A simple procedure for measuring pharyngeal sensitivity: a contribution to the diagnosis of sleep apnoea

M Dematteis, P Lévy, J-L Pépin

Sleep disordered breathing (SDB) corresponds to a continuous clinical spectrum from snoring, upper airway resistance episodes, to obstructive hypopnoeas and apnoeas according to the severity of upper airway collapsibility. The common characteristic is a repetitive partial or complete collapse occurring during sleep at the pharyngeal level, a region lacking rigid support. Thus, pharyngeal patency is dependent on both its anatomy (calibre) and on the activity of pharyngeal dilator muscles (PDM) such as the genioglossus muscle. PDM have inspiratory phasic activity preceding diaphragmatic contraction, thus anticipating the development of intrapharyngeal negative pressure related to inspiration. This muscle activity is reduced during sleep leading to pharyngeal obstruction in patients with high pharyngeal collapsibility. There is increased evidence that upper airway mucosal sensory receptors may play a role in the patency of the upper airway through a reflex PDM activation. During wakefulness a negative pressure applied to the upper airway increases genioglossus muscle activity. This response is reduced by topical anaesthesia, suggesting that upper airway receptors may be involved in the afferent limb of this reflex. Anaesthesia of the upper airway increases pharyngeal airflow resistance, induces apnoeas/hypopnoeas in healthy subjects, and increases the frequency of obstructive events in snorers and the duration of apnoeas in apnoeic subjects. Thus, impairment of pharyngeal sensitivity may play a role in the pathophysiology of SDB through impairment of the pharyngeal dilator reflex.

Sleep apnoea syndrome is highly prevalent and represents a major public health problem. Diagnosis is by polysomnography which is expensive, labour intensive and time consuming. Simpler alternative diagnostic procedures are therefore strongly welcomed. Assessment of pharyngeal sensitivity could facilitate the diagnosis of SDB in some groups of patients with high clinical probability. While the anatomy of the upper airway can only predict the severity of SDB in young lean subjects who represent only a small proportion of SDB patients, evaluation of functional pharyngeal impairment may allow the presence and severity of SDB to be predicted.

We therefore investigated, in a prospective study, the accuracy of a new simple technique to evaluate whether impairment of pharyngeal sensitivity correlates with SDB severity and assessed the clinical usefulness of this procedure in the diagnosis of SDB.

METHODS
Study design
Seventeen controls and 50 patients with SDB (all men aged over 20 years who were not receiving any medication that may produce drowsiness and had no recognised cause of polyneuropathy, recent upper airway infection, or history of surgery of the upper airway except past tonsillectomy) were included in the study. Patients had SDB symptoms and a respiratory disturbance index of >20 events/hour. Control subjects did not report any symptoms compatible with SDB such as habitual snoring, daytime fatigue or sleepiness, morning headache, and had normal nocturnal oximetry. In accordance with the ethical standards of the Grenoble University Hospital, all subjects gave informed consent to participate in the study.

Abbreviations: AHI, apnoea/hypopnoea index; BMI, body mass index; PDM, pharyngeal dilator muscles; RDI, respiratory disturbance index; SDB, sleep disordered breathing
detectable stimulus (suprathreshold stimulus, 2 l/min) was any difference in sensitivity due to catheter location. A distance between the tip of the catheter and the mucosa contact with the mucosa, then pulled 1 cm back and fixed. The catheter was introduced in the guide and gently pushed until 2 cm behind the posterior face of the incisors, a fixed anatomical landmark. The catheter was graduated to allow length adjustments through a guide fixed into the upper part of a cylinder and articulated in its distal part.

The pharyngeal sensory perception threshold was measured by varying airflow rates using the psychophysical method of limits. Sensory testing was most often performed the day after the diagnostic polygraphy or, at the latest, within the week following the sleep study and always before any SDB treatment. The test was conducted in a temperature controlled quiet room with only the subject and the investigator, blinded to the subject status for SDB. The subject wore a pair of earmuffs and was instructed to close his eyes to prevent the use of visual and auditory cues and to improve concentration. Wakefulness was maintained throughout the session test by regularly asking the subject to give his best response—that is, the smallest pharyngeal sensation that could be felt.

Quality control and repeatability of the procedure
To prevent anticipation of the stimulus and distinction between external and internal stimuli—that is, the impression of feeling a sensation—null stimuli (similar procedure with no airflow) were randomly applied throughout sessions of the appearance threshold procedure. Signalling a perception during a null stimulus invalidated the test and the subject was re-instructed. To prevent interference between the airflow administered through the catheter and the breathing related airflow, the subject was instructed to breathe quietly through the nose.

