SCOTTISH SLEEP FORUM

OBSTRUCTIVE SLEEP APNOEA HYPOPNOEA SYNDROME

Working towards the development of minimal standards for referral, investigation and treatment in Scotland
Obstructive sleep apnoea/hypopnoea syndrome (OSAHS) can be defined as the coexistence of excessive daytime sleepiness with irregular breathing at night. This distinguishes it from Sleep Disordered Breathing (SDB) in which irregular breathing occurs at night in the absence of excessive daytime sleepiness.

OSAHS is a significant public health problem and there is a large and increasing demand for sleep service facilities due to the high prevalence and growing public awareness of sleep disorders, including OSAHS. A conservative estimate of the prevalence of OSAHS in middle-aged men (30-65 years) is in the range 0.3–4%, with most studies giving a prevalence of 1-2% which is a similar prevalence to Type 1 diabetes and approximately double that of severe asthma.\(^1\)\(^2\)\(^3\)\(^4\) The prevalence of OSAHS in middle-aged women has been less well studied but is probably about half that in males, at around 0.5–1%.\(^2\)

The consequences of untreated OSAHS on daily function are multiple and include increased daytime sleepiness, impairment of cognitive function, mood and personality changes.\(^5\) OSAHS is also associated with a reduction in quality of life\(^6\) and there can be adverse effects on others including impaired relationships between spouses and partners.\(^7\) Symptoms of sleepiness and impaired concentration resulting from untreated OSAHS are thought to have serious consequences during activities where reduced alertness is dangerous, such as driving, leading to an increased risk of road traffic accidents.\(^8\)\(^9\) There is objective evidence for a 1.3 to 12-fold increase in accident rates among patients with OSAHS.\(^2\)\(^8\)\(^10\) Sleepiness at the wheel is estimated to cause about 20% of road accidents on major highways, although it is unclear how many of these are due to OSAHS. These accidents usually occur at high speed, without avoidance reactions and are associated with serious injuries and a high mortality rate.\(^9\)\(^11\)\(^12\)

The estimated cost to society of a fatal road traffic accident is approximately £1,250,000, making it highly desirable to produce a national guideline which may help to reduce the medical, social and financial costs of excessive sleepiness.\(^13\)

Significant variation exists across Scotland in the availability of both diagnostic tests and the delivery of treatment of OSAHS. This is against a background of increasing referrals numbers of new patients suspected of having OSAHS throughout Scotland over recent years. Taking Edinburgh as an example there has been an 84% rise in new patient referrals from 2000-2010 (1246 in 2000/01 to 2293 in 2009/10) with a 26% rise in the last 2 years alone and these figures are representative of Scotland as a whole. Approximately two thirds of these referrals come from GP’s and one third from colleagues in Secondary care. This is placing significant and unsustainable pressure on the ability of the current system to cope with this rising demand. The typical waiting time from new patient referral of a suspected routine case of OSAHS to treatment in the Edinburgh and Glasgow, the two largest centres in Scotland, is currently 42 and 44 weeks respectively and these figures are typical of the current picture throughout Scotland. There is therefore a need to
try to improve patient flows through the system and this is one of the main drivers to develop sustainable solutions to the problem of delivering a high quality, equitable and patient centred service for those patients suspected of having OSAHS no matter where they reside in Scotland.

It was felt that the Scottish Sleep Forum would be an ideal group to oversee the development of core minimum standards in the delivery of care in this group of patients and this document aims to progress that goal.

The Scottish Sleep Forum was established in 2008 in an attempt to share knowledge and experience of those multi-disciplinary health care professionals based in Secondary Care throughout Scotland dealing with patients referred for investigation and treatment of suspected OSAHS. This group is chaired by Dr Robin Smith, Consultant Respiratory Physician, Ninewells Hospital, Dundee and Sr Phyllis Murphie, Respiratory Nurse Specialist, Dumfries and Galloway Infirmary with representatives from all the major Centres throughout Scotland dealing with sleep referrals (Edinburgh, Glasgow, Aberdeen, Inverness, Borders, Forth Valley, Lanarkshire, Ayrshire and Arran) and meets twice each year in Stirling.

