Background
Anesthesia worsens OSA, and may lead to respiratory and cardiac complications. Three critical incidents have occurred in the Oxford Hospitals in recent years. OSA is very common at around 5–25%, but half the cases are not diagnosed. So should we screen for OSA pre-operatively?

Audit
Over 9 months from July 2015 all patients completed a STOP-BANG questionnaire in a gynaecology pre-operative clinic. Those with snoring and a score of 3 or greater were referred for a sleep study. Data is presented for 102 patients (100 female; 2 transgender) with a mean ± SD age of 55.7 ± 11.4 yrs, BMI 35.8 ± 7.6 kg/m² and collar size 40.0 ± 4.8 cm.

The rate of non-attendance was high at 19/102 (19%), with those with a lower STOP-BANG score being more likely not to attend. Of those undergoing a sleep study, a new diagnosis was made in 53/83 (64%) patients. Symptoms and OSA/hypventilation were sufficient for CPAP to be started in 23 patients and NIV in 1 (29%) of those screened, with positive diagnoses more likely with higher STOP-BANG scores. The median (IQR) time to CPAP set-up was 80 (52, 100) days, thus a substantial proportion of patients had surgery before treatment.

How should we ensure anaesthetic safety for patients at risk of OSA?

Completing a sleep study and establishing OSA patients on CPAP prior to surgery would significantly slow the surgical pathway, and there is no evidence that this would improve outcome. However it seems sensible for anesthetists to have a STOP-BANG score of 3+ or 2 with clinical suspicion of OSA, who are undergoing major surgery AND in whom it is deemed the study did not require ethical approval. 84 patients were included in the study. The selected patients’ case notes were used to review their STOPBANG score, Epworth Sleepiness Score, type of sleep study performed, Oxygen Desaturation Index (ODI), diagnosis and treatment. If the patient had an ODI ≥ 15, or was successfully started on treatment with a borderline ODI ≥ 5 < 15, this was considered an appropriate referral for that threshold.

The sensitivity and specificity of the different STOPBANG thresholds were calculated to assess if the threshold score of STOPBANG ≥ 3 is appropriate, or if this should be adjusted to more appropriately identify those patients with OSA.

Results
For a threshold of ≥ 3, the sensitivity is very high (100%). The specificity is decreased for the threshold of ≥ 5 (71%), and further decreased for the ≥ 4/8 (3 from STOP) threshold (33%). For the ≥ 3 threshold, the specificity is 0%. The specificity is dramatically increased for the ≥ 5 threshold (70%), and highest in the ≥ 4/8 (3 from STOP) category (85%).

Conclusion
The statistical analysis confirms that a threshold of ≥ 3 has a very high sensitivity, but very low specificity. A threshold of ≥ 5 has a lower sensitivity however is much more specific and may be a more useful way of identifying the high risk of OSA surgical patient. A change in protocol to ≥ 5 aims to reduce the unnecessary delay or cancellation of surgery and avoid inappropriate referrals into the Respiratory and Sleep department.

EVALUATION OF THE STOPBANG THRESHOLD IN THE PRE-OPERATIVE SCREENING FOR OBSTRUCTIVE SLEEP APNEA AT SHERWOOD FOREST HOSPITALS FOUNDATION TRUST

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Background
Undiagnosed Obstructive Sleep Apnoea (OSA) has been associated with a higher perioperative morbidity and mortality. The aim of this study is to prepare a comprehensive review of the STOPBANG score, a pre-operative screening tool for patients with possible OSA. This study investigates if the current STOPBANG threshold of ≥ 3/8 is appropriate, or if it should be increased to ≥ 5/8 or ≥ 4/8 (with ≤ 3 in the STOP category) to avoid the unnecessary cancellation/postponement of surgery and inappropriate referrals into the sleep service.

Methods
This was a retrospective study of patients referred to the Sleep Service following a positive STOPBANG score (≥ 3). The Research and Development Department of the hospital deemed the study did not require ethical approval. 84 patients were included in the study. The selected patients’ case notes were used to review their STOPBANG score, Epworth Sleepiness Score, type of sleep study performed, Oxygen Desaturation Index (ODI), diagnosis and treatment. If the patient had an ODI ≥ 15, or was successfully started on treatment with a borderline ODI ≥ 5 < 15, this was considered an appropriate referral for that threshold.

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