OSA for Primary Care
Part 1

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Learning objectives

- Appropriate screening in a primary care setting
- Approach to diagnosing OSA

Should sleep manage all OSA patients?

Wisconsin Sleep Cohort Study
1988-1994 to 2007-2010
10% with mild OSA
3.8% to 6.5% with moderate to severe OSA

Extrapolated to 2009
16% with mild OSA
20-30% for men, 10-15% for women age 30-70
10% with moderate to severe OSA

The OSA burden falls on the PCP

- As high as 90-99% in PCP waiting rooms have sleep complaints when screened
- 22% self-report Patients
- 30-40% "high risk" OSA Patients
- 23% screen Primary care physicians


Screening asymptomatic patients

- USPSTF; 2017
  “The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for OSA in asymptomatic adults.”
- AASM response to above; 2017
  “…the AASM recommends screening patients who have a high risk for OSA, even if they don’t have any sleep-related symptoms.”

Routine health examination

Questions to ask, prompting a comprehensive sleep evaluation.
- Patient obese?
- Retrognathia?
- Daytime sleepiness?
- Snoring?
- Hypertension?

1. Consensus statement by the AASM clinical practice guidelines: 2009

Screening surveys

- STOP-BANG scoring
- ESS (Epworth Sleepiness Scale)
- Berlin Questionnaire
- Flemon’s Modified Neck Circumference
- Multivariate apnea prediction index
Case 1 – Symptomatic patient

55 year old male is accompanied by his wife. He has gained weight over the years and his wife is now frightened by him holding his breath while asleep, followed by gasping for air. He falls asleep at work and when watching TV, has morning headaches and sleeps elevated on a wedge pillow because of nocturnal acid reflux.

Symptoms of OSA

- Witnessed apneas, snoring, gasping, or waking up choking at night
- Insomnia (sleep fragmentation, difficulty staying asleep)
- Excessive sleepiness or non-refreshing sleep
  - Need to ask sleep hours to know if sleep deprived
- Nocturia, morning headaches, decreased libido, GERD
- Decreased concentration, memory loss, irritability

Physical Examination

- BMI > 30
- Blood pressure
- Respiratory, cardiovascular, neurologic exams
- Neck circumference
  - ≥ 17” men  ≥ 16” women
- Facial anatomy
  - Nasal patency/septal deviation
  - Crowded oropharynx
  - Mallampati commonly used

Mallampati Scoring

Image adapted from https://commons.wikimedia.org/wiki/File:Mallampati.svg
Retrognathia

Gnathion (midline chin)
Sits >0.5 cm behind Nasion (between eyes)

Malocclusion and unbalanced facial profile

https://medlineplus.gov/ency/imagepages/8500.htm

Home testing (minimum)

- Airflow
- Respiratory effort
- Blood oxygenation
In-laboratory testing

- Airflow
- Respiratory effort
- Blood oxygenation
- EEG → Sleep staging
- EOG → REM sleep
- EKG → Single lead
- EMG → Detect leg movements
- CO2 monitoring (Optional)

• Apnea
  – Airflow cessation
  Each last at least 10 seconds

• Hypopnea
  – Reduced airflow
  – Associated oxygen desaturation

• Respiratory Effort-Related Arousal (RERA)
  – Arousal caused by airflow, not qualifying for above

AHI (Apnea Hypopnea Index)

\[
AHI = \frac{\text{Apneas} + \text{Hypopneas}}{\text{Total sleep time}}
\]

RDI (Respiratory Disturbance Index)

\[
RDI = \frac{\text{Apneas} + \text{Hypopneas} + \text{RERAs}}{\text{Total sleep time}}
\]

REI (Respiratory Event Index)

\[
REI = \frac{\text{Apneas} + \text{Hypopneas}}{\text{Total Recording Time}}
\]

<table>
<thead>
<tr>
<th>Home Sleep testing</th>
<th>In-lab polysomnogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited channels</td>
<td>Full study</td>
</tr>
<tr>
<td>Only if OSA has a</td>
<td>Gold standard OSA test</td>
</tr>
<tr>
<td>high pretest probability</td>
<td></td>
</tr>
<tr>
<td>Not appropriate if severe comorbid diseases</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$$$</td>
</tr>
<tr>
<td>Reports REI Events / Recording Time</td>
<td>Reports AHI, RDI Events / Sleep Time</td>
</tr>
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</table>
### OSA (Obstructive sleep apnea)