Following a meeting of The Scottish Sleep Forum on the 5th March 2010 – there was agreement from delegates that Sleep Medicine service providers should work towards delivering common minimum, evidence based, and equitable standards across NHS Scotland.

A core steering group have since met on two occasions to write this report for consideration by the National Respiratory MCN Steering group.

The report recommends adopting the following actions in NHS Scotland:

1. Referral Standards
2. Diagnostic Standards and Treatment Standards
3. Review Standards
4. National core data set for Sleep medicine services
1: Referral Standards

The minimum data set required from the referring clinician is based on the following information.

- Sleep quantity / quality
- Snoring
- Witnessed apnoeic episodes
- Wakens feeling refreshed / unrefreshed
- Daytime sleepiness (ESS)
- Occupation / shift working pattern
- Marital disharmony
- Driving issues
- PMH / co morbid problems
- Medications
- Blood results (TFT’s / glucose / FBC / Cholesterol / Triglyceride)
- BMI / weight / height / collar size / BP

Once the referral letter is received it can be triaged into either an urgent or routine category based on driving concerns, marital disharmony, occupational risk or associated co morbid conditions such as the metabolic syndrome, nocturnal hypoventilation or respiratory failure. The patient and their partner are then sent out questionnaires and diary cards to complete in advance of the clinic appointment and they should bring them along to the clinic when they attend. This gives useful background information on the following:

- Basic patient demographic information
- Sleeping pattern details
  
  Bed time, Rise time, Duration  
  Restlessness / Violent movements  
  Nocturia, Snoring, Witnessed apnoeic episodes  
  Nocturnal choking episodes, Leg / arm jerks  
  Vivid dreams, Sleep onset / wakening hallucinations  
  Sleep paralysis, Sleepwalking / Sleep talking / Screaming  
  Muscular weakness / collapse (? cataplexy)
- Height / weight
- Collar size
- Occupation / shift working pattern
- Driving details
- Caffeine intake (quantity / frequency)
- Medication / allergies
• Past medical history
• Questions about non OSAHS sleep conditions
• Epworth Sleepiness Scale: ESS (filled out by both the patient and their partner on their behalf) to give an assessment of the degree of subjective sleepiness which is present. The ESS relies on assessing the level of sleepiness present during certain activities and not the degree of tiredness present and the result needs to be taken as part of the overall clinical assessment and should be relied upon in isolation.

See Appendices 1, 2 and 3 for typical examples of a questionnaire, diary card and the Epworth Sleepiness Scale.
2: **Diagnostic and Treatment Standards**

This section is based on the IMPRESS Document produced jointly by BTS/GPIAG/ARTP/Sleep Apnoea Trust in March 2009. The full document can be found at: [http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Sleep%20Apnoea/OSAS4-web.pdf](http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Sleep%20Apnoea/OSAS4-web.pdf).

**Diagnosis of OSAHS**

Accurate diagnosis of sleep apnoea and assessment of the likely future benefit from treatment are essential before long term treatment is initiated and should be the responsibility of an experienced physician. The service requires an appropriately experienced medical lead (usually a consultant respiratory physician) to provide clinical leadership, service development and innovation. In addition to overall supervision of the service, his /her roles include clinical assessment, recognition of relevant comorbidities, interpretation of the sleep study in the context of the overall clinical picture, diagnosis (and differential diagnosis), decisions on treatment and availability for advice to other members of the team and provision of reports to relevant external agencies (e.g. occupational health, DVLA).

