not mentioned by the authors, such as falls, fractures, delirium, impaired functioning, hospitalisations, and mortality,[2] burdening both patients and society.[3] Second, international groups have made strong recommendations against the use of BZRAs in older adults, or recommendations to use them only short term (typically up to 4 weeks for the treatment of insomnia). Yet, BZRA overuse is one of the most prevalent and harmful overuse practices in older adults.[4]

Deprescribing guidelines recommend to consider deprescribing in older adults taking a BZRA for insomnia.[5] Such recommendations should ideally be integrated into the guidelines on the management of insomnia. Better addressing patients' and healthcare professionals' barriers to BZRA deprescribing is also essential.[6] Beyond the authors' call for further research on new therapeutic approaches, we need further research on the effectiveness of theory-driven implementation approaches and a cultural change that promotes de-implementing potentially harmful strategies into the routine management of insomnia for older people.

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Authors' reply

We appreciate Antoine Christiaens and colleagues' Correspondence on our Series paper regarding the assessment, diagnosis, and treatment of insomnia.[1] Their Correspondence highlights that care should be taken with respect to the management of insomnia in older adults, specifically regarding the use of pharmacotherapy and the implementation of deprescribing. Although cognitive behavioural therapy should be the first-line treatment (regardless of age cohort),[2,3] it is advisable to consider deprescribing before the initiation of cognitive behavioural therapy or represcribing in cases where older adults are being maintained on benzodiazepines or benzodiazepine receptor agonists, particularly in cases where there is increased risk for falls, disorientation, or parasomnias. The medical management of insomnia in older adults is complicated by a number of factors including comorbidity, existing medication regimens, the tendency towards advanced sleep phase, the higher incidence of napping, highly variable sleep–wake schedules, potentially histaminergic overactivity, or a combination of these.[4] Given these age-related considerations, and a necessity for the pharmacological treatment of insomnia, older adults might benefit from the use of low-dose doxepin, capitalising on its selective anti-histaminergic activity with minimal unwanted cholinergic effects at low doses. This recommendation is supported by a recent risk–benefit analysis conducted by our group. Cheung and colleagues[5] found that low-dose doxepin possesses the most favourable risk–benefit profile of the various US Food and Drug Administration indicated approaches, and that this is especially true for sleep maintenance insomnia. This finding was presaged by at least one large-scale network meta-analysis where Chiu and colleagues[6] concluded that low-dose doxepin is the optimal choice for older adults. Alternatively, older adults with reduced light exposure, or clear evidence of circadian rhythm disturbance, or both, might disproportionately benefit from the carefully timed use of exogenous melatonin or melatonin receptor agonists. In closing, we are grateful to Christiaens and colleagues for the opportunity to highlight that, when it comes to the management of insomnia, one size does not fit all, and we should not have implied otherwise.

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Becker JC, Ugurel S, Leiter U, et al. Adjuvant immunotherapy with nivolumab versus observation in completely resected Merkel cell carcinoma (ADMEC-O): disease-free survival results from a randomised, open-label, phase 2 trial. Lancet *2023; **402:** 798–808*— In this Article, the spelling of Alexander van Akkooi and Kimberley Farmer's names were incorrect in the DeCOG working group. This correction has been made to the online version as of Oct 19, 2023.