The repeatability of the procedure (disappearance and appearance thresholds) was assessed only in control subjects since SDB treatment may improve the impairment of pharyngeal sensitivity. Ten controls were re-evaluated after a relatively long delay (mean (SD) 31.9 (3) weeks) to reduce possible learning effects.

Sleep studies
Overnight polygraphy included airflow assessment using nasal cannulae and a thermistor. Respiratory efforts were assessed using thoracic and abdominal movements and pulse transit time or by monitoring oesophageal pressure. Sleep stages were scored according to Rechtschaffen and Kales’ criteria. Apnoea episodes were defined as complete airflow cessation for >10 seconds. Hypopnoeas were defined as a 50% decrease in airflow or a reduction in airflow of 30–50% with a microarousal or a 3% desaturation, both for

![Image](http://thorax.bmj.com/ on October 29, 2017 - Published by group.bmj.com)
>10 seconds. Inspiratory flow limitation episodes had a “plateau” aspect of the inspiratory flow curve of 10 seconds ending by a microarousal or returning to a rounded aspect of the flow curve. Apnoeas and hypopnoeas events were classified as obstructive based on the presence or the increase in respiratory effort, respectively. The RDI (number of apnoeas + hypopnoeas + flow limitation episodes) was considered abnormal above 20/hour of sleep.

**Statistical analysis**

For the 10 control subjects assessed twice, a two way analysis of variance (ANOVA) for repeated measurements was used to assess the effect of measurement conditions (baseline and successive anaesthesias) for each session, as well as the effect of session and the interaction between condition measurements and sessions. The repeatability of the procedure performed in these 10 control subjects was analysed in two different ways:

1. Repeatability was first assessed using a one way ANOVA for repeated measurements. This analysis allowed estimation of the different components of variance required for the calculations of test-retest reliability—that is, the intraclass correlation coefficient (ICC 3,1). The ICC was defined by \( \frac{(BMS - EMS)}{(BMS + (n - 1) \times EMS)} \) where BMS is the between subjects mean square and EMS is the error (residual) mean square. 95% confidence intervals for the ICC values were calculated. The repeatability coefficient assumes independent subjects, the calculations were done separately for measurements obtained at baseline and after each administration of anaesthetic for both the disappearance and appearance sensory thresholds. Using this method, 95% limits of agreement were calculated (mean ± 1.96 SD—that is, the range in which the difference may be expected to lie in 95% of the measurements—and SD is the standard deviation of the differences between paired measurements); 95% confidence intervals (95% CI) were calculated to indicate the precision of the limits of agreement. As a measure of repeatability, the British Standards Institution repeatability coefficient was calculated as 1.96 times the standard deviation of the differences. This coefficient indicates the maximum difference likely to occur between the measurements of the two sessions.

For the rest of the analyses, heterogeneity of variances (Levene’s test) required the use of non-parametric tests to analyse the results, expressed as mean (SD) values. Intergroup comparisons were done with the Kruskall-Wallis test followed, if necessary, by a post hoc pairwise Mann-Whitney U test between controls and patients. The Spearman rank correlation test was used for correlation analysis between sensory values and anthropometric data and polysomnographic measurements, and was performed for the whole patient cohort. Pharyngeal sensitivity was then analysed according to SDB severity using classical indices such as apnoea/hypopnoea index (AHI) and RDI. However, since AHI and RDI only referred to the frequency of the repeated measurements (y axis) against their average (mean of the differences, x axis). Since the Bland-Altman procedure assumes independent subjects, the calculations were done separately for measurements obtained at baseline and after each administration of anaesthetic for both the disappearance and appearance sensory thresholds. Using this method, 95% limits of agreement were calculated (mean ± 1.96 SD—that is, the range in which the difference may be expected to lie in 95% of the measurements—and SD is the standard deviation of the differences between paired measurements); 95% confidence intervals (95% CI) were calculated to indicate the precision of the limits of agreement. As a measure of repeatability, the British Standards Institution repeatability coefficient was calculated as 1.96 times the standard deviation of the differences. This coefficient indicates the maximum difference likely to occur between the measurements of the two sessions.