Both snoring and sleepiness are very common, with snoring affecting about 40% of the adult population and sleepiness about 10%. Consequently, the two will often occur together by chance and correct attribution of the symptoms and the identification of other reasons for sleepiness require an appropriate clinical history in addition to a sleep study. Other conditions which can cause, or contribute to, daytime sleepiness include narcolepsy and other neurological disorders, depression and periodic limb movement disorder, in addition to the effects of medication, social factors and shift work. Misdiagnosis, and consequent inappropriate provision of CPAP, are both wasteful economically and potentially harmful to patients. As with any other serious condition, confirmation of diagnosis is necessary before embarking on...
potentially lifelong treatment. Incorrect diagnosis and inappropriate provision of CPAP equipment are not uncommon, leading to waste for the NHS, delaying optimal treatment of the individual and undermining the value of an otherwise highly effective form of treatment. If a patient’s care is transferred to a different sleep service (e.g. due to relocation or seeking a further opinion) the evidence for the diagnosis and appropriateness of the treatment should be fully reviewed. Differential diagnosis also includes the distinction from central sleep apnoea (e.g. as seen in some patients with congestive heart failure) and the recognition of patients with chronic respiratory failure, due, for example, to obesity hypoventilation syndrome or coexistent COPD, as they may require alternative treatment such as nocturnal non-invasive ventilation. Furthermore, it is important that other health problems associated with OSAS, such as hypertension, diabetes and the metabolic syndrome are identified and treated appropriately.

Types of investigation
The technology used for investigating sleep apnoea is of secondary importance to the experience and training of those interpreting the results. Investigations for suspected OSAS are often performed in the patient’s home, using either oximetry or Respiratory polysomnography. A minority of patients require full polysomnography (PSG) in hospital, particularly if there is serious doubt about the diagnosis. Oximetry alone can confirm severe OSAHS but has significant rates of both false negatives and false positives, such that Respiratory PSG is now preferred as the primary investigation in many departments. Respiratory PSG involves the measurement of chest and abdominal breathing pattern, airflow, snoring, pulse rate and oximetry and is performed over a single night. Neither oximetry nor a Respiratory PSG recording actually measure whether or not the subject sleeps and thus a negative result cannot be used to definitely exclude a diagnosis of OSAHS. Irrespective of the type of investigation, accurate reporting, recognition of artefacts and interpretation in the clinical context are essential, and these require considerable experience. Reliance on automated analysis to decide potentially lifelong treatment produces too many
errors for clinical acceptability and all sleep studies should be subject to
detailed manual review of any automated scoring. A minority of patients
require full polysomnography in hospital, particularly if there is serious doubt
about the diagnosis. Full PSG is undertaken in North Glasgow and Edinburgh
Royal Infirmary and referrals for this are accepted by each site.

Grading of severity of OSAHS is based on the frequency of apnoeas and
hypopnoeas per hour of sleep or of the study period (Apnoea/Hypopnoea
Index – AHI events/hour) and the consequent symptoms. Alternatively, the
frequency of accompanying dips in oxygenation during sleep is used (oxygen
dip rate – ODI). The most widely used classification is that recommended by
the American Academy of Sleep Medicine: patients with significant symptoms
are graded as having mild (AHI 5–14), moderate (AHI 15–30) or severe (AHI >
30) OSAHS. However, the relation of AHI to symptom severity is, at best, very
weak and it is the symptoms which relate best to the potential benefits of
treatment.

Many otherwise healthy individuals have brief periods of apnoea and/or
hypopnoea during sleep and it is important to distinguish those patients who
have physiological breathing irregularities during sleep in the absence of
daytime symptoms of excessive sleepiness from those with OSAHS, which
implies the combination of sleep disordered breathing with attributable
symptoms i.e. daytime sleepiness. It is the latter which requires a specialist
service for diagnosis and treatment.

