respectively) were recorded. Patients underwent polysomnography (PSG) and multiple sleep latency tests (MSLT).
Results 9 patients (5 male/4 female, age 44.1 (14.6) years, BMI 30.5 (6.7) kg/m^2; obstructive sleep apnoea (OSA, n = 4), narcolepsy (n = 2), idiopathic hypersomnia (n = 1), insomnia (n = 1), no sleep disorder (n = 1)) were studied. The PSG results showed a short total sleep time (TST 360.1 (69.7) min) with a slightly reduced sleep efficiency (SE 79.6 (11.4)%), there were no relevant periodic limb movements (PLM index 7.3 (4.3)/h) but mild-moderate OSA (apnoea-hypopnoea index (AHI) median 6.4 (interquartile range 0.2–30.5)/h). The ESS was 13.9 (7.2) points, the MSL was 7.6 (5.9) min, the SSS was 3.0 (1.3) points and the SPS was 4.0 (1.3) points. The GVS was 5.6 (2.2) points and the GAS was 4.8 (1.6) points, the HADS-A was 8.7 (6.2) points and the HADS-D was 8.9 (5.9) points, the PAS was 23.9 (10.7) and the NAS was 25.6 (8.0) points. There was a positive correlation between the ESS and the SPS, but no other significant correlations (Table 1).

Abstract P64 Table 1 Spearman's rho correlation coefficients

	ESS	MSL
MSL	r = 0.086 / p = 0.872	–
SSS	r = −0.980 / p = 0.802	r = 0.000 / p = 1.000
SPS	**r = 0.675 / p = 0.045***	r = −0.088 / p = 0.868
GVS	r = 0.160 / p = 0.682	r = 0.200 / p = 0.704
GAS	r = 0.370 / p = 0.327	r = 0.860 / p = 0.872
HADS-A	r = 0.479 / p = 0.192	r = −0.600 / p = 0.208
HADS-D	r = 0.207 / p = 0.594	r = 0.086 / p = 0.872
PAS	r = 0.172 / p = 0.658	r = 0.257 / p = 0.623
NAS	r = 0.768 / p = 0.160	r = −0.600 / p = 0.208

*p<0.05.

Conclusion The ESS and the MSL did not correlate well, nor did they relate to measures of affect, emotion, mood, or quality of life. Conversely, there was an interaction between measures of fatigue and the ESS. These findings emphasise the need to develop better scores to characterise EDS, other than the ESS.

P65 OSAS AND DRIVING – BTS RETURN SURVEY TO ASSESS CONSISTENCY OF ADVICE GIVEN TO PATIENTS AT DIAGNOSIS AND AFTER TREATMENT– A REPEAT OF THE 2013 SURVEY TO EVALUATE THE IMPACT OF A BTS STATEMENT AND NEW DVLA REGULATIONS

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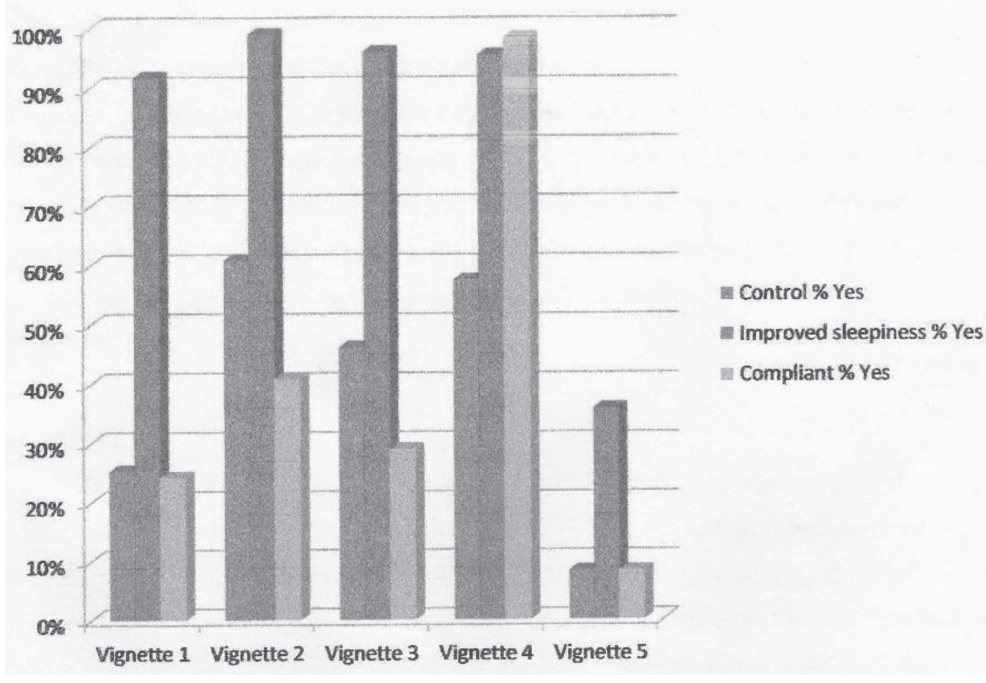
Introduction In 2013 a BTS survey showed substantial variability in the advice that patients with obstructive sleep apnoea syndrome (OSAS) would be likely to receive from clinicians with regard to whether they were fit to drive or not. Since then the BTS has issued guidance and the DVLA changed its emphasis to sleepiness "likely to impair safe driving", rather than sleepiness in general. The survey was divided into two parts, the first focusing on patients at presentation and the second after treatment, with the wording of the questions reflecting that used in the DVLA forms. We repeated this study in 2016 to assess whether these changes had resulted in greater consistency. Additional questions about BTS and DVLA guidance were included.
Methods Web based survey of members of BTS, BSS and ARTP.
Results 304 respondents. The vignettes at diagnosis are directly comparable between the surveys and the results are very similar (p = NS). In the most contentious case there remains an approximately 50:50 chance of a patient receiving opposing advice.



