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Roundtable: Experts Recommend Tools to Diagnose and Monitor Excessive Daytime Sleepiness in Obstructive Sleep Apnea

Announcer:
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Dr. Malhotra:
Hi, my name is Dr. Atul Malhotra. I'm a Professor of Medicine Pulmonary Critical Care Sleep Medicine Specialist, and the Research Chief for the Division here, and I run a big NIH-funded laboratory. I see a lot of patients. We're here for the Roundtable: Experts Recommend Tools to Diagnose and Monitor Excessive Daytime Sleepiness in Obstructive Sleep Apnea. I'm here with my friend and fellow Red Sox fan, Dr. Christina Finch. I'll have her introduce herself.

Dr. Finch:
Hi, I'm Dr. Christina Finch, and I'm a Clinical Sleep Doctor at UC San Diego and also on the faculty. Excited to be here.

Dr. Malhotra:
Christina, what are your thoughts on monitoring excessive sleepiness in people with sleep apnea?

Dr. Finch:
Yes, I think it's really important. I think it's often overlooked. Sometimes patients, you know, when we assume they're on sleep apnea treatment, that they're doing great. But there's a significant portion of these patients who really do have ongoing daytime sleepiness that we really have to address.

Dr. Malhotra:
I think one of the rookie mistakes is people try and start to reach for pharmacotherapy before they monitor treatment appropriately. Do you find that as well?

Dr. Finch:
Absolutely. I think it's super important for us to make sure that they're adequately treated, not just, you know, check the box, 'yes, I have the CPAP.' But that they're using it every night, ideally, for at least 7 to 9 hours, and that we're not seeing any excessive leak from their mask. And we're making sure that the residual events that they're having with the device is under our threshold.

Dr. Malhotra:
Yeah. Do you have any tricks if you do see residual apnea? How do you troubleshoot? Or is it more individualized?

Dr. Finch:
It kind of depends on the person. Oftentimes, if there's any sort of mask concern whatsoever, if they've only ever tried one, I usually recommend trying a different

style mask, or if they really love whatever style they have, just trying a different size or a different format within there.

Dr. Malhotra:
You troubleshoot the mask for residual apnea, because sometimes I'll order a titration because I'll find limb movements, or I'll find central apneas that weren't obvious in the history, or there's opioids that weren't disclosed or this kind of thing. Do you find that as well?

Dr. Finch:
Absolutely.

Dr. Malhotra:
Yeah?

Dr. Finch:
Yeah, certainly low threshold for doing a titration study to make sure we're not missing something else that can be contributing to the daytime sleepiness.

Dr. Malhotra:
Okay. And then if you do find somebody that's got legitimate sleepiness, or you're concerned about them, and they're using their CPAP adequately, and they don't have residual disease, and they don't have a lot of leak, what do you do next? Do you order tests? Or do you do an Epworth? What do you do?

Dr. Finch:
Yeah, so I love the Epworth. I think that's a great tool that we use, in most of our clinics, even just kind of monitoring patients as they come in. It's really helpful to It'll take just a couple moments for them to fill it out before we even see them. And it kind of gives a good timeline of how they're doing over time. And if we're worried that that number is not improving, despite what we're doing, we can kind of look for other things. What's your approach?

Dr. Malhotra:
Yeah, you know, the Epworth is not everybody. I recently had a patient respond to the question about: Do you fall asleep in a theater or church?, and they said, 'I've never been to a theater or a church.' So, you know, the questions are a bit antiquated from 1991, or whenever Murray Johns published that, but sometimes it's the best we have. And I do use it clinically. We recently published data from Mozambique, and just a lot of the questions are not relevant to –

Dr. Finch:
They don't apply, yeah.

Dr. Malhotra:
They don't apply. But I still find it useful, particularly in the patients I'm seeing in San Diego.

Dr. Finch:
Yeah, I've actually seen some neat ones that are just visual representations. Like if you're fishing by the creek, you know, what your symptoms might be? So kind of me changing that for the patient setting is really important.

Dr. Malhotra:
Yeah. Then do you order MSLT's and MWT's in this context? Or not really?

Dr. Finch:
Yeah, good question. So I typically don't order them, certainly not first line in this context. We usually reserve those when we're really concerned about narcolepsy or idiopathic hypersomnia. And oftentimes with these folks with residual sleep apnea, or with residual sleepiness with sleep apnea, it's just not the best setting. What about you? What are your thoughts?

Dr. Malhotra:
Yeah, I was recently involved in a Delphi conference, like a global consensus thing. And it's not published yet. But I can sort of share that the MSLT and MWT are really not available in a lot of locations. There are global experts and said, 'Yeah, we don't order this test because we don't have them.' So we didn't put in the recommendations there to do that kind of testing. And honestly, even if they are available, I find the confidence intervals are so wide, that if you do test, retest reproducibility on MSLT's, it's kind of all over the place. So I occasionally use them in medical legal kind of settings. But beyond that, I don't really use them for management or for that kind of thing.

Dr. Finch:
I agree.

Dr. Malhotra:

Yeah. Are there patients you see that are sort of drug seeking or that kind of thing, where you find that they really don't have residual sleepiness, and they're looking for medications? Because I don't think that's a big problem, even though people express concerns about it.

Dr. Finch:
Yeah, very rarely. I can count on maybe one hand the times that I've even thought about that. Most people, you know, they're just trying to do well in their daily life and wish they weren't as sleepy. So I think really taking those concerns as truths is important. What about you?

Dr. Malhotra: Yeah, I agree. And I'll often try people medications just to see how they do. And I've used Modafinil, I've used solriamfetol. I've had reasonably good success with both of those. Do you have a preference? Or do you have an order you choose in terms of medications?

Dr. Finch:
Yeah, so I usually start off with the Modafinil, armodafinil options first. They're easier, usually easier to obtain with better pricing and more insurance coverage. And they have a longer track record. So those are typically the ones I start with, but certainly if they're not effective, I move on to other options.

Dr. Malhotra:
Yeah, as you know, full disclosure, I was involved in some of the solriamfetol studies, and so I always disclose that to my patients, but I do find the efficacy is pretty good and the side effects are pretty minimal. So that was good success. And the other warning I was given with Modafinil and armodafinil was, in premenopausal women, it interferes with birth control and their teratogenics, so I consider that a bit of a double whammy, so I'm careful about those.

Dr. Finch:
Very careful. Yeah, Good point. Perfect. So looks like we're out of time, but it was really lovely talking to you about this.

Dr. Malhotra:
Yeah, thank you, Christina.

Announcer:
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