Management of OSAHS
The treatment of a patient with OSAHS (or any other type of sleep-disordered
breathing) should not be determined solely by the result of a sleep study. The
decision requires specialist medical input and depends on the combination of
symptoms, clinical assessment, the results of the sleep study and the
patient’s willingness to accept the treatment proposed. A sleep study is used
to identify the presence of sleep disordered breathing, clarify its nature and
assess the severity of the physiological disturbance, but the decision to treat
and the long term benefits of treatment depend more on pre-treatment
symptoms than on precise indices derived from a sleep study. A decision to
treat based solely on measurements such as the apnoea/hypopnoea index (AHI) is not appropriate and is unlikely to result in good compliance with therapy. Weight reduction advice is important for the overweight and obese, but many patients with OSAHS are of normal weight or only mildly overweight. Other forms of treatment which may be relevant to particular individuals include Continuous Positive Airways Pressure (CPAP), an intraoral mandibular repositioning splint device (MRS) and rarely a tonsillectomy or bariatric surgery.

**Continuous Positive Airway Pressure (CPAP)**

The treatment of OSAHS by CPAP is highly effective. It usually implies an indefinite commitment by both the patient and the sleep service, as treatment, at least of more symptomatic individuals, is potentially lifelong. It is a testament to the efficacy of CPAP that many thousands are willing to use it every night despite the inconvenience and occasional discomfort. Few other medical treatments have such profound effects on quality of life and social functioning and relationships. It is important that CPAP is provided within the context of a face to face education package, so that patients fully understand the nature and aims of treatment, how to recognise when these are not being achieved, how to maintain the equipment and whom to contact for advice and replacement parts. Unlike most forms of medical treatment for chronic conditions, CPAP has the distinct advantage that use of the treatment can be continuously monitored. Such monitoring should be an essential component of periodic surveillance and is an important outcome to document as part of clinical audit. Units undertaking sleep studies should have access to providing CPAP therapy locally.

Some patients struggle at first with CPAP treatment and without appropriate support would not persist. Education, encouragement, attention to detail and time spent with the patient are essential at the start and during the early period of treatment and have a major influence on long term compliance. Prescription of the equipment alone, without such support, is likely to be unsuccessful. It is common experience in specialist centres that inadequate
initial introduction of the treatment can have a negative effect and can lead to individuals being regarded incorrectly as “CPAP intolerant”. Although subsequent re-introduction with more appropriate education, encouragement and support may still succeed, the initial experience can seriously prejudice eventual success.

In many centres, the decision about long term treatment with CPAP follows a trial period (often 2–4 weeks). In the early weeks of treatment with CPAP, frequent contact may be required by the patient for troubleshooting, encouragement, re-fitting or changing interfaces, adding a humidifier etc. Such contact can be either face to face or by telephone but, in either case, it is essential that patients have ready access to experienced staff. Even with optimum encouragement, education, trials of various interfaces etc, a proportion of patients eventually do not persist with CPAP treatment. In some, the symptoms may have been due to other causes such as depression or medication, while a few are genuinely intolerant of the treatment due to problems such as claustrophobia. Early review should allow most of these issues to be clarified and with appropriate choice of patients, the “failure rate” is likely to be no more than 20%.

A minority of patients remain sleepy despite good compliance with CPAP. Causes include inadequately titrated pressure or mask leakage, in addition to other causes of sleepiness, such as co morbidity, medication or social factors e.g. shift work or inadequate sleep duration. Persistent sleepiness should prompt senior medical review to consider alternative diagnoses, the need for a more detailed sleep study and/or the need for repeat CPAP titration.

NB pressure setting and long-term supervision is covered in IMPRESS full document
Other Methods of Treatment

Intraoral Mandibular Repositioning Splints (MRS)
A variety of intraoral devices, aimed at stabilising the pharyngeal wall during sleep, is available. Most are made to fit over the upper and lower teeth, with the lower jaw partly protruded. They range from simple “boil and bite” devices which can be purchased directly to more complex custom made devices supplied by dentists or orthodontists after appropriate impressions have been taken with the lower jaw protruded to the desired extent. Some are “titratable”, in that they allow gradual mandibular protrusion over days or weeks. The exact place of these devices in management of OSAHS is unclear, although their efficacy is clearly less than that of CPAP in patients with more severe disease. They are used as “next best” treatment in patients with milder disease who find CPAP difficult to tolerate.

