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EXPLORING SYMPTOMATIC RELIEF OF PATIENTS WITH CENTRAL SLEEP APNEA WHEN USING CPAP OR BiPAP THERAPY

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Introduction: About 0.9% of peoples over the age of 40 in the United States have Central Sleep Apnea (CSA). The key to treating CSA is to address any underlying health issues causing the condition as there are no clear, established treatment guidelines. For example, approaches will be made to mitigate congestive heart failure. Often, patients may require the use of CPAP or BiPAP device to decrease cessations in respiration during sleep.

Methods: We investigated those patients diagnosed with CSA who use CPAP or BiPAP therapy and it's potential therapeutic effects through a retrospective chart review over a three-year period. We excluded those who were diagnosed with treatment emergent CSA and those using ASV. Data was collected from each patient's chart about patient demographics, modality of PAP therapy, and information pertaining to symptomatic relief.

Results: 42 patients were identified who had a diagnosis of CSA. 25 of 42 (59.5%) were excluded as they were using alternative therapies. Of the 17 patients, 14 (82.4%) were male with an average age of 70.7 and 3 (17.6%) were females with an average age of 50. 15 of the 17 (88.2%) used CPAP therapy and the 2 (11.8%) patients used BiPAP. Prior to PAP therapy, the average Epworth Sleepiness Scale was 8.08 which improved to 3.79 post therapy. 9 out of the 17 (52.9%) patients reported improvement in nocturnal gasping while 2 (11.8%) did not report relief and 6 (35.3%) patients we were unable to determine through chart review. 9 out of 17 (52.9%) patients reported unrefreshed sleep and later 6 of the 9 (66.7%) patients reported refreshed sleep with initiation of PAP therapy while 1 patient reported no improvement and 2 (22%) we were unable to determine. 15 of the 17 (88.2%) patients complained of waking up multiple times throughout the night before PAP therapy. 5 (33.3%) patients had improvement of the frequency of nighttime awakenings while we were unable to determine the remaining 10 patients.

Conclusion: When central sleep apnea persists despite adequate treatment of the primary cause, CPAP or BiPAP may be used for symptomatic relief.

Support (If Any):

0793

POSTOPERATIVE MONITORING IN CHILDREN LESS THAN 2 YEARS OF AGE UNDERGOING ADENOTONSILLECTOMY FOR OBSTRUCTIVE SLEEP APNEA

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Introduction: To analyze variables associated with postoperative monitoring in children <2 years of age undergoing adenotonsillectomy (T&A) for the management of obstructive sleep apnea (OSA).

Methods: Retrospective case series of children <2 years of age who underwent T&A for the management of OSA between 1/1/08-6/1/18. Postoperative respiratory complications and

hospital course were analyzed to determine higher acuity of monitoring in Intensive Care Unit (ICU) versus observation unit was indicated.

Results: A total of 69 children were analyzed. Fifty-two (75.4%) patients were male, and their mean age was 18.8 months. Fifty-six (81.2%) children had severe OSA, 6 (8.7%) had moderate OSA, and 7 (10.1%) children had mild OSA. Thirty-seven (53.6%) children were monitored in the ICU; one (2.7%) child was admitted to the ICU directly from the sleep lab, and 3 (8.1%) children were intubated. The average Apnea Hypopnea Index (AHI) for those who were intubated was 64.6 events/hour and low SpO₂ average was 66.3%, when compared to an average of 36.2 events/hour and 75.5% respectively for the entire group. Three (8.1%) patients needed >2 liters/minute of O₂, and 5 (13.5%) had minor O₂ requirements. Only 7/32 (21.9%) patients monitored in the observation unit required supplemental O₂.

Conclusion: A greater severity of AHI and low SpO₂ nadir were associated with respiratory issues requiring monitoring of children in ICU after T&A for OSA. No specific PSG cut-off values for ICU versus observation unit were noted. Low incidences of respiratory issues were observed, and most children could have been monitored safely outside of the ICU setting.

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UNDERSTANDING BARRIERS AND COMMUNICATION BEHAVIORS IMPACTING REFERRAL TO SLEEP SURGERY: QUALITATIVE PATIENT PERSPECTIVES

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Introduction: Shared decision-making is a process when patients, families, and clinicians work together to make optimal, personalized medical choices in the face of more than one reasonable treatment option. These interactions can influence the joint decision and may have lasting impressions for future healthcare encounters. Considering the American Academy of Sleep Medicine's recent clinical practice guideline on the referral of adults with obstructive sleep apnea (OSA) for surgical consultation, we aimed to understand patient experiences, in terms of barriers and communication behaviors in the referral process to sleep surgery consultation.

Methods: We performed a qualitative study consisting of in-depth semi-structured virtual interviews with adult patients (aged ≥18 years) with OSA (apnea-hypopnea index ≥5 events per hour of sleep, scored by AASM-accredited standards) and who were recommended for sleep surgery at a tertiary Sleep Surgery Clinic. Open ended questions focused on patient experiences during healthcare encounters from diagnosis, trials with noninvasive management options and ultimate referral to sleep surgery. The interviews were audio-recorded, transcribed, and analyzed using content analysis to identify themes.

Results: Ten adult patients with OSA who were evaluated in sleep surgery clinic were approached and enrolled from March through April 2021. Barriers to sleep surgery clinic included delays in OSA diagnosis due to limited OSA awareness and perceived inconvenience of sleep study, providers faulting patient for persistent sleep symptoms, patient-reported lack of urgency by providers in troubleshooting noninvasive