Sleep Disordered Breathing scope: stakeholder subgroup discussions **Date: Thursday 12 April 2018** **Group: 1**	
Population: **Groups that will be covered:** • Adults (18 and older) with obstructive sleep apnoea/hypopnoea syndrome (OSAHS) • No specific subgroups of people have been identified as needing specific consideration.	Is the population appropriate? • Are there any specific subgroups that have not been mentioned? <u>Notes from stakeholder discussion</u> A question regarding why paediatrics are excluded was raised. There was consensus regarding the appropriateness of a separate guideline for paediatrics. There were no specific subgroups raised as needing different consideration within adults relevant to this guideline.
Key clinical issues that will be covered: We will look at evidence in the areas below when developing the guideline, but it may not be possible to make recommendations in all the areas. 1 Initial identification, assessment and referral of suspected cases of OSAHS.	These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion? • Is treatment of rhinitis a priority question to ask? Would you ever not treat the rhinitis? • Does severity of disease impact response to treatment (other than with mandibular devices)?

2 Diagnosis of OSAHS. 3 Management of OSAHS – Treatment of rhinitis in people with OSA – Upper airway surgical interventions – Positional modifiers – Mandibular advancement devices – Positive airway pressure support. 4 Monitoring of people with OSAHS – Determining efficacy of treatment – How to monitor – How to improve adherence 5 Information and support for people with OSAHS. **Key clinical issues that will not be covered:** 1 Clinical and cost effectiveness of CPAP 2 Assessment and management of central sleep apnoea	<u>Notes from stakeholder discussion</u> 1. Preoperative patients were considered to be a high risk group that should be prioritised for testing as OSAHS can lead to complications with the operation. The need for OSAHS testing to become routinely performed in preoperative patients was raised by one group member. Drivers were considered a group needing prioritisation. HGV and DVLA drivers were considered a special group of patients that warrant fast tracking for assessment. 2. An increasing lack of beds available in hospitals to allow hospital diagnosis was stressed. Adopting a patients' perspective, diagnosis at home was favoured by part of the group as it was mentioned that sleeping in one's own bed is different from sleeping in a hospital bed, and would permit a more accurate diagnosis. 3. Management of OSAHS was considered by the group to cover the right areas. It was mentioned that the point on surgical interventions was not wide enough considering the different types of existing surgical interventions and that expansion on this point would be likely to affect committee membership. The importance and usefulness of mandibular advancement devices was emphasised. The group raised the fact that these are associated to surgery and particularly noted that currently people frequently have to pay for their own devices. 4. In terms of monitoring, it was noted that in some areas people with OSAHS are responsible for their own treatment and that it is their responsibility to contact hospitals for follow-up. It was proposed that people may appreciate being contacted by hospitals instead. There was agreement

	that monitoring should involve examining the adherence and efficacy of treatment. The proposed time for monitoring was one year following the beginning of treatment. A potential benefit of an earlier initial follow-up such as at six months after the start of treatment was also mentioned and that people should be monitored yearly after that. It was highlighted that this should also be determined by disease severity. The group raised the need for different recommendations relative to the frequency and timing of monitoring applicable to different groups including drivers. 5. The importance of providing advice on lifestyle factors including weight status, smoking, alcohol consumption and information on health risks including cardiovascular diseases risk and arrhythmias for people with OSAHS was expressed. The group agreed that information on relevant smartphone applications and existing lay-led support groups such as hope2sleep would provide support to people with OSAHS. • Treatment of rhinitis was agreed as an important topic to cover. It was specifically mentioned that rhinitis often goes untreated if not diagnosed in the first examination and an appropriate diagnosis can improve response to treatment for OSAHS. • Disease severity was considered relevant for all management options specified in the draft scope.
Further Questions:	
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?	
Driving considerations constitute an area that the group considered missing from the draft scope as it stands. Sleep apnoea and driving was proposed as an area that would involve the examination of special considerations required for drivers; that is, the examination of who should be fast-tracked for testing and ensuring monitoring and compliance to treatment. Within this framework, road fatality and the financial implications of road crashes was underlined as	

an area to be covered and expanded in the scope. A further important issue the group thought should be covered is the range of different treatment masks that can be used and the importance of providing patients a mask that is tailored to their needs.
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?
No area was considered irrelevant.
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?
The group agreed that the aforementioned area of sleep apnoea and driving needs to be addressed.
4. Which area of the scope is likely to have the most marked or biggest health implications for patients?
It was noted that the condition is underdiagnosed, and under recognised. Greater awareness of the condition should in turn lead to an improved patient pathway. This was seen as a positive outcome that is likely to arise from the development of a guideline on the topic. Alternative options for people who can't use CPAP was also highlighted as an area of the scope that would have an impact on health for patients.
5. Which practices will have the most marked/**biggest cost** implications for the NHS?
Road fatality and its financial implications were raised. It was mentioned that about 10% of accidents are due to sleepiness and the consideration of this issue is likely to impact the economic evaluation. The group stressed the importance of diagnosis as undiagnosed sleep apnoea is likely to have cost implications.
6. Are there any **new practices** that might **save the NHS money** compared to existing practice?
The group agreed that new practices have been adequately covered within the draft scope.
7. If you had to delete (or de prioritise) two areas from the Scope what would they be?

None.
8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?
The group raised the importance of establishing quicker pathways for referral for testing for specific groups of people such as people who are overweight, have depression or symptoms of sleep apnoea. The effectiveness of surgery for treating sleep apnoea was also addressed. Another issue raised by the group was the importance of raising people's awareness regarding a rise in the prevalence of sleep apnoea due to obesity and the increasing relevance of the disease for younger generations as a result to this.
9. What are the priority outcomes? Is the current list correct?
The group agreed that the diagnostic accuracy of tests should not be listed here. Cognitive function and the link between sleep apnoea and dementia was raised as an outcome that should be considered.
10. Any comments on guideline committee membership?
The group expressed the importance of having a broader committee membership. They stressed the important role of nurses in sleep apnoea and proposed that nurses should be included as members of the committee. The important role of anaesthetists in picking up the disease and doing a pre-assessment was also raised and it was proposed that an anaesthetist should therefore constitute a full member. The inclusion of an ENT surgeon, a dentist and orthodontist as a co-opted committee member was strongly supported by the group.