Weight reduction and bariatric surgery
Weight management advice should be readily accessible where clinically appropriate. Occasionally, dieting is sufficiently effective for the symptoms of OSAHS to resolve and for CPAP no longer to be necessary, but in most symptomatic individuals this remains a long term aim which is never realised. In a few individuals with severe obesity and appropriate indications, bariatric surgery may be considered as a treatment option for OSAS. Depending on the weight loss achieved, this type of treatment has been shown to improve or cure OSAHS, along with its other recognised health benefits. Referral should follow agreed protocols and will often be initiated by the General Practitioner. Such patients are likely to continue to require CPAP therapy up to and after surgery, though in the longer term it may prove possible to discontinue it, provided that reassessment confirms adequate resolution.
ENT surgery
Before the introduction of CPAP, tracheostomy was sometimes used as the only effective treatment for patients with OSAHS, but it is performed very rarely nowadays. Tonsillectomy has a role in the management of some, usually younger, individuals with significant tonsillar hypertrophy and may be curative, especially in children. Other types of pharyngeal surgery are not usually recommended in patients with symptomatic OSAHS. Procedures to improve nasal patency are occasionally helpful, for example in individuals in whom compliance with CPAP is limited by nasal obstruction.
3: **Review Standards**

Standards for Follow-up of Patients with Obstructive Sleep Apnoea

**Background points to consider**

Sleep apnoea syndrome is a chronic condition and treatment tends to be long term.

There are large numbers of patients requiring follow-up and this number is likely to continue rising for several more years as awareness of the condition increases and referrals continue to rise. Stable state of numbers of patients is some years away yet.

The numbers of patients on CPAP poses significant challenge to centres providing sleep apnoea services. The focus of a sleep apnoea centre and its resources tend to be deployed towards the assessment of new referrals and the initiation of CPAP therapy.

Once on treatment most patients are stable and require minimal follow-up. However, certain subgroups of patients do require regular surveillance, and all should have access to advice when problems arise and have a means by which their equipment and masks can be maintained and replaced as necessary.

**Recommendations**

Patients on CPAP should have access to advice and support from trained staff e.g. via helpline or ‘drop-in’ service (Monday–Friday 9-5pm).

A blend of technician and nurse-specialist support should be available.

Multidisciplinary team working is recommended.

Local access to patient record (ideally held electronically) together with robust clerical and administrative support is essential for an efficient and responsive service.

An up-to-date database should be maintained for all patients on CPAP therapy and available to all staff dealing with these patients. This database is also crucial for audit and service management issues.

Most patients who are stable on CPAP can be discharged from regular clinical follow-up. These patients should still have access to the advice help-line, and to a service that provides replacement masks and parts as required.

More complex patients (e.g. cardiovascular co morbidity, persistent day-time symptoms, CPAP side-effects, DVLA issues (e.g. HGV, bus, taxi drivers etc) should
have regular clinical follow-up where compliance, symptom control and side-effect data are collected. This follow-up should be with a doctor or a specialist nurse.

Access to other services should be available: intra-oral mandibular repositioning devices, obesity services, dietary advice, cardiovascular risk reduction, diabetic services.

**Driving Issues**

- Always ask about driving issues
- If the patient admits to sleepiness whilst driving tell him / her NOT to drive and document that in writing (in notes and in letters to patient and GP)
- If the patient denies sleepiness whilst driving tell him / her NOT to drive if they develop sleepiness in the future
- Once a diagnosis of OSAHS is made: (AH / AHI / desaturation index result + ESS >11 / 24 and / or a history of excessive daytime sleepiness) → tell patient to inform DVLA (in writing)
- DVLA usually write to hospital for information once the patient has reported the diagnosis of OSAHS to them
  → send a standardised reply to DVLA
  → send a standardised letter to the patient and a copy to the GP

