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The Sandman in a Bottle
The Types and Functions of Sleep Aids

by Matthew Koh

For millions of Americans who lay awake at night unable to fall asleep, sleeping pills offer a quick and easy way to prevent drowsiness and fatigue the next day. As of 2006, according to an article in Forbes, prescription sleeping pills garnered around $2 billion annually in the United States (Wells 2006). In 2005, 43 million prescriptions were written for prescription sleep aids, and sales of these drugs are projected to rise to $5 billion annually by 2010 (Lazarus 2006). A poll conducted by the National Sleep Foundation found that 10% of working Americans use either a prescription or over-the-counter medication to help them fall asleep (NSF 2008). Yet even as the use of sleep aids rises, scientists are still in the process of figuring out the details of how these drugs work.

Today, sleep aids, also known as sedative-hypnotics, fall into three main categories. The first category consists of drugs that act at the GABA receptor. These include the benzodiazepines and the barbiturates. The newest additions to this group are the "z-drugs" such as Ambien® and Lunesta®, so called because their chemical names all begin with z. The second category of drugs is the antihistamine family of drugs. These drugs are the primary sedative ingredients in medicines like Benadryl®, NyQuil® and other over-the-counter sleep aids. Finally, newest category of sleep aids consists of drugs that act as melatonin receptor agonists. Currently, the only such drug approved for use by the FDA is Rozerem®, although others are undergoing clinical trials.

The Neural Circuitry of the Sleep-Wake Cycle

Like many animals, humans cope with the daily rising and setting of the sun by sleeping at night and being awake during the day. This cycle involves two competing brain pathways—one involving arousal and the other involving sleep promotion. The arousal and sleep promotion pathways inhibit one another so that when one becomes strongly activated, the other is rapidly inactivated. This circuit has been called a flip-flop switch, named after the similarly functioning circuit known to electrical engineers. This mechanism accounts for the suddenness of falling asleep and waking up (Saper et al. 2005).

The arousal pathway actually consists of two separate pathways. The first pathway activates the thalamus, the area of the brain responsible for transmitting information to the cortex. The second pathway activates the cortex and involves a number of different brain regions. One area that is particularly relevant to the action of sleep aids is the tuberomammillary nucleus (TM). The TM contains neurons that respond to the neurotransmitter histamine. From the TM, these neurons project to multiple regions of the brain, including the basal forebrain, hypothalamus, and amygdala. H1 receptors are located on the postsynaptic cells of these projections and promote wakefulness by stimulating these cells (Barbier and Bradbury 2007).

The ventrolateral preoptic nucleus (VLPO) is the main area involved in sleep promotion. The cells in this region contain gamma-aminobutyric acid (GABA) and galanin, two inhibitory neurotransmitters. The VLPO projects to all of the major wakefulness-promoting areas of the brain and inhibits these regions (Saper et al. 2005).

Central control of all circadian rhythms is provided by the suprachiasmatic nucleus (SCN), a brain region located directly above the optic chiasm. The SCN receives information from the retina that it uses to coordinate the body's internal clock with the outside world. Cells in the SCN contain receptors for melatonin, which is secreted by the pineal gland in response to signals from the SCN itself (Moore 2007). When activated, melatonin receptors inhibit the SCN. Next, the dorsomedial nucleus of the hypothalamus (DMH) receives input from the SCN and sends output to the VLPO and LHA. The connections to the VLPO are inhibitory whereas those to the LHA are excitatory (Chou et al. 2003). So, when the SCN is inhibited by melatonin, the VLPO becomes less inhibited while the LHA becomes more inhibited and sleep is induced.

These details of the anatomy involved in sleep regulation are necessary for an overall picture of the mechanisms of sleep aids. All of the sleep aids that are mentioned below interact with some step in the sleep-wake neural circuitry.

GABAA Receptor Drugs
Many drugs that have traditionally been used as sedatives exert their effects at GABAergic receptors in the brain. For instance, alcohol, perhaps the world’s oldest known sedative, is a GABA receptor agonist, although the details of this interaction are still unknown. In addition, barbiturates, benzodiazepines and anesthetics act at the GABA receptor. GABAergic receptors are ligand-gated chloride ion channels activated by the neurotransmitter ?-amino butyric acid. When these channels are opened, the membrane potential of the neuron becomes more negative, resulting in inhibition of the neuron’s activity. The effects of GABA binding are modulated by the binding of benzodiazepines and barbiturates. When these drugs bind to GABA receptors, the inhibitory effects of GABA are enhanced (Delorey and Olsen 1992).

GABAergic receptors are composed of five protein subunits arranged around a central ion channel. There are at least nineteen different subunits, grouped into families by amino acid sequence similarity. The subunit composition of a receptor varies between different cells and even between different locations within the same cell (Nutt 2006). It is believed that the large number of possible combinations accounts in part for the wide variety of effects that are mediated by GABA receptors (Paronis 2005).

Most prescription sleep aids work by activating the benzodiazepine site of GABA receptors. As a result, wake-promoting neurons that receive GABAergic projections from the VLPO become more inhibited (Lu 2006). In the past, barbiturates were prescribed as sleep aids. However, due to their high potential for abuse and dependency, their use in this capacity was phased out with the introduction of benzodiazepines (Bateson 2006). Although the data regarding tolerance is unclear, daytime side effects are well-documented, including drowsiness and decreased reaction times (Barbier and Bradbury 2007).

Ramelteon acts as a selective agonist at MT1 and MT2 receptors. It was found to have six times more affinity for MT1 receptors and three-and-a-half times more affinity for MT2 receptors than melatonin. It was found to have six times more affinity for MT1 receptors and three-and-a-half times more affinity for MT2 receptors than melatonin. In contrast, the affinity of ramelteon for MT3 receptors is 1/110 the affinity of melatonin (Kato et al. 2005). This action is responsible for the sleep-inducing effects of ramelteon.

Ramelteon (Rozerem®) is currently the only melatonin agonist approved for use by the FDA as a sleep aid. However, Vanda Pharmaceuticals and Tikvah Therapeutics are both in the process of conducting clinical trials for drugs with the same mechanism of action. Similar drugs are also being investigated for treatment of depression (Becker 2008). The manufacturers of Rozerem® claim that it is the only sleep aid with no evidence of risk of dependence or negative daytime side effects (Takeda Pharmaceuticals 2008).

References
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ment of insomnia. Sleep Medicine 7(S1): S3-S9.