**AHI, RDI, REI**

<table>
<thead>
<tr>
<th></th>
<th>5-15</th>
<th>15-30</th>
<th>30+</th>
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<tbody>
<tr>
<td><strong>Mild</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* AHI > 5 - 15 with symptoms
  - Excessive daytime sleepiness
  - Impaired cognition
  - Mood disorders
  - Insomnia
  - Waking up breath holding, gasping, or choking
  - HTN, ischemic heart disease, or stroke

### Central Sleep Apnea

- Absence of air-flow and **respiratory effort**
- Examples:
  - Cheyne-Stokes respiration in heart failure.
  - Opiates causing ataxic breathing

### Obesity hypoventilation syndrome

**Diagnostic criteria:**
- BMI > 30
- Sleep disordered breathing
- Daytime hypercapnia
  - PaCO2 ≥ 45 mm Hg
  - Other hypoventilation causes excluded

**Obesity hypoventilation syndrome**

Prevalence 8-20% in patients undergoing sleep testing

- High pretest probability: BMI ≥ 40
  - Obtain ABG
- Low/mod pretest probability: BMI 30-40
  - Obtain serum bicarbonate
  - If bicarbonate ≥ 27 → ABG
Home sleep study results = REI 3.9

Overview

REI(ahi) 3.9 h ODI: 3.1 h Snore Percentage: 11.0 %

Respiratory Indices

<table>
<thead>
<tr>
<th>Index</th>
<th>Total</th>
<th>Supine</th>
<th>Non-supine</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apnea + Hypopnea (AHI)</td>
<td>3.9</td>
<td>11.2</td>
<td>2.2</td>
<td>36</td>
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<tr>
<td>Apnea</td>
<td>1.5</td>
<td>3.7</td>
<td>1.0</td>
<td>15</td>
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<tr>
<td>Obstructive (OA)</td>
<td>1.3</td>
<td>2.7</td>
<td>1.0</td>
<td>13</td>
</tr>
<tr>
<td>Mixed (MA)</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Central (CA)</td>
<td>0.2</td>
<td>1.1</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Hypopnea</td>
<td>2.4</td>
<td>7.5</td>
<td>1.2</td>
<td>24</td>
</tr>
<tr>
<td>Obstructive (OH)</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Central (OCH)</td>
<td>0.2</td>
<td>1.1</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Obstructive Apnea-Hypopnea (OA + MA + OH)</td>
<td>1.3</td>
<td>2.7</td>
<td>1.0</td>
<td>13</td>
</tr>
<tr>
<td>Central Apnea-Hypopnea (CA + CH)</td>
<td>0.2</td>
<td>1.1</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td>Hypoventilation</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Respiration Rate (per min)</td>
<td>18.4</td>
<td>18.3</td>
<td>18.4</td>
<td></td>
</tr>
</tbody>
</table>

Percentage of Sleep

<table>
<thead>
<tr>
<th>Score</th>
<th>Supine</th>
<th>Non-supine</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.0</td>
<td>7.9</td>
<td>11.7</td>
<td></td>
</tr>
<tr>
<td>65.9</td>
<td>18.7</td>
<td>8.6</td>
<td></td>
</tr>
</tbody>
</table>

For this patient...

Concern for OSA

High OSA pre-test probability?

Cardiopulmonary disease, NOG, recent stroke, opiate use?

Risk for OHS or hyperventilation?

Another sleep disorder (parasomnia, severe insomnia)?

In-lab polysomnogram

Negative; repeat testing if clinical suspicion remains high

Low-moderate risk

Referral to sleep specialist

For this patient...

Concern for OSA

High OSA pre-test probability?

Cardiopulmonary disease, NOG, recent stroke, opiate use?

Risk for OHS or hyperventilation?

Another sleep disorder (parasomnia, severe insomnia)?

In-lab polysomnogram

Negative; repeat testing if clinical suspicion remains high

Low-moderate risk

Referral to sleep specialist
Case 2 – Hospital follow up

A 63 year old male who had a heart attack 6 months ago. Recent echocardiogram shows ischemic cardiomyopathy with an estimated ejection fraction of 40-45%. When asked, he has always snored but it never bothered him.