**Notification to the DVLA**

- The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders have a condition, which may, now or in the future, affect their safety as a driver
- Make sure that the patient understands the condition may impair their ability to drive.
- If the patient is incapable of understanding this advice (e.g. demented) inform the DVLA immediately
- Explain to the patient that they have a legal obligation to inform the DVLA
- The vast majority of patients take your advice and inform the DVLA
- If the patient refuses to accept the diagnosis or the effect of the condition on their ability to drive safely, suggest that the patient has a second medical opinion and make the appropriate arrangements to allow this to occur.
- Advise the patient NOT to drive (in writing with a copy to the GP) until the second opinion has been obtained
- If the patient continues to drive when they are not fit to do so and they have been informed by you in writing to cease, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin if they agree that you may do so
- If you still do not manage to persuade the patient to stop driving, or you are given or find evidence that the patient is continuing to drive
contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA

- Before giving information to the DVLA you should inform the patient of your decision to do so and contact your medical defence society.
- Once the DVLA has been informed you should also write to the patient to confirm that disclosure has been made

Guidelines from the GMC and the DVLA

**Driving Issues in those patients that deny sleepiness whilst driving (Epworth Score < 11)**

- If they are simple snorers
  
  AH / AHI / desaturation index is normal and ESS < 11/24

  → Treat snoring (MRS / rarely CPAP)

  Give written advice about stopping driving in the future if sleepiness develops

- If they have Sleep Disordered Breathing (SDB)
  
  = A MORE DIFFICULT GROUP
  
  AH / AHI / desaturation index is high
  
  but ESS < 11/24 and they deny excessive sleepiness

  Treat the underlying problem (usually with MRS)

  Give written advice about stopping driving in the future if sleepiness develops.

  ? Organise an objective test of daytime alertness (Maintenance of Wakefulness Test MWT)

Examples of letters which can be sent to patients / DVLA regarding driving issues can be found in Appendix 4
4: **National Core data set for Sleep Medicine Services.**

A national core data set for Sleep Medicine services would facilitate:

- Improved outcomes of care for patients
- Improved communication locally and nationally
- Document pathway of care for patients with Sleep Breathing Disorders (OSAHS and Sleep Disordered Breathing)
- Allow comparison of current practice against recognised clinical standards/guidelines e.g. SIGN 73, IMPRESS 2009.
- Allow comparisons of subgroups e.g. age, sex, BMI, severity of SBD
- Facilitate service improvements locally and nationally, by providing robust comparable data for staff involved in Sleep Medicine, Health Boards, MCNs, ISD, etc
- Monitor the effects of changes in practice
- Facilitate clinical research

**Recommendations:**

Developing a National Clinical Datasets in Sleep Medicine

- ISD Scotland - National Clinical Dataset Development Programme (NCDDP) - established in 2003 by CMO
- "All sectors will progressively use national data standards with data definitions, data format and coding structures to provide common language across health and social care." - NHS Scotland eHealth Strategy: eHealth Aims and Framework, (Feb 2007)
- Approach ISD via the National Respiratory MCN steering group to take this forward.

**What data is important to collect?**

**Health Board Level:**

- Service Specification/configuration of staff
- Number of referrals to sleep service annually
- Number of sleep investigations carried out annually
- Number of patients on CPAP/NIV/ Auto CS
- Number of patients followed up in clinics
- Predicted growth of service in order to plan future budget expenditure
- Referral to treatment time
What Clinical data should we collect?

- CHI
- DOB
- Gender
- Referral Source
- Referral Date
- Name
- Address
- Telephone
- GP details
- BMI
- Neck circumference
- Blood Pressure
- Baseline Epworth Sleepiness Score
- Vocational Driving Licence
- AHI
- DI
- Diagnosis
- Therapeutic Intervention (e.g. CPAP/ MRS / Weight Loss)
- Referral on to ENT specialist
- CPAP/NIV generator type
- CPAP/NIV pressures
- Interface type
- CPAP/NIV therapy adjunct (e.g. humidification)
- Post treatment AHI
- Post treatment Epworth Sleepiness Score
- CPAP compliance
CONCLUSIONS

The Scottish Sleep Forum has outlined and recommended core minimum service standards for delivery of sleep medicine services in NHS Scotland in this report. The Scottish Sleep Forum would ask the national Respiratory MCN steering group to comment on their recommendations and how they may be progressed.

