Friday General Session

**Diagnosis and Management of Obstructive Sleep Apnea in Primary Care**

W. David Brown, PhD
Sleep Psychologist, Department of Psychiatry
Children’s Medical Center
Dallas, Texas

**Educational Objectives**
By the end of this activity, the participant should be better able to:
1. Identify common symptoms and risk factors for obstructive sleep apnea (OSA).
2. Describe how to screen and diagnose OSA.
3. Explain the different treatment options for OSA.
4. Identify the different co-morbidities that are associated with OSA.

**Speaker Disclosure**
Dr. Brown has disclosed that he has no actual or potential conflict of interest in relation to this topic.
Obstructive Sleep Apnea
TEXAS ACADEMY OF FAMILY PHYSICIANS
JUNE 3, 2016
W. DAVID BROWN, PHD, FAASM, CBSM

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“Sleep!” said the old gentleman, ‘he’s always asleep. Goes on errands fast asleep, and snores as he waits at table.”
Charles Dickens – The Pickwick Papers - 1836

1889 - Dr. W. Hill British Medical Journal
“The stupid-lazy child who frequently suffers from headaches at school, breathes through his mouth instead of his nose, snores and is restless at night, and wakes up with a dry mouth in the morning, is well worthy of the solicitous attention of the school medical officer.”

1892 – William Osler Text
“Chronic enlargement of the tonsillar tissues is an affection of great importance, and may influence in an extraordinary way the mental and bodily development of children.”
“At night the child’s sleep is greatly disturbed; the respirations are loud and snorting, and there are sometimes prolonged pauses, followed by deep, noisy inspirations.”

Obstructive Sleep Apnea

- Discovered in Europe in 1965 (Gastant, Jung and Zarcone)
- 1972 – Stanford recruits Christian Guilleminault
- Gained terms apnea and hypopnea
- 1972 - First CME Conference on Sleep
- 1981 - Sullivan uses CPAP to treat OSA
- 1991 – Johns develops Epworth sleepiness Scale
- 2008 – Young finds high mortality risk with OSA
- 2010 – Redline, OSA associated with increased stroke in men

SDH and Mortality: The Wisconsin Sleep Cohort—Young et al., SLEEP, Vol. 31, No. 8, 2008

MRI UPPER AIRWAY

Normal Apnea

Change in Upper Airway During Sleep

- Loss of Wake Stimulus
- Muscles Relax and cross-sectional area is reduced
- Change in AP and Lateral Dimensions
- AP due primarily to posterior movement of soft palate
- Lateral changes due to thickening of the lateral pharyngeal walls

Schwab, RJ et al. Upper Airway Imaging in Obstructive Sleep Apnea, in Lee-Chiong et al. Sleep Medicine, 2002.

Primary Snoring

During snoring, air flow is partially blocked.

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OBSTRUCTIVE APNEA

During sleep apnea, air flow is completely blocked.

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Pathogenesis of Sleep Apnea

- African Americans, Hispanic men, and Pacific Islanders have more OSA than White Europeans.
- Asians have more severe apnea with equal or lower BMI’s.


PSG of Obstructive Apnea

- No airflow with continued effort
- Must be at least 10 seconds
- No desaturation requirement
- No arousal requirement

Obstructive Sleep Apnea

- Central sleep apnea
- Central sleep apnea associated with Cheyne-Stokes Breathing
- Central apnea due to a medical disorder without Cheyne-Stokes breathing
- Central sleep apnea due to high altitude periodic breathing
- Central sleep apnea due to medication or Substance
- Primary central sleep apnea
- Primary central sleep apnea of infancy
- Primary central sleep apnea of prematurity
- Treatment-emergent central sleep apnea

Disorder | ICD-10-CM code
--- | ---
Obstructive sleep apnea disorders | G47.33
Obstructive sleep apnea, adult | G47.33
Obstructive sleep apnea, pediatric | G47.33
Central sleep apnea syndromes | G47.37
Central sleep apnea due to high altitude periodic breathing | G47.32
Central sleep apnea due to medication or Substance | G47.36
Primary central sleep apnea | G47.31
Primary central sleep apnea of infancy | P28.5
Primary central sleep apnea of prematurity | P28.4
Treatment-emergent central sleep apnea | G47.39

Sleep related hypoventilation disorders

- Obstructive sleep apnea
- Congenital central alveolar hypoventilation syndrome
- Sleep related hypoventilation due to a medical disorder
- Sleep related hypoventilation due to medication or Substance
- Sleep related hypoventilation due to a medical disorder

Hypopneas

- Reduced airflow at nose and mouth
- Associated with a 4% desaturation
- Non-Medicare can be 3% desaturation or an arousal

Central Apnea

- No airflow and no effort
- 10 seconds for adult, 2 breaths for children
- No desaturation or arousal requirement
Complex Apnea (Treatment Emergent Apnea)

Clear Obstructive apneas on Diagnostic Study

Central Sleep Apneas appear with any CPAP pressure

Severe Sleep Apnea

55 YO WM BMI=44.1
ESS: 18
Rx: Insulin Glargine
Insulin Aspart
Furosemide
AHI = 115.2
Supine AHI = 122.6
Min O2 = 50%

Positional/REM Sleep Apnea

STOP-BANG

Based on the Stop-Bang How many Questions Did You Answer Yes?

