Patient Name: Example Patient

Date of Birth: 3/28/1960

Study Date: 4/30/2018

PORTABLE SLEEP MONITORING REPORT

PATIENT INFORMATION:

This 58 year old patient was referred for a type 3 portable sleep study. The study was conducted using the Nox T3 home bruxism/sleep testing device. The test was conducted to investigate the possibility of sleep disordered breathing.

The study included the following channels: Nasal-Oro pressure, snoring, thoracic and abdominal RIP effort belts, actigraphy, oximetry, heart rate and body position.

IMPRESSION:

There were moderate snoring, apneas, hypopneas and arterial oxygen desaturations, all consistent with OSA. The **overall apnea/hypopnea index (AHI) was 51.5.** The supine apnea/ hypopnea index (AHI) was 51.6. The mean arterial oxygen saturation was 93.2%. The **lowest arterial oxygen saturation was 79.0%.** Total evaluation time was 7 h 35 m.

Bruxism Episodes Index: **17.4**/h	Apnea to Bruxism Index: **0.7**/h
Bruxism Bursts Index: 65.6/h	Arousal to Bruxism Index: 0.0/h

Findings were consistent with **severe obstructive sleep apnea (G47.33).** There was evidence of sleep related bruxism.

RECOMMENDATIONS:

1. **Consider nasal continuous positive airway pressure (CPAP) as the initial treatment choice for severe obstructive sleep apnea.** If the patient chooses CPAP therapy, a nocturnal PSG with CPAP titration is recommended. As an alternative, an Auto PAP with pressure range 5-20 cmH20 with download is an option. Consider PAP interface (mask) fitted for patient comfort, heated humidification & PAP compliance monitoring (1month, 3 months & 12 months after PAP initiation).

2. Positive airway pressure therapy (PAP) is the first line of treatment for patient with severe OSA. Alternative treatment for severe OSA in patients who cannot tolerate and have failed or refused CPAP therapy includes:
    a. The patient may benefit from the use of a nocturnal mandibular repositioning appliance. If that line of therapy is to be pursued, the patient should be evaluated by a dentist trained in the treatment of sleep related breathing disorders.
    b. An ENT consultation which may be useful to look for specific causes of obstruction and possible treatment options.

3. Weight loss, as an adjunct, may be of benefit in reducing the severity of snoring and respiratory events.
4. Consider advising patient against the use of alcohol or sedatives as these substances can worsen excessive daytime sleepiness and respiratory disturbances of sleep.
5. Consider advising patient against participating in potentially dangerous activities while drowsy such as operating a motor vehicle, heavy equipment or power tools.
6. Consider advising patient of the long term consequences of OSA if left untreated, need for treatment & close follow up.
7. Clinical follow up as deemed necessary.

Thank you for the referral of this patient. If we can be of further assistance, please feel free to contact us.

Sincerely,

Sleep Physician

DEFINITIONS:
Apnea = cessation of airflow (reduces by ≥90%), that lasts > 10 seconds. Hypopnea = ≥50% decrease in airflow for > 10 seconds with a decrease in O2 saturation of =>4% or EEG arousal Apnea/Hypopnea Index (AHI) = apnea plus hypopnea/hour(s) of sleep. AHI Scale= < 5 events /hour = (normal); 5-14 events/hour = (mild); 15-30 events/hour = (moderate); >30 events/hour = (severe). Arousal: An arousal in sleep is defined as an EEG frequency shift of at least 3 seconds. Normal baseline O2 saturation (Awake): > 93% SaO2 desaturation scale: 85-89% (mild) 80-84% (moderate) <80% (severe) Desaturation = Drop in O2 saturation by 4% for Medicare and 3% for all others. TTT = Total Test Time BMI (Body Mass Index) = BMI assesses weight compared to height. (BMI=kg/m^2). Epworth Sleepiness Scale: = > 11 indicates daytime sleepiness. Sleep Efficiency: (Normal is > 80%)