For the rest of the analyses, heterogeneity of variances (Levene’s test) required the use of non-parametric tests to analyse the results, expressed as mean (SD) values. Intergroup comparisons were done with the Kruskall-Wallis test followed, if necessary, by a post hoc pairwise Mann-Whitney U test between controls and patients. The Spearman rank correlation test was used for correlation analysis between sensory values and anthropometric data and polysomnographic measurements, and was performed for the whole patient cohort. Pharyngeal sensitivity was then analysed according to SDB severity using classical indices such as apnoea/hypopnoea index (AHI) and RDI. However, since AHI and RDI only referred to the frequency of the

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Controls</th>
<th>All patients</th>
<th>Mild group</th>
<th>Moderate group</th>
<th>Severe group</th>
<th>p value†</th>
<th>p value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>42.1 (7.82)</td>
<td>48.5 (12.7)</td>
<td>31.4 (8.82)</td>
<td>50.1 (8.27)</td>
<td>50.6 (13.8)</td>
<td>0.0020</td>
<td></td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>24.3 (2.57)</td>
<td>28.5 (4.54)</td>
<td>25.6 (3.29)</td>
<td>27.4 (3.39)</td>
<td>29.9 (5.08)</td>
<td>0.0003</td>
<td></td>
</tr>
<tr>
<td>Sleepiness Epworth score (0–24)</td>
<td>4.76 (7.29)</td>
<td>11.0 (4.37)</td>
<td>13.6 (4.34)</td>
<td>10.9 (3.48)</td>
<td>10.5 (4.89)</td>
<td>0.0001</td>
<td></td>
</tr>
<tr>
<td>Gag reflex intensity (0–3)</td>
<td>1.42 (0.52)</td>
<td>1.34 (0.82)</td>
<td>2.10 (0.89)</td>
<td>1.50 (0.81)</td>
<td>1.48 (0.80)</td>
<td>0.4917</td>
<td></td>
</tr>
<tr>
<td>Tobacco consumption (packs/year)</td>
<td>13.1 (4.7)</td>
<td>13.5 (17.0)</td>
<td>0.9193</td>
<td>11.4 (11.8)</td>
<td>16.4 (20.6)</td>
<td>0.8327</td>
<td></td>
</tr>
<tr>
<td>Alcohol consumption (drinks/day)</td>
<td>0.70 (0.74)</td>
<td>1.88 (2.04)</td>
<td>0.51 (0.47)</td>
<td>1.12 (1.22)</td>
<td>2.70 (2.36)</td>
<td>0.0079</td>
<td></td>
</tr>
<tr>
<td>Spicy food consumption (0–3)</td>
<td>0.79 (0.95)</td>
<td>1.09 (0.93)</td>
<td>0.2146</td>
<td>0.60 (0.53)</td>
<td>0.76 (1.03)</td>
<td>0.0161</td>
<td></td>
</tr>
<tr>
<td>Sleep study</td>
<td>Mean nocturnal SaO₂ (%)</td>
<td>95.3 (11.6)</td>
<td>92.7 (2.55)</td>
<td>95.5 (1.95)</td>
<td>93.8 (2.27)</td>
<td>91.4 (2.01)</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>Minimal nocturnal SaO₂ (%)</td>
<td>91.8 (1.89)</td>
<td>79.5 (11.2)</td>
<td>91.6 (1.82)</td>
<td>83.6 (9.07)</td>
<td>74.4 (10.8)</td>
<td>0.0003</td>
</tr>
<tr>
<td></td>
<td>Percentage of time spent below 90% of SaO₂ (%)</td>
<td>0.05 (0.19)</td>
<td>15.1 (20.4)</td>
<td>0.00 (0.00)</td>
<td>7.81 (16.6)</td>
<td>23.4 (21.4)</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>RDI (events/h of sleep)</td>
<td>47.0 (20.5)</td>
<td>28.7 (10.7)</td>
<td>41.4 (16.2)</td>
<td>54.6 (21.5)</td>
<td>0.0172</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AH1 (events/h of sleep)</td>
<td>41.7 (21.3)</td>
<td>15.6 (7.54)</td>
<td>32.5 (11.9)</td>
<td>53.4 (21.0)</td>
<td>0.0001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apnoea index (events/h of sleep)</td>
<td>9.54 (13.1)</td>
<td>0.25 (0.22)</td>
<td>6.54 (9.05)</td>
<td>13.5 (15.5)</td>
<td>0.0026</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypopnoea index (events/h of sleep)</td>
<td>32.2 (16.7)</td>
<td>13.3 (5.99)</td>
<td>26.0 (9.37)</td>
<td>39.9 (18.2)</td>
<td>0.0004</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flow limitation index (events/h of sleep)</td>
<td>5.31 (6.48)</td>
<td>13.2 (5.18)</td>
<td>8.90 (6.89)</td>
<td>11.8 (9.77)</td>
<td>0.0001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obstructive index (events/h of sleep)</td>
<td>45.3 (19.8)</td>
<td>26.7 (10.6)</td>
<td>40.1 (15.9)</td>
<td>52.6 (20.4)</td>
<td>0.0128</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Central index (events/h of sleep)</td>
<td>1.75 (2.51)</td>
<td>2.07 (1.36)</td>
<td>1.37 (2.19)</td>
<td>1.96 (2.90)</td>
<td>0.5527</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharyngeal sensitivity</td>
<td>0.40 (0.19)</td>
<td>0.85 (0.40)</td>
<td>0.70 (0.29)</td>
<td>0.77 (0.36)</td>
<td>0.04 (0.43)</td>
<td>0.0005</td>
</tr>
<tr>
<td></td>
<td>Disappearance threshold at baseline (l/min)</td>
<td>0.22 (0.07)</td>
<td>0.56 (0.57)</td>
<td>0.25 (0.03)</td>
<td>0.42 (0.44)</td>
<td>0.72 (0.66)</td>
<td>0.0100</td>
</tr>
</tbody>
</table>

