Sleep Disordered Breathing scope: stakeholder subgroup discussions **Date: Thursday 12 April 2018** **Group: 2**	
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> Populations raised as of particular importance to consider: • **Patients undergoing elective surgery including dental surgery**. This is so that OSAHS can be identified and managed such that complications with anaesthesia or sedation are reduced. There may be a need for this population to have a pre-operative assessment, e.g. STOP-BANG, with potential benefits to having an assessment 6-8 weeks before elective surgery. In particular, people with a BMI >35 undergoing bariatric or other elective surgery as they have an increased risk of OSAHS. • **Elderly people as** aging increases incidence of OSAHS and there may be co-morbidity with dementia. There is some evidence that the treatment of OSAHS has benefits in terms of mental state in the elderly. Elderly people may also have different requirements as they generally sleep less and have a lower quality of sleep. • **People with learning disabilities** as there may be potential difficulties in terms of diagnosis due to communication issues, but it was considered likely that the same treatment would be provided though a different care pathway taking learning disabilities into account.

	There was a suggestion that the lower age limit should be 16 not 18. The increase in childhood obesity was noted as this may result in more 16 and 17 year olds with OSAHS.
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. 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	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)? <u>Notes from stakeholder discussion</u> The treatment of rhinitis was not considered a particular priority by some members of the group, but it was also raised that rhinitis was important to consider as a factor in patient experience of use of CPAP, especially in terms of the need for humidification. The group agreed that disease severity would impact on response to 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	

Further Questions:

1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?

Issues raised:

- Screening, including discussion of whether screening should be universal or targeted e.g. screening of pregnant women. Strategies to ensure that the most symptomatic cases of OSAHS are identified and managed quickly.
- Management of OSAHS prior to elective surgery – see population, above.
- Telemonitoring as an issue to consider within monitoring.
- Patient use of opiates, especially as treatment for chronic pain.
- Patient use of alcohol.
- Medical alert cards.
- Patient information and support,
    - Patients need a wide variety of information including DVLA rules, how to look after equipment and lifestyle advice. The Sleep Apnoea Trust Association guidance could be signposted.
    - Patients need quick access to advice if they have equipment failure.
- Multi-disciplinary team approach, including:
    - upper airway examination and intervention
    - dental examination and intervention.

- Direct referral to the sleep team from health care professionals, such as dentists

2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?

None identified.

3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?

Areas of diverse practice:

- Treatment of rhinitis – sometimes patients are given maintenance instead of treatment dose.
- Whether or not dentists can refer patients to sleep clinics.
- When patients are referred to ENT.
- Information provided to patients, which varies by trust and may not reflect best practice.
- Level of support provided to patients using CPAP machines, e.g. delays experienced by patients seeking information about problems with CPAP machines, variation between the levels of support offered by manufacturers.
- Provision of mandibular devices.

Areas of unsafe practice:

- Lack of technical standards of devices including CPAP (refer to Association for Respiratory Technology & Physiology standards).
- The delay between diagnosis and treatment, which is a particular problem for drivers due to DVLA requirements and was raised as a major cause of anxiety for patients.
- Under diagnosis, demonstrated by the number of patients where OSAHS is only detected when under anaesthesia for surgery.
- SATA has found a concerning lack of knowledge around OSAHS which may be contributing to unsafe levels of under diagnosis.
- On-line sales of mandibular devices which may be ineffective or cause adverse events.

4. Which area of the scope is likely to have the most marked or biggest health implications for patients?

- Early identification and diagnosis.
- Reduction in the time between diagnosis and treatment.

• Patients with severe symptoms or co-morbidities and drivers/pilots most likely to benefit from improvements in practice.
5. Which practices will have the most marked/**biggest cost** implications for the NHS?
The largest current cost is under diagnosis and lack of treatment causing other problems e.g. social cost of accidents, mortality and morbidity associated with cardiovascular incidents (evidence from 2005 Marin study).
6. Are there any **new practices** that might **save the NHS money** compared to existing practice?
It was suggested that early identification could save the NHS money by preventing cardiovascular disease.
7. If you had to delete (or de prioritise) two areas from the Scope what would they be?
Lowest priority was considered to be positional modifiers, and devices which interrupt sleep.
8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?
Not discussed.
9. What are the priority outcomes? Is the current list correct?
Not discussed.
10. Any comments on guideline committee membership?
Not discussed.