The Society of Anesthesia and Sleep Medicine (SASM) has now been operating for over two years. The success of SASM is due, in no small part, to the leadership of David Hillman, past president and the board. David’s wisdom and foresight have steadily guided SASM in the past few years. SASM is also grateful to Norman Bolden, who steps down from the Board this year after a 2-year term as secretary. Norman has established the administrative infrastructure of SASM and its website.

There are now nine member elected directors. Peter Gay is the president-elect. Babak Mokhlesi is the secretary. Girish P. Joshi, MBBS, MD, FFARCSI is the treasurer. David Hillman is the past president. Other board members are Roop Kaw, Dennis Auckley, Bhargavi Gali, and Mervyn Maze. For 2013-2015, Peter Gay is the chair of the CME committee with Girish P. Joshi, MBBS, MD, FFARCSI as the co-chair. Anthony Doufas is the scientific abstracts chair whereas Susana Vacas is the scientific update chair. Starvos Memtsoudis is the membership chair with Babak Mokhlesi as the co-chair. Krishna Ramachandran is the chair of the newsletter committee and Michael Pilla is the chair of the website committee. Roop Kaw is the chair of the research committee and Norman Bolden is the chair of the OSA registry. Dennis Auckley and Bhargavi Gali are co-chairs of the clinical committee. Kimmo Murto is the chair of SASM pediatric subcommittee.

Our Annual Scientific meeting in October 2013 under the direction of Babak Mokhlesi and the committee was a huge success with over 160 registrants. There were two workshops on Thursday with a Friday main meeting. The workshop on basic science in sleep and the workshop on practical protocols for management of sleep apnea were hugely popular. This year’s theme – Opioids, Respiratory Depression and Sleep Disordered Breathing – takes us into new territory with a closer examination of the interplay between sleep, opioids and ventilatory control. There were 30...
Through several discussions over the last few years, perioperative scientists and professionals have converged on a few key programmatic safety measures to reduce risk related to sleep disordered breathing. As we transition from one year to the next, these themes remain pertinent and need rigorous testing in traditional randomized studies, observational studies and more advanced methods of outcome analyses. 2013 was a landmark year for our society as described by our incoming President Frances Chung. Her boundless energy and drive will undoubtedly serve to accelerate the development of our society, with the ultimate aim of providing knowledge and methods for safer patient care. As part of this transition, it is my great pleasure and privilege to contribute to you as the editor of the newsletter.

Girish P. Joshi, MBBS, MD, FFARCSI, my predecessor, has left me with a wealth of resources and continues to be a tireless champion of the society’s cause. I look forward to the upcoming two years to work with Michael Pilla and consolidate a plan of more effective outreach to professionals and the general public. Along those lines, I look forward to your submissions for newsletter articles that capture current trends in basic science, mechanisms of disease modification, clinical management of difficult cases, process or protocol development and implementation.

This newsletter contains articles that span preoperative screening, implementation of a screening tool in the electronic health record and the development of a PCA safety checklist. Michael Wong and Lynn Razzano present the findings of their 2013 survey of 40 hospitals regarding PCA safety and propose the development of a PCA safety checklist. They identify significant safety gaps in knowledge, screening, ongoing assessment and monitoring of patients on PCA. Such work is crucial to our refinement of monitoring standards and lays the platform for future observational research.

Preoperative screening with STOP-Bang is explored in further detail by Mandeep Singh who summarizes the major challenges and opportunities in implementation of screening processes in patients with high risk of OSA. For instance, in a recent survey, although two-thirds of respondents routinely provided care for patients with OSA, three-fourths reported lack of departmental or institutional policies for their care. Jonathon Wanderer and colleagues present the incorporation of SOA screening in the electronic health record, a process which opens the door for concurrent clinical decision support, alerts, and development of a database for further evaluation of outcome modification.

Toby Weingarten reports the postoperative strategy used to manage risk in patients undergoing bariatric surgery at Mayo Clinic. Phase 1 PACU discharge readiness is established only if patients who develop post extubation respiratory-specific events subsequently have two 30-minute evaluation periods free of recurrent events. High-risk patients subsequently transferred to a standard postsurgical ward are monitored with continuous pulse oximetry for the first 48 hours after surgery.

Through their contributions, these authors have highlighted the clinical challenges with implementation of population screening or monitoring and describe protocol-driven innovative methods to provide safer care. While these interventions reflect our collective expert opinions, the foreseeable future promises to provide greater insight into the actual value of these various elements that form a perioperative care pathway for OSA. It will also be interesting to see how the development of the perioperative surgical home impacts the implementation of OSA care pathways. In closing I wish you and your families a very happy new year and look forward to your renewed enthusiasm in developing our society’s goals.
scientific abstracts with 5 awards given to the best abstracts. SASM is grateful for the leadership of Yandong Jiang as the chair of abstract committee for past three years. For the meeting in New Orleans 2014, the theme will be on safety.