BMI, body mass index; SaO₂, oxygen saturation; RDI, respiratory disturbance index; AH1, apnoea-hypopnoea index. Patients were classified into three groups according to the proportion of the different respiratory events constituting the sleep disordered breathing: “mild” patients had apnoea-hypopnoea events <60%; “moderate” patients had apnoea-hypopnoea events 60–90%; “severe” patients had apnoea-hypopnoea events >90%.

†Comparisons between controls and all patients using Mann-Whitney U test.
‡Analysis of variance (Kruskal-Wallis test) between controls and the three groups of patients, or only between the three groups of patients when data in controls were not available.

Each group of patients was compared with controls using the Mann-Whitney U test: *p<0.05, **p<0.01, ***p<0.001.

Gag reflex was scored 0 (absent), 1 (decreased), 2 (normal) and 3 (exaggerated). Spicy food consumption was scored 0 (no consumption), 1 (little), 2 (moderate) and 3 (high consumption). Obstructive index includes mixed plus obstructive apnoeas and hypopnoeas and flow limitation episodes. Central index includes central apnoeas and hypopnoeas.
Pharyngeal sensitivity in sleep apnoea

Pharyngeal sensitivity in controls and patients

Patients had a higher baseline pharyngeal sensory detection threshold. Differences between controls and patients were enhanced by anaesthesia, as reflected by the slopes (table 1 and fig 3).

Sensory thresholds were significantly correlated with age (appearance threshold at baseline (r = 0.33, p = 0.024) and after anaesthesia (first anaesthesia: r = 0.48, p = 0.001; second anaesthesia: r = 0.37, p = 0.010; third anaesthesia: r = 0.35, p = 0.017)). They were positively correlated with BMI for both the disappearance threshold (baseline: r = 0.33, p = 0.027; first anaesthesia: r = 0.38, p = 0.010) and the appearance threshold (first anaesthesia: r = 0.29, p = 0.049). For the other sensory thresholds a trend emerged that did not reach statistical significance.

Pharyngeal sensitivity and severity of SDB

Individual values for baseline sensory thresholds and slopes in controls and the three groups of patients are shown in fig 4. At baseline, control values were grouped in a narrow range, particularly for the appearance sensory threshold, while values in “moderate” and “severe” patients were widely dispersed with a mean value significantly higher than that of controls. In contrast, pharyngeal sensory perception of the “mild” group was close to that of controls (see also table 1 and fig 3). However, some patients in the two most severe groups had sensory thresholds similar to controls. Patients with normal sensitivity were compared with patients exhibiting an impaired sensitivity in the same groups. Patients with normal sensitivity had a higher proportion of flow limitation episodes (15.0 (9.32) v 9.07 (4.34), p = 0.049) reflecting less severe SDB, and a lower BMI (25.4 (4.24) v 29.6 (4.34), p = 0.014) than patients with impaired pharyngeal sensitivity.