Abstract P65 Figure 1

Significant variation in the assessments of control of patient's condition, improvement in sleepiness and compliance after treatment remains (Figure 1). 2 36% were not aware that the BTS have issued a statement 63% felt the change in emphasis from excessive sleepiness to sleepiness likely to impair safe driving helpful. 64% of respondents were not aware that DVLA had changed its guidance in January 2016. 18% of respondents advise patients to inform the DVLA when diagnosis felt to be likely based on symptoms. 57% when diagnosis confirmed following investigation, 13% when CPAP first trialled and 12% when CPAP issued to the patient.

Conclusions The results of the 2016 survey confirm the results of the 2013 survey. Disappointingly the guidance from the BTS appears to have had little impact. The change in emphasis from excessively sleepy to sleepiness likely to impair safe driving was felt to be helpful by a small majority. There is a clear need for tools which are felt to be robust by clinicians and patients to help make decisions about fitness to drive and for these to be disseminated to clinicians.

P66 FALLING ASLEEP WHILE DRIVING: IS DRIVING SAFETY ADVICE GIVEN TO PATIENTS WITH EXCESSIVE DAYTIME SLEEPINESS?

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Background 3.5 million people in the UK have excessive daytime sleepiness and 1 in 5 Road Traffic Accidents are due to sleepiness while driving.

Aim To improve Patient and Public safety by auditing whether DVLA's driving safety advice is given to patients with excessive daytime sleepiness in two settings: (i) at referral as recommended by The Royal Society for the Prevention of Accidents guidelines and (ii) at the Regional Sleep Clinic as recommended by the BTS guidelines.

Method Retrospective study between 01/10/15 and 06/01/16 of (i) 100 referral letters to the Regional Sleep Clinic and (ii) 100 sleep clinic letters to patients' GP. In both cases, patients were included if the letter mentioned 'Daytime sleepiness' or if their Epworth Sleepiness Score (ESS) was over 10 (indicating excessive daytime sleepiness).

Results Only 19% of referral letters from primary and secondary care had documented giving driving safety advice to patients with daytime sleepiness. Sixteen specialties referred patients to the Sleep clinic. General Practice accounted for three quarters of these referrals and driving safety had only been discussed in 14% of cases. Even with specialties like Respiratory medicine and Neurology which see patients with sleep disorders regularly, very few had discussed driving safety.

The Sleep Clinic gave DVLA advice to 85% of patients. In the 15% where no advice was given, patients usually had ESS <10 (but symptomatically sleepy) or sleepiness as a secondary consequence of insomnia/non-REM parasomnia.

7 patients reported falling asleep while driving (only 2/7 were discovered at referral). Moreover, the Sleep Clinic noted that 1 had a Road Traffic Accident and 1 had a near miss. Average waiting time from referral to Sleep Clinic appointment was 3 months. Thus driving advice needs to be given at referral.

A limitation of this audit is that not all clinicians record discussions about driving even though it is important for medicolegal purposes.

Conclusion Driving safety discussions on referral can be improved by educating GPs/secondary care and introducing an Alert on eReferral. The Sleep Clinic should use a pro forma to remind clinicians to discuss driving regardless of a patient's ESS or diagnosis.

P67 IS THERE A DIFFERENCE BETWEEN THE SLEEP PHYSIOLOGY OF OBESE AND SUPER OBESE PATIENTS?

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Introduction Bariatric surgery is increasingly recommended for managing patients who are both obese and super obese (BMI ≥45 ref. WHO Classification). We have compared if there are physiological and subjective differences between patients in these two categories.

Methods Patients assessed for bariatric surgery were split into the super obese and obese group. Their physiological parameters including Apnoea Hypopnoea Index(AHI), Desaturation Index (ODI >4%) and subjective results i.e., Epworth Sleepiness Score (ESS) and STOPBANG Questionnaire were compared.

Results 111 patients assessed for bariatric surgery attended for limited sleep studies from a period between July 2013 to December 2014. 57 patients were obese (40 females) and 54 were superobese (37 females) and the results are tabulated below. (Table 1)

The superobese patients had a higher AHI, ODI and time spent desaturated when compared to the obese patients.

Conclusion 1) There is more physiological derangement in the super obese patient group so greater caution is needed in the administration of anaesthetic to such patients.

2) Despite the physiological derangement, superobese patients were less sleepy based on their ESS, the reasons for which are not entirely clear.

Abstract P67 Table 1

	Obese (n = 57)		Super obese (n = 54)		p value
	Mean	SD	Mean	SD	
ODI > 4%	20.64	18.78	31.46	26.53	0.024
Time spent <90%	8.03	14.78	12.93	17.65	0.012
Time spent <85%	1.85	7.66	2.99	5.615	0.007
AHI	21.71	19.67	31.49	27.11	0.047
ESS	8.85	5.2	6.72	4.77	0.035
STOPBANG	Median – 5	IQR 4–6	Median – 5	IQR 4–6	0.22
Mallampatti Score	Median – 3	IQR 2–4	Median – 3	IQR 1–4	0.711

SD - Standard Deviation IQR - Interquartile Range

P68 TO SCREEN OR NOT TO SCREEN FOR OBSTRUCTIVE SLEEP APNOEA (OSA) PRE-OPERATIVELY?

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