# Assessment Referral & Treatment of Obstructive Sleep Apnoea / Hypopnoea Syndrome (OSAHS)

## Criteria Based Access

Before consideration of referral for management in secondary care, please review advice on the Remedy website (www.remedy.bnssg.icb.nhs.uk/) or consider use of advice and guidance services where available.

## Section A - Criteria to Access Treatment

Funding Approval for assessment and treatment will only be provided by the ICB for patients meeting the criteria set out below:

a. Patients must have symptoms suggesting a probable diagnosis of OSAHS (including mild, moderate or severe OSAHS)

AND

b. Conservative management has been fully engaged with if appropriate and complied with for a period of at least 6 months by the patient and has not proven successful in reducing the impact of OSAHS.

OR

c. Conservative management is inappropriate before commencing treatment where the patient falls within one of the priority groups:

- Patients that have a vocational driving job
- Patients that have a job for which vigilance is critical for safety
- Patients that have unstable cardiovascular disease, for example, poorly controlled arrhythmia, nocturnal angina or treatment-resistant hypertension
- Patients that are pregnant
- Patients that are undergoing preoperative assessment for major surgery
- Patients that have non-arteritic anterior ischaemic optic neuropathy
- (Note: These patients should be referred for urgent assessment – and without further delay)

Note: Referral will be made by the locally agreed process. Where conservative management is inappropriate patients will be expected to fully engage with conservative management once treatment has commenced).

## Section B - Primary care referral notes

When assessing people with suspected OSAHS:

- Use the Epworth Sleepiness Scale in the preliminary assessment of sleepiness.
- Consider using the STOP-Bang Questionnaire as well as the Epworth Sleepiness Scale.

Do not use the Epworth Sleepiness Scale alone to determine if referral is needed, because not all people with OSAHS have excessive sleepiness.

GP's should take a sleep and occupational history, (and advice to update clinician if occupation changes) and assess people for OSAHS if they have 2 or more of the following features:

Symptoms:

- Snoring
- Witnessed apnoeas
- Unrefreshing sleep
- Waking headaches
- Unexplained excessive sleepiness, tiredness or fatigue
- Nocturia (waking from sleep to urinate)
- Choking during sleep
- Sleep fragmentation or insomnia
- Cognitive dysfunction or memory impairment.

## Section C - Secondary Care Pathway Management

CPAP For mild OSA:

For patients with mild OSAHS who have no symptoms or symptoms that do not affect usual daytime activities, treatment is not usually needed. Advise changes to lifestyle and sleep habits to help prevent OSAHS from worsening.

Patients with mild OSAHS who have symptoms that affect their quality of life and usual daytime activities, should be offered continuous positive airway pressure (CPAP) at the same time as lifestyle advice if they have any of the following priority factors:

- They have a vocational driving job
- They have a job for which vigilance is critical for safety
- They have unstable cardiovascular disease, for example, poorly controlled arrhythmia, nocturnal
- angina or treatment-resistant hypertension
- They are pregnant
- They are undergoing preoperative assessment for major surgery
- They have non-arthritic anterior ischaemic optic neuropathy

(Continued Below)

## Section B cont'd

OR

If lifestyle advice alone has been unsuccessful or is considered inappropriate.

CPAP for moderate and severe OSAHS:

CPAP is recommended as a treatment option for adults with moderate or severe symptomatic OSAHS

OSAHS in NICE's technology appraisal guidance on continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome states that:

Patients with moderate or severe OSAHS should be offered CPAP in addition to lifestyle advice.

For all patients having CPAP:

- Offer telemonitoring with CPAP for up to 12 months
- Consider using telemonitoring beyond 12 months

## Section D - Treatment Cessation

Patients will have been considered to have failed to comply with treatment with CPAP, if over a six-month period:

- The patient has failed to use the device on average for 70% of days

AND

- The patient has failed to use the device on average for 4 hours per night when used.