Significant differences in response to topical anaesthesia were identified in the different groups (fig 4, lower panel).
While controls and “mild” patients behaved similarly, some patients in the “moderate” and “severe” groups clearly had an increased response to anaesthesia. This allowed us to discriminate some patients with normal baseline values from controls, and moderate from severely affected groups, while their baseline values were close (fig 3).

Sensory detection thresholds were negatively correlated with the flow limitation index (disappearance threshold at baseline and after anaesthesia: $r = -0.32$, $p = 0.030$; $r = -0.30$, $p = 0.050$ respectively). In contrast, detection thresholds were positively correlated with the obstructive hypopnoea index (appearance threshold at baseline ($r = 0.28$, $p = 0.058$) and after anaesthesia (first anaesthesia: $r = 0.33$, $p = 0.026$; second anaesthesia: $r = 0.32$, $p = 0.029$; third anaesthesia: $r = 0.29$, $p = 0.044$); disappearance threshold after one anaesthesia: $r = 0.30$, $p = 0.038$). While a trend was apparent, no significance was reached for the other disappearance sensory thresholds.

The higher the percentage of hypopneas constituting SDB, the higher the sensory threshold (disappearance sensory threshold after anaesthesia (first anaesthesia: $r = 0.29$, $p = 0.049$; second anaesthesia: $r = 0.33$, $p = 0.030$); appearance sensory threshold at baseline ($r = 0.25$, $p = 0.085$) and after anaesthesia (first anaesthesia: $r = 0.28$, $p = 0.055$; second anaesthesia: $r = 0.32$, $p = 0.028$; third anaesthesia: $r = 0.37$, $p = 0.011$)). Similarly, the percentage of apnoeas + hypopneas constituting SDB was positively correlated with the sensory thresholds (disappearance sensory detection thresholds at baseline ($r = 0.32$, $p = 0.032$) and after anaesthesia ($r = 0.30$, $p = 0.053$)). In contrast, there was no significant correlation or any trend between sensory detection thresholds and the classical AHI and RDI and nocturnal oxygen saturation.

Pharyngeal sensitivity and diagnosis of SDB

Overall, the sensitivity of the test for SDB diagnosis (RDI >20/hour) was 79.6% and decreased from the most severe (88.5%) to the least severe (30%) group, with an intermediate sensitivity (73.7%) for the “moderate” group.

DISCUSSION

The simple new approach described in this study enabled us to measure pharyngeal sensory perception easily and reliably without any side effects. Using this system, we have confirmed that impairment of pharyngeal sensory perception is correlated with the severity of SDB. When evaluated as a diagnostic tool, the test showed a high repeatability and sensitivity for SDB diagnosis in our sleep clinic population.
Table 2

Repeatability of the procedure

<table>
<thead>
<tr>
<th>Procedure</th>
<th>One way ANOVA</th>
<th>Repeatability coefficient (1)</th>
<th>Intraclass correlation coefficient (ICC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disappearance threshold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>0.990 (0.554)</td>
<td>0.779 to 0.839</td>
<td>0.495 to 0.595</td>
</tr>
<tr>
<td>Anaesthesia 1</td>
<td>0.260 (0.673)</td>
<td>0.231 to 0.282</td>
<td>0.309 to 0.428</td>
</tr>
<tr>
<td>Anaesthesia 2</td>
<td>0.345</td>
<td></td>
<td>0.152 to 0.338</td>
</tr>
<tr>
<td>Anaesthesia 3</td>
<td>0.168</td>
<td></td>
<td>0.047 to 0.076</td>
</tr>
<tr>
<td>Appearance threshold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>0.732</td>
<td>0.671 to 0.800</td>
<td>0.777 to 0.940</td>
</tr>
<tr>
<td>Anaesthesia 1</td>
<td>0.800 (0.579)</td>
<td>0.752 to 0.849</td>
<td>0.615 to 0.819</td>
</tr>
<tr>
<td>Anaesthesia 2</td>
<td>0.345</td>
<td></td>
<td>0.263 to 0.373</td>
</tr>
<tr>
<td>Anaesthesia 3</td>
<td>0.485</td>
<td></td>
<td>0.140 to 0.190</td>
</tr>
</tbody>
</table>

(1) One way ANOVA: F ratio for subjects (p value) for subjects is the ratio BMS/WMS and F ratio for repeated measurements is the ratio BMS/EMS. The intraclass correlation coefficient (ICC 3,1) was calculated as the ratio (BMS - EMS)/(BMS + n(n - 1)EMS). 95% CI of ICC is the 95% confidence intervals of the intraclass correlation coefficient. (2) Bland-Altman procedure: mean of the differences is the mean of the differences between paired measurements; limits of agreement (LA) are calculated as the mean difference ± 1.96SD. 95% confidence intervals (95% CI) of the upper and lower LA indicate the precision of the upper and lower limits of agreement respectively.