The Research Committee, under its chair, Roop Kaw, adjudicated our first research award of 10,000 dollars. Congratulations to Susana Vacas with the University of California-San Francisco, for winning the first Society of Anesthesia and Sleep Medicine (SASM) Research Grant! The project title is Obstructive Sleep Apnea and Postoperative Cognitive Decline. For 2014, SASM will be giving a research award of 20,000 dollars to the best application in the area of sleep medicine and anesthesia.

Another exciting project by the research committee is the development of a white paper articulating a research agenda for sleep medicine and anesthesia. Roop Kaw is providing the leadership in this important project.

Norman Bolden leads the project on the obstructive sleep apnea registry. This project is to register sentinel events relevant to postoperative deaths and near misses in OSA patients. This involves collaboration with the Seattle group who have extensive experience with the ASA closed claims project.

Our Clinical committee, co-chaired by Dennis Auckley and Bhargavi Gali have been extremely active. The committee has finalised two important documents: (a) the SASM Recommendations for Management of Obstructive Sleep Apnea in the Perioperative Period (an educational tool for health care providers who wish to develop institutional protocols for patients with known or suspected OSA); and (b) the SASM Education Brochure 2013 (a short document to be used as a quick reference regarding perioperative management of OSA). These useful references will foreshadow the eventual development of formal guidelines.

SASM is pleased to accept new members and encourages Gold Patron membership. We are a unique society in that 70% of the members are from anesthesiology specialty while 30% are from other specialties like sleep medicine, research scientists, ENT specialists etc. We have now established a firm track record of successful CME meetings, articulated a research agenda, and informed clinical practice. The next phase requires us to broaden our membership base. Stavros Memtsoudis as chair of the membership committee will be leading the SASM membership drive.

Communication is a key to growth. Girish P. Joshi, MBBS, MD, FFARCSI has worked extremely hard in providing excellent SASM newsletter three times a year for over two and a half years. Satya Krishna Ramanchandran is the editor of SASM newsletter for the coming two years. This is an essential communication and educational tool for SASM members. New initiatives will be undertaken. Another important communication tool is the monthly literature updates by the Scientific Updates subcommittee under leadership of Susana Vacas. Michael Pilla has assumed the chair of SASM website committee. He will play a significant role in modernization of SASM communication via social media such as Facebook or twitter. We are looking forward to introducing these innovations.

Pediatric OSA brings its own challenges. It is of major interest to many anesthesiologists and ENT surgeons as, among other things, surgery has a far greater role in OSA treatment in children than in adults. The SASM Pediatric subcommittee was newly established in October 2013 with Kimmo Murto as the chair of this subcommittee and we are looking forward to the new dimension they will bring to SASM.

The board of SASM has met with the Board of Trustees of IARS in May and October 2013. We are exploring a closer collaboration with them. They are keen to give sleep prominence in their programs and to have us as an affiliate. We are keen to share ideas and resources, including CME and to explore the possibility of expanding the presence of sleep-related matters in Anesthesia and Analgesia, the IARS journal.

SASM has a lot of talented, dedicated and devoted members. The success of SASM is due to their energy and enthusiasm. I look forward to work with the board, the committee chairs and the committee members in the next two years to further develop SASM and the fascinating field with which it is engaged.
Assessing patients for respiratory compromise prior to commencement and during use of patient-controlled analgesia (PCA) ensures that patients start and continue on a continuum of safe care. Although PCA use has become standard practice to help patients manage their pain, ensuring safe use has been emphasized repeatedly. As Robert Stoelting, MD (President, Anesthesia Patient Safety Foundation) explains:

“Clinically significant drug-induced respiratory depression (oxygenation and/or ventilation) in the postoperative period remains a serious patient safety risk that continues to be associated with significant morbidity and mortality.”

At the Patient, Safety Science & Technology Summit, Dr. Stoelting stated more than 13 million patients each year receive PCA in the United States and estimates of respiratory depression range from 0.16 percent to 5.2 percent. This means annually between 20,800 to 676,000 PCA patients experience unnecessary opioid-induced respiratory depression, arrest and significant compromise. Estimates of respiratory depression are evidenced in the number of Code Blue and failure to rescue events. Fifty percent of Code Blue events involve patients receiving opioid analgesia. Unrecognized and unassessed post-operative respiratory failure resulting in cardiopulmonary arrest is a daily clinical occurrence at healthcare facilities. Since cardiopulmonary arrest often results in death or anoxic brain injury, these events have been termed “failure to rescue.” Failure to rescue is the first and third most common cause of adverse events related to patient safety, accounting for 113 events per 1,000 at-risk patient admissions.