1. None
2. One
3. Two
4. Three or More
Prevalence of OSA

- Severity usually defined by apnea-hypopneas index
- Defining OSA as AHI \( \geq 5 \) events/hr. Wisconsin Cohort study find a prevalence of 24% in men and 9% in women 30 – 60 years old.
- Prevalence of OSA with daytime sleepiness is 3 -7% in adult men and 2 – 5% in adult women
- Prevalence studies are about the same world – wide

Epidemiological aspects of obstructive sleep apnea

Prevalence Increasing with Obesity

- Related to obesity – as global obesity epidemic spreads, prevalence will go up.
- Recent re-examination of the Wisconsin data adjusted for current levels of obesity, showed a marked increase.
- 34% of men and 17.4% of women have an AHI \( \geq 5 \).
- EDS 14% of men and 5% of women


Symptoms

- Snoring
- Pauses in breathing (Unless Hypopneas)
- Gasping and choking
- Breakthrough Snorrs
- Frequent urination
- Excessive daytime sleepiness
- Difficulty falling or staying asleep
- Excessive sweating
- GERD
- Decreased Libido
- Depression/Irritability

Spicuzza L. Et al. Ther Adv Chronic Dis 2015, Vol. 6(5) 273–285

Common physical examination findings in Obstructive Sleep Apnea

- Obesity (body mass index \( \geq 30 \) kg/m2)
- Neck circumference > 17 inches in men, > 16 inches in women
- Deviated nasal septum
- Narrow mandible
- Narrow maxilla
- Dental overbite and retrognathia
- High and narrow hard palate
- Elongated and low-lying uvula
- Prominent tonsillar pillars
- Large tongue

Mehra R. CLEVELAND CLINIC JOURNAL OF MEDICINE VOLUME 81 • NUMBER 8 AUGUST 2014

Retrognathia

Risk Factors

• Risk increases with increased body weight and neck circumference
  • Most significant risk factor is being overweight
  • 10% increase in weight is associated with a 6-fold increase in risk of AHI > 15
  • 10% weight reduction can lower risk by 26%
  • Neck Circumference > 17 in in men and >16 in women
  • Women have marked increase in apnea after menopause
  • Down Syndrome (94% have at least mild apnea)
  • Familial factors
  • Smoking and alcohol near bedtime
  • PCOS, Hypothyroidism, Pregnancy

What percentage of your patients diagnosed with sleep apnea are on CPAP?

1. < 25%
2. 26 – 50%
3. 51- 75%
4. 76 – 100%

What percentage of your apnea patients use CPAP regularly?

1. < 25%
2. 26 – 50%
3. 51- 75%
4. 76 – 100%

What percentage of your apnea patients have had upper-airway surgery?

1. < 25%
2. 26 – 50%
3. 51- 75%
4. 76 – 100%

Sleep Apnea Co-Morbidities

Down-Risk Hypertension 87%
Obesity 77%
Pacemakers 66%
Congestive Heart Failure 78%
Arterial Hypertension 49%
Diabetes 48%
All Hypertension* 57%
Coronary Artery Disease* 26%

Wisconsin Sleep Cohort Study 18 year Follow-Up

• AHI > 30 had 3-fold increase for all cause mortality
• There was a 4 – 5 fold increase if take out CPAP users
• Strong cardiovascular link if remove CPAP users
• Indication that CPAP lowers blood pressure.

n = 1522

Excluding 126 CPAP Users

SDH and Mortality: The Wisconsin Sleep Cohort—Young et al. SLEEP. Vol. 31, No. 8, 2008
**OSA and Stroke Risk**

- 8 year prospective study in men and women
- n = 5422 with 2462 men and 2960 women
- Men with moderately severe OSA had an almost 3-fold increase in ischemic stroke
- This was not seen in women
- Risk of stroke increased 6% for every increment of AHI from 5 – 25
- Age and AHI were the only significant risk factors after adjusting for confounds
- Marked surges in systemic blood pressure occur with each apneic and hypopneic event, followed by abrupt drops in systemic blood pressure.
- Parallel large fluctuations in cerebral blood flow velocity
- Atrial fibrillation is estimated to increase the risk of stroke by twofold or more and moderate to severe OSA increases the risk of atrial fibrillation by fourfold

**Patented Devices**


**Treatment Strategies**

- Position training
- Medication:
  - Protriptyline
  - Doxepine
  - SSRI’s
  - Modafinil
- Weight Loss
- Oral Appliance
- EPAP
- Oral Pressure Therapy
- Nasal PAP
- Surgical Intervention
- Upper-Airway stimulation

