Restless Legs Syndrome in Pregnancy: a Frequent Underdiagnosed Disorder

Dear Editor,

We realize that the restless legs syndrome (RLS) is underdiagnosed in pregnancy, despite being an important cause of insomnia and impaired sleep. Our objective is to report the case of a pregnant woman with RLS surveilled at our Department and briefly review the main points of this disorder, to alert obstetricians, neurologists and family doctors to this entity.

We describe the case of a 35-year-old pregnant woman with RLS diagnosed during adolescence, presenting sporadic symptoms. Pregnancy progressed uneventfully until the third trimester, when the symptoms worsen, occurring three times per week. The symptoms, characterized by a strong urge to move the legs, developed at night and were related to fatigue and evening exercise. Counseling related to lifestyle changes and sleep hygiene was provided, with improvement of complaints. There were no other significant complications in pregnancy or delivery.

RLS is a sensorimotor disorder that was first described in 1685 by the British physician Sir Thomas Willis.[1] The diagnosis depends on four criteria that include: undesirable sensations in the legs that occur before sleep onset; irresistible urge to move the limbs; partial or complete relief of the symptoms on movement of the limbs and return of symptoms on cessation of the movements.[2] It is classified as idiopathic or secondary, based on the presence of associated conditions. Primary RLS is thought to have an autosomal dominant inheritance. Pregnancy is a major secondary cause, together with iron deficiency and end-stage renal disease.[2] A medication history is important to rule out drug induced RLS, as dopamine-antagonists.[3]

RLS is the most common movement disorder of pregnancy, but is infrequently recognized, despite the frequent complaint of sleep disturbance in pregnancy.

The prevalence is higher in women and can rise to 30% in pregnancy,[4] while has a prevalence of 10% on the general population.[1] The symptoms may worsen as the pregnancy progresses and improve after delivery.[3,5]

RLS can be treated nonpharmacologically or pharmacologically.[3,5] Listening to the concerns of the woman is therapeutic itself and should not be underestimated.[5] The dopamine antagonists should be avoided and correction of a possible iron deficiency anemia must be performed. Counseling related to lifestyle changes has to be provided, including sleep hygiene.[3]

Medical treatment is recommended in moderate or pronounced RLS.[3,5] Cabergoline may be considered the first line therapy based on the large experience in pregnancy (0.5 mg daily), but Levodopa / Carbidopa (100/25 mg daily) might be an alternative option.[5]

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