Prevalence in hypertension

- Up to 50% of patients with hypertension have OSA in observational studies
- Cohort of patients with difficult to control hypertension
  64% prevalence of OSA

Prevalence in atrial fibrillation

- Cohort of patients with atrial fibrillation in 2005
  32-49% of patients had OSA
- 12 month period after cardioversion in OSA patients
  - 82% recurrence rate if untreated
  - 42% recurrence rate while on effective CPAP


AASM 2009 Guidelines.
Prevalence in Systolic Heart Failure

- 61% of 450 patients with a sleep related breathing disorder.
  - Obstructive sleep apnea
  - Central sleep apnea

A home sleep study would not be appropriate in this group since the prevalence of central sleep apnea is high.


Prevalence in stroke patients

- Cohort studies
  - 1996 study, 47 patients monitored for SaO2 desaturations. 18 of 19 tested with PSG.
    - 38% with AHI over 10
  - 2008 prospective study in 25 patients with ischemic stroke
    - 74% of patients with AHI > 5


Prevalence in type 2 diabetes

- Data from SHHS (Sleep heart health study)
  - 58% of type II diabetes patients had elevated AHI
  - Type 2 diabetes and obesity
    - 87% of patients had OSA
  - Primary care setting (2012)
    - Retrospective study; 16,066 patients
    - 18% of type 2 diabetics with OSA diagnosis


Increased weight = increased OSA

- 10% weight gain increases OSA severity (AHI) by about 32%
- 10% weight loss reduces OSA severity (AHI) by about 26%

Other associations

- Prevalence of OSA in Coronary Artery Disease
  - 35-57%
- Prevalence of OSA in Pulmonary Hypertension
  - 17-52%
    - (in patients with pulmonary or cardiac disease)
- Increased risk for cardiac arrhythmias
  - Type II-III AV block/sinus arrest in 7% of OSA patients
  - Odds ratio for ventricular ectopy of 1.7


Hypertension  | Atrial Fibrillation  | Congestive Heart Failure  | Stroke  | Obesity  | Type II Diabetes  | Others

OSA treatment

- PAP is recommended 1st line
  - All OSA severity
  - Excessive sleepiness
  - Impaired quality of life
  - Comorbid hypertension
- In-lab CPAP titration
- AutoCPAP
  - Symptomatic patients
  - No significant comorbid illnesses
**Recommended Reading/Guidelines**

**Journal of Clinical Sleep Medicine**

**2019**

**TREATMENT OF ADULT OBSTRUCTIVE SLEEP APNEA WITH POSITIVE AIRWAY PRESSURE: AN AMERICAN ACADEMY OF SLEEP MEDICINE SYSTEMATIC REVIEW, META-ANALYSIS, AND GRADE ASSESSMENT**


**AMERICAN THORACIC SOCIETY DOCUMENTS**

**EVALUATION AND MANAGEMENT OF OBESITY HYPVENTILATION SYNDROME: AN OFFICIAL AMERICAN THORACIC SOCIETY CLINICAL PRACTICE GUIDELINE; EXECUTIVE SUMMARY**

Bakaeen, F.; Meller, S.; Bhan, S.; Shaw, R.; et al.

**2019**

**Recommended Reading/Guidelines**

**Journal of Clinical Sleep Medicine**

**2017**

**SCREENING FOR OBSTRUCTIVE SLEEP APNEA IN ADULTS: EVIDENCE REPORT AND SYSTEMATIC REVIEW FOR THE US PREVENTIVE SERVICES TASK FORCE**

Davidoff, J.; Wise, M.; Breslau, N.; et al.

**CLINICAL REVIEW**

**Screening and assessment for obstructive sleep apnea in primary care**

Jennifer N. Miller, An M. Berger

**Recommended Reading/Guidelines**

**Journal of Clinical Sleep Medicine**

**2009**

**CLINICAL PRACTICE GUIDELINE FOR DIAGNOSTIC TESTING FOR ADULT OBSTRUCTIVE SLEEP APNEA: AN AMERICAN ACADEMY OF SLEEP MEDICINE CLINICAL PRACTICE GUIDELINE**


**Recommended Reading/Guidelines**

**Journal of Clinical Sleep Medicine**

**2009**

**CLINICAL GUIDELINE FOR THE EVALUATION, MANAGEMENT, AND LONG-TERM CARE OF OBSTRUCTIVE SLEEP APNEA IN ADULTS**

Adult Obstructive Sleep Apnea Task Force of the American Academy of Sleep Medicine