Pharyngeal sensory impairment: a factor explaining increased pharyngeal collapsibility in SDB

The pharynx functions as a collapsible conduit which tends to collapse during negative pressure induced by inspiration. Factors predisposing to upper airway collapse include anatomical narrowing and/or abnormal collapsibility of the upper airway. Patients with obstructive sleep apnoea have an anatomically small upper airway, even during wakefulness, which may be the result of obesity through fat deposition around the upper airway, small mandible (micrognathia), jaw position (retrognathia), soft palate elongation and thickness, tonsil or tongue hypertrophy. Pharyngeal patency is also largely dependent on the activity and efferent limb (motor nerves and muscles). The purpose of our study was to investigate the afferent limb without prejudging the aetiology of the sensory impairment.

The mechanisms underlying the impairment of pharyngeal sensitivity may include chronic upper airway inflammation with mucosal oedema, fat deposition, and pharyngeal neuropathy. The presence of oedema has been histologically demonstrated. Oedema may be related, at least in part, to repeated mechanical trauma in the upper airway from snoring-related vibration and apnoea-related suction and stretching. Such oedema is indeed reduced during chronic treatment with continuous positive airway pressure. Infectious disease, allergy, tobacco, alcohol, gastro-oesophageal reflux, oral hygiene, and hot spicy foods may also contribute to upper airway inflammation as suggested by the higher intake of alcohol and spicy food in our apnoeic group. However, the higher rate of spicy food consumption observed may have been a consequence rather than a cause of decreased pharyngeal sensitivity.

The existence of pharyngeal neuropathy in patients with SDB is supported by the increased density in sensory nerve endings in biopsy specimens from the soft palate mucosa of snorers and apnoeic subjects, and by focal degeneration of the myelin sheaths and axons in uvulopalatopharyngoplasty specimens from subjects with apnoea. These observations suggest that progression from mild occasional snoring to heavy habitual snoring and then to sleep apnoea may represent a progressive local neuropathy. Mechanisms that could lead to sensory receptor or nerve damage in the upper airway may include mucosal oedema resulting from mechanical stress, vascular changes and inflammation that could interfere with the function of nerve endings, and direct vibration-related injury analogous to nerve lesions in the upper extremities of hand held vibrating tool users. In addition, the course of this vibration syndrome may be affected by associated diseases, smoking, neurotoxic drugs, and alcohol intake. As we have previously shown for peripheral nerves, hypoxia related to apnoea may also contribute to the neuropathy. All these mechanisms may explain the difference in sensitivity impairment observed between the three groups of patients. The “severe” group was older, suggesting a longer disease duration and possibly a physiological age-related decreased sensitivity, as for the...
mouth opening. As previously described, unlike measure-
calibre, our system could be adapted to various degrees of
excluding possible bias selection. Using devices of different
intense gag reflex and small oropharyngeal cavity, thus
were able to assess pharyngeal sensitivity in subjects with an
standard equipment readily available in any sleep laboratory.

Our ability to demonstrate a difference in impairment of
pharyngeal sensitivity testifies to the higher capacity of
discrimination of our procedure. Indeed, our stimulus
consisted of an air pulse administered at a constant distance
from the mucosa. Unlike previous studies, we did not use
any device that may induce gag reflex or interfere with
the sensory perception because of the difficulty in maintain-
ing a constant contact pressure with the mucosa, particularly
on the soft palate. Another explanation for the capacity to
discriminate between SDB severity levels was the use of
topical anaesthesia. As we suspected, it clearly enabled us to
separate some patients with normal baseline values from
controls, and medium from severely affected groups while
values were close at baseline. However, despite a dose-effect
response, differences between subgroups were not statisti-
cally significant due to overlapping values. Indeed, even
patients with severe SDB could have normal pharyngeal
sensitivity at baseline and under anaesthesia (see below).