The guiding principles behind this report adhere to the six dimensions of healthcare quality listed in the 2001 Institute of medicine publication, Crossing the Quality Chasm: Providing Sleep Medicine services across NHS Scotland that is safe, effective, patient-centred, timely, efficient and equitable.

Appendix 1: Patient and Partner Questionnaires
Appendix 2: Sleep Diary
Appendix 3: Epworth Sleepiness Scale
Appendix 4: Driving Letters
References


7 Cartwright RD, Knight S. Silent partners: the wives of sleep apneic patients. Sleep 1987;10:244-8.


Appendix 1: Patient and Partner Questionnaires - attached
Appendix 2: Sleep Diary - attached
Appendix 3: Epworth Sleepiness Scale - attached

Appendix 4: Driving Letters

Letter 1:
Letter to be sent to sleepy drivers after first consultation if sleepiness whilst driving has been identified

Dear

Re: Diagnosis

Further to our recent consultation in the sleep clinic this is a note to confirm that you confirmed during the course of our consultation that you currently feel sleepy whilst driving and I therefore advise that you should not drive at present to allow us time to investigate the cause of your sleepiness and recommend treatment.

Yours sincerely

- SEND A COPY TO GP TOO
Letter 2:

Letter to be sent to DVLA re OSAHS patient (issued once the diagnosis of OSAS is confirmed and at the request of the DVLA) if it is considered that it is safe for the patient to drive

Dear

Re: Diagnosis:

Many thanks for your letter dated asking for a medical report on the above patient who holds a Gp1 / Gp 2 driving licence. I confirm that he/she was originally referred by with a history of and seen in the sleep clinic on . At that time his / her Epworth sleepiness score was /24 (anything > 11 is high) and he / she did / did not admit to problems with sleepiness whilst driving.

We performed a home based / hospital based sleep study and this showed apnoeas/hypopnoeas per hour in bed; anything more than is high. He/she was then commenced on CPAP and when last reviewed in the sleep clinic on and compliance with CPAP was excellent at hrs per night and his/her Epworth score was /24. He/she currently denies any problems with sleepiness whilst driving.

I would therefore support his/her application to go on driving normally as long as he/she always uses common sense and errs on the side of safety by stopping driving if he/she ever feels sleepy in the future.

Yours sincerely

- SEND A COPY TO GP TOO
Letter 3 : Letter to be sent to OSAHS patient once a letter has been sent to the DVLA if it is considered that it is safe for the patient to drive

Dear

Re: Diagnosis

We’ve been asked by the DLVA in Swansea to issue a medical report on your behalf regarding your ability to drive. I’ve written supporting your application to go on driving normally but please always use common sense and err on the side of safety by stopping driving if you ever feel sleepy. The decision regarding your entitlement to drive rests with the DVLA. Hopefully you will get confirmation of their decision in the near future.

Yours sincerely

- SEND A COPY TO GP TOO
Dear 

Re: 
Diagnosis:

Your recent sleep study confirmed that you are a snorer / suffer from a condition known as sleep disordered breathing but currently excludes the sleep apnoea syndrome. I enclose an information sheet regarding these conditions. I recommend that you try wearing a gum shield device overnight to see if this helps and I will organise this for you via our orthodontist.

I also recognise that you do not have any problems with sleepiness whilst driving at present. However it is important that you continue to use common sense and please always err on the side of safety by stopping driving if you ever develop sleepiness whilst driving in the future and if so please ask your GP to re-refer you to my clinic.

Yours sincerely

SEND A COPY TO GP TOO