Patients who fail to comply with these treatment requirements, must cease treatment and return the device to the provider for refurbishment and reissue to another patient where appropriate, or reimburse the NHS the full replacement cost of the device.

Note: it is well recognised that a small number of patients gain significant clinical benefit (improved ESS scores) from CPAP when using the device for less than 4 hours per night and these patients should be allowed to continue treatment for the long term.

Patients who do not receive adequate benefit from the treatment (i.e., there is little or no improvement in their AHI or ESS scores) should also be assessed to establish whether it is appropriate for their treatment to continue.

## NOTE

If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form.

## BRAN

For any health- related decision, it is important to consider "BRAN" which stands for:

- Benefits
- Risks
- Alternatives
- DoNothing

## Benefits

Benefits of treatment can include:

- Motor vehicle accident prevention
- Improved daytime alertness
- Improved concentration
- Improved emotional stability
- Eliminate snoring

## Risks

Untreated sleep apnoea is associated with high blood pressure and may make it more difficult to control your blood pressure with medication.

OSA can reduce your ability to think clearly, leading to poor work performance and reliance on stimulants such as caffeine and sugary foods.

Sleep apnoea is a risk factor for heart attack, stroke and blood clots in the legs. The risk is higher with moderate or severe OSA and other comorbidities.

OSA may make you excessively sleepy and cause you to fall asleep at the wheel. The risk of fatal car accidents is much greater.

OSA is associated with emotional disturbances and may increase the risk of mental health conditions such as anxiety and depression.

Untreated sleep apnoea increases the risk of airway obstructions, abnormal heart rhythms and other complications during surgery.

## Alternatives

Potential alternatives can include;

- Mandibular devices
- Medication changes
- Smoking and alcohol cessation
- Weight loss

Patients with mild, moderate or severe OSAHS and symptoms that affect their usual daytime activities, who are unable to tolerate or decline to try CPAP, consider a customised or semi-customised mandibular advancement splint as an alternative to CPAP if they are aged 18 and over and have optimal dental and periodontal health.

Patients with mild or moderate positional OSAHS, consider a positional modifier if other treatments are unsuitable or not tolerated. Positional modifiers are unlikely to be effective in severe OSAHS.

Patients with OSAHS who have large obstructive tonsils and a body mass index (BMI) of less than 35 kg/m2, consider direct onward referral to ENT for tonsillectomy.

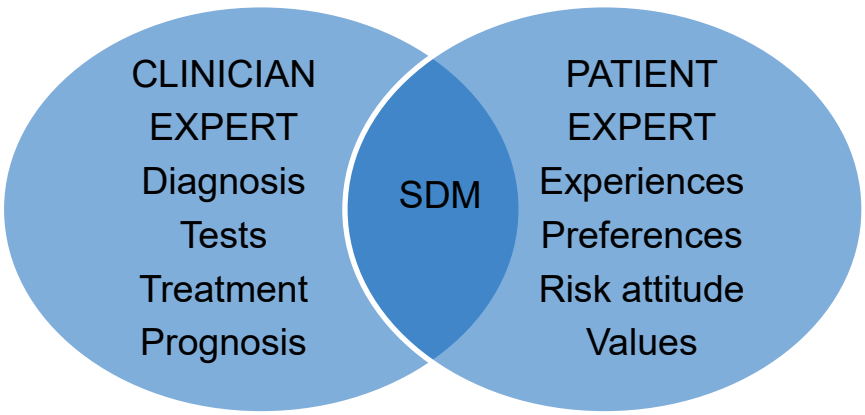
## Do Nothing

Remember, you always have the option to do nothing. Doing nothing is an equally reasonable option to doing something. Sometimes “not yet” is a good enough answer until you gather more information.

## Shared Decision Making

If a person fulfils the criteria for Apnoea / Hypopnoea Syndrome (OSAHS) treatment, it is important to have a partnership approach between the person and the clinician.