Figure 3: Pharyngeal sensory thresholds in controls and in the three patients groups before and after anaesthesia. The patients were classified into three groups according to the proportion of the different respiratory events constituting the sleep disordered breathing: “mild” patients had apnoea-hypopnoea events <60%; “moderate” patients had apnoea-hypopnoea events 60–90%; “severe” patients had apnoea-hypopnoea events >90%. Left panel: Disappearance sensory perception threshold. Right panel: Appearance sensory perception threshold. Values are mean (SD).

Advantages and limitations of the procedure for
measuring pharyngeal sensitivity
Our device allowed easy and non-invasive assessment of
pharyngeal sensitivity in terms of tactile perception without
requiring specialised materials or professional skills. The
device is simple and the procedure can be performed with
standard equipment readily available in any sleep laboratory.

Compared with previously described procedures, we were able to assess pharyngeal sensitivity in subjects with an
intense gag reflex and small oropharyngeal cavity, thus
excluding possible bias selection. Using devices of different
calibre, our system could be adapted to various degrees of
mouth opening. As previously described, unlike measure-
ment of pharyngeal sensation, gag reflex was not informative
since we found no difference between groups.

Measurements were obtained rapidly (around 30 minutes)
and were repeatable, thus making the test reliable and
unconstrained for both the patient and the investigator. One
limitation of psychophysical evaluations is the subjective
character of the answers which rely on the subject’s
cooperation. However, although our results require further
validation in a larger population, the repeatability of the
measurements (fig 2, table 2) shows that the subjectivity of
the answers was reduced by repeating the measurements
during each test session and by using random null stimuli.

The anatomical region tested was the soft palate because of
its critical involvement in the pathophysiology of SDB (see
above). Experiments are currently in progress in our
laboratory to test additional areas. Indeed, the adjustability
of the guide allows testing of other oropharyngeal areas such as
the tonsil pillar, hard palate and uvula (data not shown)
which are either differently innervated and/or differently
exposed to mechanical stress during sleep.

We have shown that pharyngeal sensitivity is differentially
impaired according to the severity of SDB in terms of the type
of respiratory events while no significant correlation was
found with the classical AHI and RDI or with nocturnal
desaturation. This argues for the pathophysiological involve-
ment of pharyngeal sensitivity in collapsibility of the upper
airway. Compared with patients in the two most severely
affected groups, patients in the “mild” group were younger
and suffer from SDB with a high proportion of flow
limitation episodes and no nocturnal desaturation. The
“mild” group therefore represented patients suffering from
upper airway resistance syndrome or mild obstructive sleep
apnoea, while the “moderate” and “severe” groups repre-
sented hypopnoeic and apnoeic patients respectively. Patients
in the “mild” group had pharyngeal sensitivity which was
close to controls or intermediate between controls and
“moderate/severe” patients. These results are in agreement
with a previous study showing that collapsibility of the upper
airway during sleep in upper airway resistance syndrome is
intermediate between that of normal subjects and patients
with mild to moderate obstructive sleep apnoea.

Our ability to demonstrate a difference in impairment of
pharyngeal sensitivity testifies to the higher capacity of
discrimination of our procedure. Indeed, our stimulus
consisted of an air pulse administered at a constant distance
from the mucosa. Unlike previous studies, we did not use
any device that may induce gag reflex or interfere with
the sensory perception because of the difficulty in maintain-
ing a constant contact pressure with the mucosa, particularly
on the soft palate. Another explanation for the capacity to
discriminate between SDB severity levels was the use of
topical anaesthesia. As we suspected, it clearly enabled us to
separate some patients with normal baseline values from
controls, and medium from severely affected groups while
values were close at baseline. However, despite a dose-effect
response, differences between subgroups were not statisti-
cally significant due to overlapping values. Indeed, even
patients with severe SDB could have normal pharyngeal
sensitivity at baseline and under anaesthesia (see below).

Compared with previous studies, the anaesthesia was light
and localised since the gag reflex was unchanged by the
procedure. Such anaesthesia was, however, sufficient to
sensitise the test from the first spray and may be useful to
simplify the procedure by decreasing the number of
measurements and the duration of the examination.

Pharyngeal sensitivity: a tool to predict the severity of
SDB?