**Obstructive Sleep Apnea Part 2: Follow Up**

Madelyn Rosenthal, MD
Assistant Professor - Clinical
Department of Internal Medicine
Division of Pulmonary Medicine
The Ohio State University Wexner Medical Center
## Disclosures

- Nothing to disclose

## Objectives

- What to address at a follow up visit?
- PAP adherence
- Residual Daytime Sleepiness
- Nasal Congestion

### What should be addressed at follow up for OSA? ¹

1. OSA specific quality of life measures
   - Ex. Functional Outcomes of Sleep Questionnaire²
2. Patient and bed partner satisfaction

### What should be addressed at follow up for OSA continued?

3. Avoidance of factors worsening disease severity
   - Alcohol and sedatives
4. Obtaining adequate amount of sleep
5. Weight loss for overweight/obese patients

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What should be addressed at follow up for OSA continued?

6. Adherence
   - Up to 30% of newly diagnosed patients refuse PAP treatment from the beginning.\textsuperscript{1}
   - Approximately 25% discontinue PAP within the first year. \textsuperscript{2}


Adherence

What defines adherence to therapy per CMS?
1. Office visit follow-up between 31 and 90 days after starting PAP.
2. Within the 1\textsuperscript{st} 90 days, PAP use $\geq$ 4 hours per night on $\geq$70% of nights over a consecutive 30 day period.
3. Patient's symptoms have improved.

Factors associated with poor adherence:
- Poor early adherence
- Bed partner referral
- High Mask Leak
- High nasal resistance
- Race
- Lower socioeconomic group
- Psychiatric Comorbidity

Factors associated with good adherence:
- Pretreatment daytime somnolence
- Good early adherence
- Subjective improvement
- High oxygen desaturation index
Ways to Improve Adherence

- Education
- Cognitive behavioral therapy
- Desensitization
- Telemedicine

- The earlier patients seek help, the more likely they will succeed!!

Adherence

- What defines adherence to therapy per CMS?
  1. Office visit follow-up between 31 and 90 days after starting PAP.
  2. Within the 1st 90 days, PAP use ≥ 4 hours per night on ≥70% of nights over a consecutive 30 day period.
  3. Patient’s symptoms have improved.

Case 1

- 35 year old man with a history of Down Syndrome presents for follow up.
- First visit since diagnosis of severe obstructive sleep apnea (AHI 55 events/hr).
- He is accompanied by his aunt who reports no change in symptoms of excessive daytime sleepiness.
- Reports that he is using his machine every night while sleeping.

Case 1 Continued

<table>
<thead>
<tr>
<th>Compliance Summary</th>
<th>3/3/20X</th>
<th>3/14/20X EEG data</th>
<th>7/12/20X EEG data</th>
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</thead>
<tbody>
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<td>Epoch Start</td>
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<td>15:41</td>
<td>15:41</td>
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<tr>
<td>Epoch End</td>
<td>15:41</td>
<td>15:41</td>
<td>15:41</td>
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<tr>
<td>Total Sleep Duration</td>
<td>5 mins</td>
<td>5 mins</td>
<td>5 mins</td>
</tr>
<tr>
<td>Minute Sleep</td>
<td>2 mins</td>
<td>2 mins</td>
<td>2 mins</td>
</tr>
<tr>
<td>Minute Wake</td>
<td>3 mins</td>
<td>3 mins</td>
<td>3 mins</td>
</tr>
<tr>
<td>Minute Gaps in Sleep</td>
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<td>6 times</td>
</tr>
<tr>
<td>Average Gaps Between</td>
<td>10 secs</td>
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<td>10 secs</td>
</tr>
<tr>
<td>Percentage Gaps in Sleep</td>
<td>95.7%</td>
<td>95.7%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Maximum Gaps (1 Day)</td>
<td>13 hrs, 29 mins, 27 secs</td>
<td>13 hrs, 29 mins, 27 secs</td>
<td>13 hrs, 29 mins, 27 secs</td>
</tr>
<tr>
<td>Average Sleep (All Days)</td>
<td>7 hrs, 3 mins, 52 secs</td>
<td>7 hrs, 3 mins, 52 secs</td>
<td>7 hrs, 3 mins, 52 secs</td>
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<tr>
<td>Average Sleep (All Days)</td>
<td>7 mins, 3 mins</td>
<td>7 mins, 3 mins</td>
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<tr>
<td>Average Wake (All Days)</td>
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<td>5 mins, 3 mins</td>
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<tr>
<td>Average Wake (All Days)</td>
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<td>3 mins, 3 mins</td>
<td>3 mins, 3 mins</td>
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<tr>
<td>Average Gaps Between</td>
<td>10 secs</td>
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<tr>
<td>Average Wake (All Days)</td>
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<td>5 mins, 3 mins</td>
<td>5 mins, 3 mins</td>
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<tr>
<td>Average Wake (All Days)</td>
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<td>15 days, 7 mins, 7 mins, 7 mins</td>
</tr>
</tbody>
</table>
Case 1 continued- Why still sleepy?

