Abstract P291 Table 1

	High Risk Group (N=23)	Low Risk Group (N=34)	p-value
Age	62 ± 3.6	66 ± 2.4	0.3149
Weight (Kg)	85 ± 3.0	62 ± 2.2	<0.0001
Midazolam dose (mg)	5.2 ± 0.45	4.0 ± 0.36	0.0344
Fentanyl dose (mcg)	43 ± 9.5	36 ± 7.5	0.4951
Lignocaine dose (ml)	13 ± 0.34	14 ± 0.63	0.794
Sedation score (OAASS) immediate post procedure (1–4)	2.2 ± 0.14	2.3 ± 0.11	0.794
Deeper sedation score in post procedure observation	0	0	NS
RR immediately post procedure	17 ± 0.69	18 ± 0.69	0.737
Oxygen Sats	95 ± 0.50	95 ± 0.43	0.2866
Patients required observation beyond 2 h (number and percentage)	1 (4.3%)	1 (2.9%	NS
RR <8	0	0	NS
RR 25% drop from baseline	2 (8.6%)	1 (2.9%)	NS

P291 OBSTRUCTIVE SLEEP APNOEA SCREENING FOR PATIENTS UNDERGOING BRONCHOSCOPY – IS IT REQUIRED?

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Introduction A recent meta-analysis shows obstructive sleep apnoea (OSA) increases the incidence of postoperative desaturation, respiratory failure, cardiac events, and ICU transfers (Kaw, R., *et al*, 2012). A study in gastrointestinal endoscopy showed no increased risk of cardiopulmonary complications in OSA screening positive patients (Mador, M. J., *et al*, 2012). There are no published studies in patients with OSA undergoing bronchoscopy, as far as we are aware. It has been suggested that patients should be screened for OSAS prior to endoscopy and bronchoscopy.

Methods Nursing staff in the bronchoscopy suite used a validated OSA screening tool STOP-BANG score prior to the procedure. The physician performing the rpocedure was unaware of the score. The amount of sedation used during the procedure is recorded. Sedation score, Respiratory Rate (RR), Oxygen Sturation (SpO2) were documented 0,30,60,120 min post procedure.

Results Procedures were performed in 57 patients; diagnostic bronchoscopy 28, EBUS 29. Twenty-three patients (40.3%) were identified high risk for OSA (STOP-BANG score 3 or above). The mean age was 64 +/- 15. Male 29 (50.8%). There was no statistically significant difference in: amount of sedation used (midazolam, fentanyl or both), lignocaine use, initial sedation score, RR, SpO2, between high and low risk group. (Table 1). There was no correlation between initial sedation score with STOP-BANG score. There was no evidence of deeper sedation, drop in RR or SpO2 noticed in the post procedure observation period in the high risk group. Median length of observation was same in both groups. There were no complications or emergency admissions.

Conclusion In this small study there is no evidence of increased cardio respiratory complications in patients at high risk for OSA undergoing bronchoscopy under conscious sedation.

REFERENCES

1 Kaw, R, *et al*. Meta-analysis of association between obstructive sleep apnoea and postoperative outcome. *Br J Anaesth* 2012;109(6):897-906

2 Mador, MJ, *et al*. D patients at risk of sleep apnea have an increased risk of cardio-respiratory complications during endoscopy procedures? *Sleep Breath* 2012;16 (3):609-615

P292 VALIDATION OF THE STOP-BANG QUESTIONNAIRE AS A SCREENING TOOL FOR SLEEP APNOEA IN PATIENTS UNDERGOING ABLATION FOR PAROXYSMAL ATRIAL FIBRILLATION

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Background Patients with treated obstructive sleep apnoea have a greater chance of treatment success compared to those untreated, when undergoing ablation for atrial fibrillation (AF) (Patel *et al* 2010). The STOP-BANG questionnaire has previously been validated as a screening tool for detecting sleep apnoea in surgical patients (Chung *et al* 2008), but has not been validated for use in AF patients. We present the results from a study investigating its predictive value in AF patients.

Methods Patients with paroxysmal AF undergoing ablation were approached. Those with previously diagnosed sleep apnoea were excluded. Participants completed the STOP-BANG questionnaire and underwent overnight oximetry. Of 228 patients approached, 101 participated. Sleep apnoea was defined as a 4% desaturation index of >5 per hour, and participants were reviewed by an experienced sleep physician to determine if treatment with continuous positive airway pressure (CPAP) was necessary.

Results Of the 101 patients screened, 36 had sleep apnoea, and 13 were offered treatment with CPAP. The STOP-BANG questionnaire (with a cut off of 3 or more out of 8 questions answered positively considered 'high risk') had a sensitivity of 97.2% and a specificity of 43.1% for detecting sleep apnoea in this group. The STOP questions alone (with a cut off of 2 or more out of 4 considered 'high risk') had a sensitivity of 75.0% and a specificity of 63.1%, however the sensitivity was 100% and specificity 56.8% for predicting the need for CPAP.

Conclusion There is a high prevalence of undiagnosed sleep apnoea in this patient group. The STOP-BANG questionnaire has a high sensitivity for detecting sleep apnoea in AF patients. The STOP questions alone have a high sensitivity for detecting sleep apnoea requiring treatment.

REFERENCES

Patel D, Mohanty P, Di Biase L, *et al*. Circ Arrhythm Electrophysiol. 2010 Oct;3 (5):445-51

Chung F, Yegneswaran B, Liao P, *et al*. Anesthesiology. 2008 May;108(5):812-21

Abstract P292 Table 1 Characteristics of the participants

	Sleep Apnoea	No Sleep Apnoea	p value
Number	36	65	
Age	62.2 (8.5)	62.1 (10.6)	p = 0.9571
BMI	32.3 (5.3)	28.9 (5.8)	p = 0.0052
ESS	8.9 (5.2)	7.8 (4.8)	p = 0.2897
Males	25 (69.4%)	31 (47.7%)	
Desaturation index	10.2 (9.9)	2.7 (1.2)	

Categorical variables presented as frequency and continuous variables presented as mean (SD)