Overall, this test (appearance and disappearance thresholds,
slopes) revealed a high sensitivity for identifying patients
suffering from sleep apnoea syndrome in our sleep clinic.
populations. With the chosen cut-off value, pharyngeal sensitivity considered abnormal was systematically associated with SDB. In contrast, the existence of SDB was not systematically associated with an impairment of pharyngeal sensitivity, as shown by the sensitivity of the test in the “mild” (50%), “moderate” (73.7%), and “severe” (88.5%) groups. These findings confirm that pharyngeal sensitivity is only one determinant—together with airway anatomy—among the predisposing factors of collapse of the upper airway. In subjects with an anatomical predisposition to upper airway obstruction, partial impairment of the upper airway dilating muscle function may be sufficient to cause collapse of the airway. On the other hand, patients with a normal upper airway anatomy may be less vulnerable to impairment of the reflex dilation of the airway. Both the existence and severity of SDB are not dependent only on impairment of pharyngeal sensitivity. Thus, patients with similar pharyngeal sensitivity may exhibit different upper airway collapsibility since the motor part (efferent fibres and muscles) of the dilating reflex, not explored by our procedure, and the pharyngeal anatomy may also contribute to impairment of upper airway dilation.

Collapsibility of the upper airway and resulting SDB therefore appear to result from an equation including several factors, each of them being weighed by different coefficients that may be characteristic for an individual and may also evolve over time and with treatment. Among these factors, the most severely affected group in our study had a higher BMI and a higher alcohol intake which represent additional anatomical and functional factors that are likely to worsen SDB. In the multifactorial equation resulting in SDB, pharyngeal sensitivity is probably one of the key factors in our study, predictive not only of the existence but also of the severity of SDB.

Taken together, our results suggest a flow diagram for the diagnosis of sleep apnoea: on the one hand, lean and young patients preferentially suffer from upper airway resistance events and/or mild hypopnoeas. The pharyngeal sensitivity is then normal or subnormal. In this context, full polysomnography including respiratory effort assessment is required for diagnosis. On the other hand, more obese or older patients preferentially suffer from hypopnoea and/or apnoea. Impairment of pharyngeal sensitivity in such patients could provide a simplified diagnostic procedure. This proposed diagnostic flowchart should be prospectively validated in a larger sleep clinic population as well as in the general population.

In conclusion, we have developed a simple, repeatable, and safe procedure which confirms the presence of impaired pharyngeal sensitivity in patients with SDB and have shown

**Figure 4** Baseline sensory threshold and slope values for individual subjects in the control group and the three subgroups of patients. Left panel: baseline (upper) and slope (lower) values for the disappearance threshold; right panel: baseline (upper) and slope (lower) values for the appearance threshold. Individual circles correspond to the measurement of one subject. Circles with numbers indicate the number of subjects with similar values. Mean values are indicated by the horizontal bars. *p < 0.05, **p < 0.01, ***p < 0.001 vs controls. Note the similar grouping of values in controls compared with the higher and widely dispersed values in patients suffering from increasingly severe SDB. Some patients, even in the most severe groups, had similar sensory thresholds and slopes than controls.
that such impairment is correlated with the severity of SDB. Although this new procedure needs to be fully validated in a larger population, its simplicity suggests that it may be of use in routine clinical practice to evaluate the role of pharyngeal sensitivity in the pathophysiology of SDB and its value for simplification of the SDB diagnosis procedure.

ACKNOWLEDGEMENTS

The authors thank Drs B Lepaulle and F Arbib for their contribution to patient recruitment, C Loidio and M Selck for polysomnographic data collection, and D Villemin, J L Quesada and J L Bosson for statistical advice.

Authors' affiliations

M Dematteis, P Lévy, J-L Pépin, Laboratoire du sommeil et Laboratoire HP2 (INSERM ESPR EA3745), Centre Hospitalier Universitaire, BP 217, 38043 Grenoble Cedex 09, France

Supported by a grant from ANTADIR (Association fédérale Nationale pour le Traitement a Domicile de l’Insuffisance Respiratoire chronique).

REFERENCES


www.thoraxjnl.com
A simple procedure for measuring pharyngeal sensitivity: a contribution to the diagnosis of sleep apnoea

M Dematteis, P Lévy and J-L Pépin

Thorax 2005 60: 418-426
doi: 10.1136/thx.2003.015032

Updated information and services can be found at:
http://thorax.bmj.com/content/60/5/418

These include:

References
This article cites 31 articles, 8 of which you can access for free at:
http://thorax.bmj.com/content/60/5/418#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections

- Sleep disorders (neurology) (199)
- Sleep disorders (respiratory medicine) (199)
- Airway biology (1100)
- Sleep disorders (132)

Notes