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LETTER TO THE EDITOR

Beware of the "…"

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To the editor:

In her July 2005 article in JCSM,[1] Dr. Phillips reviewed our study[2] comparing sleep apnea survival rates between veterans provided CPAP and those having UPPP surgery. Dr. Phillips quoted part of our conclusion statement, "UPPP confers a survival advantage over CPAP …" and remarked, "Since very few ethical surgeons perform UPPP on patients with anything other than very mild apnea or heavy snoring, this statement is somewhat like reiterating the clinical truism that sicker patients are more likely to die!"

Yet, with this clinical truism in mind, we had designed our study to control rigorously for patient sickness. Though stated in the conclusion of our article, Dr. Phillips omitted, "…after adjustment for age, gender, race, year of treatment, and comorbidity."

Comorbidity is a measure of the sickness of a patient. We used a comorbidity index that was previously validated specifically to predict mortality. It comprises 19 different medical conditions, including the likely disease processes through which chronic sleep apnea kills patients (eg, cardiovascular disease, cerebrovascular disease, and others). The more severe the sleep apnea, the greater the likelihood of suffering these comorbid conditions and dying.

Our analysis revealed that UPPP confers a survival advantage over CPAP independent of how sick the patients were.

As stated in our article, we still advocate CPAP therapy as first line treatment, as long as the patient uses it. In our study, the CPAP group included all patients provided a CPAP, whether or not they were using it. By including all comer CPAP patients we attempted to evaluate the effect of CPAP in everyday life of sleep apnea patients, not just in the subset of adherent CPAP users. Presumably the patients who did not use CPAP adequately were the ones who lowered the mean survival of the CPAP group. This interpretation is supported by Peker et al, who found that inadequate CPAP use leaves sleep apnea patients at high risk for future cardiovascular disease.[3]

As with all studies, our study has limitations. Space constraints preclude us from addressing them here, but we acknowledged the main limitations in the article and explained why the results remain valid. We encourage readers to examine the data in our study and in other published studies to determine for themselves how surgery can help sleep apnea patients, especially the patients who otherwise remain inadequately treated.

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Disclosure Statement

Drs. Weaver, Maynard, and Yueh have indicated no financial conflicts of interest.

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