Many healthcare organizations have provided warnings that safe PCA use starts with selecting suitable patients. The Pennsylvania Patient Safety Authority cautions:

“... candidates for PCA should have the mental alertness and cognitive ability to manage their pain and communicate their pain level to their caregiver.”

The Joint Commission in Sentinel Event Alert #49 sets forth the patients characteristics showing higher risk for over-sedation and respiratory depression:

Assessing respiratory compromise involves doing so consistently in a standardized manner with each and every patient.

However, a 2013 national survey of hospitals conducted among almost 200 hospitals in 40 states found that, although patient risk factors are considered, this is not being done by every hospital, with every patient. The chart below indicates the percentage continued on next page
of hospitals that, prior to PCA initiation, are assessing patients for the six major risk factors considered by organizations, such as The Joint Commission and ISMP, and which form the risk factor assessment in the PCA Safety Checklist:

Less than 40 percent consider all six patient risk factors, with almost two of three hospitals considering five or less of these factors. The importance of assessing patients is strikingly apparent when three of these factors are examined in depth.

**Opioid naive patients**

National Comprehensive Cancer Network defines opioid naive patients as those “who are not chronically receiving opioid analgesic on a daily basis.” The Joint Commission recommends taking “extra precautions with patients who are new to opioids or who are being restarted on opioids.” Yet, the PCA Survey indicates that almost one out of five hospitals are not assessing patients for being opioid naive. This suggests that some opioid naive patients may be receiving PCA when perhaps they should not be. Consider the case of 18-year old Amanda Abbiehl, who was admitted for “severe strep throat.” Although opioid naive, she was placed on PCA and tragically most likely died from opioid-induced respiratory depression.

**Obesity**

The number of people considered obese has reached epidemic-like proportions in the United States. Many studies have shown the increased risk of using anesthesia with obese patients. As researchers have stated:

One of the many problems in providing anesthesia for morbidly obese patients is the influence of obesity on pharmacokinetics and pharmacodynamics. Drug administration in obese patients is difficult because recommended doses are based on pharmacokinetic data obtained from individuals with normal weights; therefore, mistakes in the determination of the appropriate dose are often made. Because of comorbidity in these patients, the function of organs involved in drug elimination (e.g. kidney, liver) can be affected making pharmacokinetics more difficult and complex.

However, the PCA Survey indicates about three out of 10 hospitals do not consider obesity as a major risk factor. This suggests some obese patients may be receiving PCA when perhaps they should not be.

**Advanced Age**

According to The Joint Commission, risk of respiratory depression increases substantially for patients over 60 years of age and is:

- 2.8 times higher for individuals aged 61-70

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![Graph showing patient risk factors and consideration in PCA initiation]

*Identifying Risk of Respiratory Compromise for Patients continued from previous page*
Identifying Risk of Respiratory Compromise for Patients continued from previous page

5.4 times higher for age 71-80
8.7 times higher for those over age 80

Yet, not all healthcare facilities consider this a risk factor, with about three out of every 20 hospitals not appropriately assessing patients for advanced age.

Assessing Respiratory Compromise: Lessons Learned from the PCA Survey

PCA Survey findings indicate areas that hospitals would like to improve their ability to assess patents for respiratory compromise.

Training: More than half of hospitals (52.9 percent) would like to see more clinical training. The survey shows that more training indeed helps - at those hospitals that provide on-going training in PCA administration, advanced age was more likely to be considered a patient risk factor.

Recommendations on assessing patients: Almost half of the respondents (44.6 percent) would like “recommendations on how best to easily make such assessments” of patients. Two available risk assessment tools are the PCA Safety Checklist which considers the six major patient risk factors mentioned above and STOPBang for identifying patients with obstructive sleep apnea. Perhaps a scoring system for the inclusion or exclusion of patients using PCA might be of assistance. Moreover, a “real-time” technological assessment of respiratory compromise would provide a continuous evaluation of the patient.

Assessment tool. Seven out of 10 hospitals (70.7 percent) would like “a single indicator that accurately incorporates key vital signs, such as pulse rate, SpO2, respiratory rate, and etCO2.” To incorporate multiple physiological parameters into a single assessment reduces the need for nursing staff to collect data from multiple sources and then extrapolate from the data an assessment of respiratory compromise. Moreover, a single indicator of respiratory compromise could be of great aid to busy nursing staff caring for multiple patients on busy wards.

Monitoring: 65 percent of hospitals that monitor their patients with oximetry or capnography or both, have experienced positive results -- either in terms of a reduction of adverse events or a return on investment when measured against costs and expenses (including litigation costs). The remaining 35 percent that monitor say it is “too early to determine or have not determined” whether they have seen similar results. Continuous monitoring, in a sense, is the canary in a cage once used by miners. When all else fails, continuous monitoring could provide a technological safety net for patients.