Causes of continued sleepiness:
1. Inadequate CPAP treatment
   • Inadequate pressure

Case 1 continued- Why still sleepy?

- What is the residual AHI?

<table>
<thead>
<tr>
<th>Auto-CMP Summary</th>
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<tbody>
<tr>
<td>ISCH Max Pressure</td>
</tr>
<tr>
<td>ISCH Min Average Pressure</td>
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<tr>
<td>Average Device Pressure &lt;= 10% of Time</td>
</tr>
<tr>
<td>Average Time in Large leaks For Day</td>
</tr>
<tr>
<td>Average AHI</td>
</tr>
<tr>
<td>Device Testing as of</td>
</tr>
</tbody>
</table>

Case 1 Continued- Why still sleepy?

Causes of continued sleepiness:
1. Inadequate CPAP treatment
   • Is the patient adherent to therapy and using PAP appropriately?
Case 1 continued- Why still sleepy?

1. Inadequate CPAP treatment
   - Mask leak, mouth leak or both arousing patient?

2. Disturbance of sleep from PAP discomfort
3. Another sleep disorder- insufficient sleep, narcolepsy, restless legs syndrome, periodic limb movements of sleep disorder
4. Depression or mood disorder

5. Chronic pain disorders.
6. Medications or other medical disorders disrupting sleep.
7. Residual hypersomnia in patients with adequately treated OSA.

• If PAP usage is optimized for at least 3 months and patient continues to be sleepy and other causes are ruled out, consider:
  - Referral to a Sleep Medicine Specialist for further evaluation.
**Case 2:**

- 45 year-old Caucasian male presents for follow up of his obstructive sleep apnea.
- An overnight PSG showed severe obstructive sleep apnea (AHI 45 events/hour).

**Case 2 continued**

- He underwent titration and was started on a CPAP of 13 cmH₂O.
- He notes minimal improvement in his symptoms with his Epworth Sleepiness Scale decreasing from 16 to 14.
- Complains of nasal congestion.
Case 2 continued

How to address mask leaks?
- Evaluate condition of mask-worn cushions or headgear?
- If the patient is wearing a nasal mask or pillows and has dry mouth consider addition of a chin strap
- Alternatively, switch to full facemask.
- Increased humidity could overcome mild leak

Case 2 continued

What to consider in a patient complaining of nasal congestion after starting CPAP?
- Did the patient have nasal congestion prior to initiation of PAP therapy?
  - Yes: evaluate for obstruction, review history of trauma, and for allergic components.

Case 2 continued

- Did the patient have nasal congestion prior to initiation of PAP therapy?
  - No: do symptoms occur only at night when sleeping? likely related to drying of the nasal mucosa.
  - Suspect mask or mouth leak

Case 2 continued

- Underlying nasal congestion
  - Use nasal corticosteroids
  - Inhaled antihistamines (astelin) or oral antihistamines
  - Inferior turbinate hypertrophy
  - Referral to ENT for turbinate reduction
Case 2 continued

- Chin strap added and humidification was increased resulting in improvement in his symptoms.

Algorithm for CPAP Success

I. Assess and Enhance Patient Readiness
- Perceived importance?
- Perceived self-efficacy?
- Educate: OSA and PAP
- Enhance motivation

II. Map a Plan for Change
- Manage patient expectations
- Set realistic behavioral goals
- Identify self-rewards

III. Identify & Overcome Potential Barriers
- Insomnia? Anxiety?
- Rhinitis? Reduced nasal airflow?
- Facial hair or mouth-breather?

IV. Maximize Early Experiences with PAP
- Mask selection?
- PAP comfort features?
- Sedative Hypnotic use?
- Cognitive behavioral therapy?

V. Follow up, Troubleshoot & Support
- Early assessment of PAP response
- Medical/physiologic
- Behavioral/motivational
- Technical