Shared Decision Making (SDM) is the meeting of minds of two types of experts:



It puts people at the centre of decisions about their own treatment and care and respects what is unique about them. This includes their preferences and values. It means that people receiving care and clinicians delivering care can understand what is important to the other person.

The person and their clinician may find it helpful to use 'Ask 3 Questions':

1. What are my options?
2. What are the pros and cons of each option for **me**?
3. How do I get support to help me make a decision that is right for **me**?

## Assessment Referral & Treatment of Obstructive Sleep Apnoea / Hypopnoea Syndrome (OSAHS) – Plain Language Summary

People who suffer from obstructive sleep apnoea/hypopnoea syndrome (OSAHS) breathe shallowly or stop breathing for short periods while sleeping.

In deep sleep, the muscles of the throat relax. Normally this doesn't cause any problems with breathing. In OSAHS, complete relaxation of the throat muscles causes blockage of the upper airway at the back of the tongue. Normal breathing then slows or stops completely. Such an episode is called an apnoea.

During an apnoea, people with OSAHS make constant efforts to breath against their blocked airway until the blood oxygen level begins to fall. The brain then needs to arouse the person from deep relaxed sleep so that the muscle tone returns, the upper airway then opens and breathing

begins again. Unfortunately, when a person with OSAHS falls back into deep sleep, the muscles relax once more, and the cycle repeats itself again and again overnight.

In OSAHS, the apnoea's can last for several seconds and in severe cases the cycle of apnoea's and broken sleep is repeated hundreds of times per night. Most sufferers are unaware of their disrupted sleep but awaken unrefreshed, feeling sleepy and in need of further refreshing sleep

## This policy has been developed with the aid of the following references:

1. NICE (2021) Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome (NICE Technology appraisal guidance TA139) www.nice.org.uk
2. National Health Service (2022) Health A to Z: Sleep Apnoea [online] www.nhs.uk/conditions
3. Epworth Sleepiness Scale (ESS) (2022) Conceptual framework questionnaires www.epworthsleepinessscale.com
4. UK Government Rules (2014) Excessive sleepiness and driving [online] www.gov.uk
5. BMJ Journals (2015) Effects of CPAP on body weight in patients with obstructive sleep apnoea 70-3-258 [Online] www.thorax.bmj.com/content
6. European Respiratory Journal (2014) Smoking status, clinical presentation and outcomes in obstructive sleep apnoea 44: 1743 [Online] www.erj.ersjournals.com
7. National Library of Medicine (2014) Compliance with continuous positive airway pressure (CPAP) therapy PMC4258250 [online] www.ncbi.nlm.nih.gov
8. National Library of Medicine (2016) Meta-analysis of randomised controlled trials of oral mandibular advancement devices and continuous positive airway pressure for obstructive sleep apnoea-hypopnoea PMID 26163056 [online] www.ncbi.nlm.nih.gov
9. National Library of Medicine (2013) The impact of diet and lifestyle management strategies for obstructive sleep apnoea in adults: a systematic review and meta-analysis of randomised controlled trials PMID 3361137 [online] www.ncbi.nlm.nih.gov

## Connected Policies

Mandibular device policy

## Due Regard

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Commissioning Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED), and NHSE Evidence-Based Interventions (EBI). This applies to all the activities for which the ICB's are responsible, including policy development and review.

# Document Control

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## Governance

Commissioning policies are assessed for their likely level of impact on BNSSG ICB and the population for which it is responsible. This determines the appropriate level of sign off. The below described the approval route for each score category.

| Policy Category | Approval By |
|---|---|
| Level 1 | Commissioning Policy Review Group. |
| Level 2 | Chief Medical Officer, or Chief Nursing Officer, or System Executive Group Chair |
| Level 3 | ICB Board |

## OPCS Procedure codes

Must have any of (primary only): E852,E853,E858,E912,E913

## Support

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: 0117 900 2655 or 0800 073 0907 or email them on BNSSG.customerservice@nhs.net.