**NASAL CPAP**

- CPAP
- BiPAP
- Autoset
- Adaptive Servo-Ventilation (ASV)

**CPAP Pressure and Upper Airway**

- Schwab, RJ et al. Upper Airway Imaging in Obstructive Sleep Apnea. In Lee-Chiong et al. Sleep Medicine, 2002

**Split Night Sleep Study**

- 38 YO WM. Snoring, Observed pauses in breathing, Daytime Sleepiness, Epworth = 19
- BMI = 40.6 Kg/m2
- Pre-CPAP
  - AHI = 88 episodes/hr, Low O2 = 81%
- Post-CPAP
  - AHI = 21 episodes/hr, Low O2 = 80%
  - CPAP Pressure of 11 cm H2O
  - AHI = 0 episodes/hr, Low O2 = 92%
  - CPAP Pressure of 10 cm H2O

- Schwab, RJ et al. Upper Airway Imaging in Obstructive Sleep Apnea. In Lee-Chiong et al. Sleep Medicine, 2002
**Weight loss and OSA over 1 year**

- Subjects who lost 10 kg or more had a reduction in AHII of 11.3 events/hr.
- After 1 year, in the stable group, the AHII actually increased.
- Shows that apnea can worsen with time.

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**Bariatric Surgery**

- Surgical weight loss resulted in reductions of AHII in nearly all patients.
- The majority of patients showed residual apnea.
- Reliance on weight loss as a "cure" may lead to inappropriate cessation of CPAP.
- Subjects who thought their snoring was resolved were at highest risk of discontinuing CPAP.
- CPAP Pressure Changed from 11.5 to 8.4 cm H2O.

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**Oral Appliances**

- OA therapy has proved effective over the past 10 years in treating patients with OSA, by reducing the apnea and hypopnea index (AHII), improving oxygen saturation during sleep, reducing snoring.
- In all studies, CPAP showed better results than OA in bringing the AHII <10.
- Several clinical studies that compared OA with UPPP and demonstrated the superiority of OA with 78% reduction in OSA in OA.
- AHII decreased from 31 ep/hr to 14 ep/hr. n = 2724.

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**Expiratory Positive Airway Pressure**

- One Way Valve – causes pressure on expiration that opens the upper airway.
- The high expiratory resistance results in positive pressure throughout exhalation, which splints open the upper airway, making it more resistant to collapse on subsequent inspiration.
- The nasal EPAP device significantly reduced the AHII and improved subjective daytime sleepiness compared to the sham treatment in patients with mild to severe OSA, with excellent adherence.

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Berry R. Et al. SLEEP, Vol. 34, No. 4, 2011.
Oral Pressure Therapy (OPT)

Works by applying a low level of suction via a mouthpiece which is placed between the teeth and over the patient’s tongue.

OPT Results

- n = 63
- Baseline AHI = 27.5
- Treatment AHI = 13.4
- After 28 days AHI = 14.8
- Clinically significant response was seen in 20 of 63 patients (AHI < 10 and 50% reduction of AHI).

Colrain IM, et al. Sleep Med. 2013 Sep;14(9):630-7

Upper-Airway Stimulation

- Neurostimulator implanted in chest
- Delivers electrical stimulation to the hypoglossal nerve
- Synchronized with ventilation by sensing lead


Upper-Airway Stimulation

- n = 23 in each group
- Therapy withdrawal group had the device turned off for 5 days before PSG

Median ± IQR

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<th>Outcome</th>
<th>Baseline</th>
<th>12 months</th>
<th>p value</th>
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<tbody>
<tr>
<td>AHI</td>
<td>32</td>
<td>15.9</td>
<td>&lt;0.001</td>
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<tr>
<td>ESS</td>
<td>11.6</td>
<td>7.3</td>
<td>&lt;0.001</td>
</tr>
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<td>FOSQ</td>
<td>14.3</td>
<td>17.3</td>
<td>&lt;0.001</td>
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<tr>
<td>% TST&lt;90%</td>
<td>8.7</td>
<td>5.9</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>


Pillar Implants

- Stiffens the soft palate, decreasing its flutter and stabilizing the retro-palatal airway. This is accomplished in a nondestructive way by the placement of small woven inserts into the soft palate, under local anaesthetic.
- After refusal or failure of CPAP; First line therapy for interested patients who meet criteria
- Mild to moderate OSA
- AHI doesn’t significantly improve for most patients
- Procedure alone may not adequately treat a patient’s OSA


The following medications were discussed in this presentation. The table below lists the generic and trade name(s) of these medications.

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
</tr>
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<tbody>
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<tr>
<td>Furosemide</td>
<td>Lasix</td>
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<td>Insulin Aspart</td>
<td>Novolog</td>
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<tr>
<td>Insulin Glargine</td>
<td>Basaglar, Lantus, Toujeo Solostar</td>
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<td>Modafinil</td>
<td>Provigil</td>
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<td>Protriptyline</td>
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