

Guidelines for the Patient with Obstructive Sleep Apnea (9/08)

Patients with Obstructive Sleep Apnea (OSA) are at increased risk of sudden death from respiratory depression after surgery and anesthesia. The cause appears to be the increased sensitivity of these patients to the depressant effects of anesthesia and postoperative narcotics. There are increasing numbers of case reports of death in patients with OSA left in an unmonitored setting overnight. To prevent these catastrophes from occurring at the UCHC, the Department of Anesthesiology follows these guidelines:

1. Preoperative evaluation of all patients, especially the morbidly obese, will include the clinical assessment of the potential for OSA. The signs and symptoms associated with OSA include: loud snoring, witnessed apnea or gasping during sleep, increased neck circumference, systemic hypertension, nasal obstruction, crowded pharynx, excessive daytime somnolence, frequent nocturnal awakening, and un-refreshed AM status. If the constellation of these signs and symptoms create concern of the possibility of OSA, surgery may be postponed until an evaluation is performed. A formal **diagnosis of sleep apnea** may be met by any of the following found on sleep study:
 - Respiratory Disturbance Index >40 (RDI)
 - Respiratory Disturbance Index >20 + obesity (BMI >30)
 - Respiratory Disturbance Index >20 + hypercarbia (PaCO₂ > 50 mm Hg)
 - CPAP mask recommendation from sleep study
2. As a policy, **OSA patients receiving general anesthesia require monitoring overnight with continuous pulse oximetry in a hospital setting.** However, a decision may be made to place the patient in an unmonitored setting either in the hospital or at home if: 1) the patient is fully compliant with and will use their CPAP mask postoperatively 2) the patient receives local, regional or brief general anesthesia 3) there is an uneventful PACU stay, and 4) there is minimal to no post op narcotic requirement. Examples of these procedures include hysteroscopy, D&C, cardioversion, AICD check, ECT, IVF egg retrieval, cystoscopy, carpal tunnel release, simple arthroscopy, etc.
3. This decision to **bypass a monitored postop setting** will be made on an **individual basis** taking into account the duration and invasiveness of the surgery, the anesthetic technique used, post operative pain control requirements, and patient compliance with their CPAP machine. It should be made clear to the surgeon and patient that the use of narcotics for pain control may be dangerous. **The surgeon takes full responsibility for the use of narcotics** in these patients when the monitored setting is bypassed and the patient is discharged.
4. **All patients diagnosed with OSA** require documentation of their evaluation, recommendations and current treatment, and **require preop consultation** with the PEC Coordinator – **Grace Brady, APRN @ 679-6688, or pager 825-0342.**