

Following the Obstructive Sleep Apnea Diagnosis

Kathy Sexton-Radek*

Professor, Elmhurst College, USA

Obstructive sleep apnea is thought to affect some 11% of the general population, worldwide, by some estimates. The early diagnosis insures that the patient will reduce the risks for metabolic disease, hypertension, insulin resistance and insomnia. Additionally, the diagnosis promotes awareness in the patient to their health and self-care. The routine of nightly cleaning and adjusting a CPAP mask involves this sensitivity in order to prevent further apneic events.

With OSA criteria, patients are diagnosed when they have met criteria of apnea events, hypopnea events, have malapamti rating of 3 or greater for the pharyngeal examination. Excessive daytime sleepiness, fragmented poor sleep quality, apnea events and complaints of loud snoring are common symptoms. Since its invention in 1980, Continuous Positive Airway Pressure (CPAP) has been the standard treatment. In some cases, where the OSA is mild, positional therapies to prevent supine using pillows or tongue/jaw advancement using specially designed dental appliances to maintain patency have some success.

As thousands of patients have received this care for their OSA symptoms, the research and clinical discoveries informing investigations have moved forward. Researchers have measured some advantage of complimentary approaches to standard CPAP treatment [1]. While not at acceptable clinical standard, the ambulatory measurements of oxygen desaturation represent a cost effective strategy in the measurement of adherence [2]. Now, partial surgery techniques of the uvula have showed some promise in the care of OSA patients without the complications of full surgery [3]. Measurement studies of nasal obstruction in OSA patients have identified the need for treatments to reduce the snoring [4]. Another new research approaches to OSA has been in the area of sleep environment where the amount of night time light is reduces. Alteration in mood and level of sleepiness in OSA patients has been reported when in dim light conditions as compared to matched controls [5].

Probably one of the largest areas in need of further investigation is that of OSA and Insomnia treatments. Currently, we do not have standards of practice for this common dual diagnosis. Some researchers have identified the merit of a multidisciplinary approach where cognitive behavior approaches are used to address Insomnia and daytime sleepiness following CPAP treatment. These approaches while effective are untested to date, on OSA patients with other illness that may complicate their condition (i.e., Cardiovascular disease, Cushing disease, Chronic Obstructive Pulmonary Disease) [6-8].

Innovative approaches to monitoring CPAP use in the OSA patient exist and provide valuable outcome data. Also, some monitoring is applied to field settings such as with truck drivers [9] where alertness is paramount.

In summary, the serious condition of OSA is now commonly diagnosed. With this, however, is the speculation that a number of individuals with OSA go undiagnosed. The newer approaches and extensions of care show promise but are largely untested. Therefore, the future areas of research of OSA are in the areas of the complicating conditions from other disorders the patient has as well as the length of time untreated and time to recovery. In the clinic, Sleep Specialists have been documenting the cognitive and affective changes of the undiagnosed and successfully treated OSA patient. Innovative extensions of monitoring CPAP used in the field may provide clinicians with meaningful data about OSA treatment adherence. Future behavioral interventions can developed to address these areas once the need has been demarcated.

References

1. Billings KR, Maddalozzo J (2013) Complementary and integrative treatments: managing obstructive sleep apnea. *Otolaryngol Clin North Am* 46: 383-388.
2. Chiner E, Andreu AL, Sancho-Chust JN, Sánchez-de-la-Torre A, Barbé F (2013) The use of ambulatory strategies for the diagnosis and treatment of obstructive sleep apnea in adults. *Expert Rev Respir Med* 7: 259-273.
3. Sirirattanapan J (2013) Minimally invasive palatal surgery for obstructive sleep apnea. *J Med Assoc Thai* 96: S108-114.
4. Meen EK, Chandra RK (2013) The role of the nose in sleep-disordered breathing. *Am J Rhinol Allergy* 27: 213-220.
5. Aubrecht TG, Weil ZM, Magalang UJ, Nelson RJ (2013) Dim light at night interacts with intermittent hypoxia to alter cognitive and affective responses. *American Journal of Physiology, Regulatory, Integrative Comprehensive Physiology*.
6. Ong JC, Crisostomo MI (2013) The More the Merrier? Working Towards Multidisciplinary Management of Obstructive Sleep Apnea and Comorbid Insomnia. *J Clin Psychol*.
7. Owens RL (2013) Supplemental oxygen needs during sleep. Who benefits? *Respir Care* 58: 32-47.
8. Collen JF, Lettieri CJ, Hoffman M (2012) The impact of posttraumatic stress disorder on CPAP adherence in patients with obstructive sleep apnea. *J Clin Sleep Med* 8: 667-672.
9. Skerjanec C (2013) Caretouch monitors and tracks sleep apnea therapy for truck drivers. Caretouch communications on PRWEB June 4, 2013

*Corresponding author: Kathy Sexton-Radek, Director, Psychological Services, Suburban Pulmonary & Sleep Associates, Elmhurst College, USA, E-mail: ksrsleep@aol.com

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