the general population, and these symptoms are not as diagnostically specific.

When narcolepsy is suspected, the diagnosis should be firmly established with a polysomnogram followed the next day by an MSLT. The polysomnogram helps rule out other possible causes of sleepiness such as sleep apnea and establishes that the patient had adequate sleep the night before, and the MSLT provides essential, objective evidence of sleepiness plus REM sleep dysregulation. Across the five naps of the MSLT, most patients with narcolepsy will fall asleep in <8 min on average, and they will have episodes of REM sleep in at least two of the naps. Abnormal regulation of REM sleep is also manifested by the appearance of REM sleep within 15 min of sleep onset at night, which is rare in healthy individuals sleeping at their habitual bedtime. Stimulants should be stopped 1 week before the MSLT and antidepressants should be stopped 3 weeks prior, because these medications can affect the MSLT. In addition, patients should be encouraged to obtain a fully adequate amount of sleep each night for the week prior to the test to eliminate any effects of insufficient sleep.

TREATMENT

Narcolepsy

The treatment of narcolepsy is symptomatic. Most patients with narcolepsy feel more alert after sleep, and they should be encouraged to get adequate sleep each night and to take a 15- to 20-min nap in the afternoon. This nap may be sufficient for some patients with mild narcolepsy, but most also require treatment with wake-promoting medications. Modafinil is often used because it has fewer side effects than amphetamines and a relatively long half-life; for most patients, 200–400 mg each morning is very effective. Methylphenidate (10–20 mg bid) or dextroamphetamine (10 mg bid) are also effective, but sympathomimetic side effects, anxiety, and the potential for abuse can be concerns. These medications are available in slow-release formulations, extending their duration of action and allowing easier dosing. Solriamfetol, a norepinephrine–dopamine reuptake inhibitor (75–150 mg daily), and pitolisant, a