Suggestions for the Future

The PCA Survey strongly results suggest both human and technological tools to ensure patients get on and stay on continuum of care that is safe. A single assessment tool, assessment recommendations, continuous monitoring – all point to the desire of hospitals to find and use tools to detect respiratory compromise. Moreover, the experience of hospitals also strongly recommends the use of continuous monitoring in catching at the earliest moment the onset of opioid-induced respiratory depression.
The Challenge

A recent editorial highlighted the perioperative obstructive sleep apnea (OSA) epidemic and served as a potent reminder to perioperative physicians. Diagnosis of this condition during the perioperative period is challenging. OSA is characterized by episodes of apnea or hypopnea during sleep, resulting in varying severity of hypoxemia and/or hypercapnia. The “gold standard” for diagnosis is a laboratory polysomnography (PSG), that helps classify and quantify the severity of the disorder based on apnea-hypopnea index (AHI). This poses major resource and cost concerns as the prevalence of OSA is deemed to be far more than can be handled by the available sleep laboratories.

In the general population, prevalence estimates for OSA range from 9 to 24% of the general population, where 80% of men and 93% of women with moderate to severe OSA remain undiagnosed. The disparity between a high prevalence of undiagnosed OSA and the low level of clinical recognition exists in the general population. The prevalence of undiagnosed moderate to severe OSA amongst surgical patients is difficult to assess but seems to be higher than general population and varies with the different surgical populations such as bariatric surgery. Recently, a historical cohort study was conducted to determine the proportion of undiagnosed OSA in the perioperative period. Of 819 patients coming for predominantly orthopedic and general surgeries, 58% (64/111) and 15% (17/111) of patients with pre-existing OSA were not diagnosed by the surgeons and anesthesiologists, respectively. Based on PSG results blinded to the physicians, 92% (n=245) and 60% (n=159) of patients with moderate to severe OSA were not diagnosed by the surgeons and the anesthesiologists preoperatively, (Figure 1). Perioperatively, untreated OSA patients are known to have a higher incidence of difficult intubation, postoperative hypoxemia, postoperative complications, increased admissions to intensive care unit, and longer duration of hospital stay. In a large population-based study, OSA was associated with a significantly higher adjusted OR of pulmonary complications after orthopedic and general surgical procedures. Needless to say, decreasing the percentage of undiagnosed OSA is a critical component of perioperative management of OSA patients.

The Barriers

There is limited literature evaluating knowledge and attitudes amongst Anesthesiologists towards OSA. A survey conducted amongst anesthesiologists in Canada had indicated that there was a need for uniform guidelines in handling patients with OSA. Sixty-seven percent of respondents provided perioperative care to one to five patients with OSA per month, and 72% reported not having departmental policies for care of OSA patients. Eighty two percent reported that perioperative guidelines were needed to assist management of these patients. Knowledge and attitude towards OSA amongst anesthesiologists was tested in a survey conducted in China. The authors used the OSAKA questionnaire that has been validated and used amongst pediatricians and cardiologists in the USA. They found that the total knowledge correct score ratio was lower amongst the Anesthesiologists in China (62%) compared to the primary care physicians at the Washington University (76%), but similar to Latin American physicians (60%). Moreover, only 51% of the anesthesiologists felt confident in identifying patients at risk for OSA indicating need for future interven-

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tions. The study however is limited by questionable external validity as the knowledge scores may be different amongst the anesthesiologists in North America due to a heightened awareness about perioperative is issues with OSA.

The Opportunity

Anesthesiologists could potentially impact a significant public health burden and reduce the percentage of undiagnosed OSA patients in major ways: proper implementation of screening guidelines, optimization of interventional therapy (e.g., continuous positive airway pressure, CPAP) perioperatively and ensuring follow up by sleep physician postoperatively.21 A perioperative diagnosis of OSA can happen at any time during the patient’s hospital stay (Figure 2). A preoperative diagnosis is the most important clinical decision point, as it can determine the future interventions and management strategies during the hospital stay. A number of simple preoperative screening tools have been described,22,23 validated and independently reviewed to look at their respective diagnostic properties in screening for OSA.24,25 In a historical cohort study,10 of the 159 patients with moderate and severe OSA and not identified by the anesthesiologists, 147 (92.5%) patients were classified as at risk of OSA by the STOP-BANG questionnaire.26 Thus, had the STOP-BANG questionnaire been used for these patients, the percentage of undiagnosed OSA would have decreased significantly. Other tools may be used as aid to diagnosis in high-risk OSA patients such as overnight oximetry,27 or laboratory tests such as a serum bicarbonate more than 28mmol/L.28

Inside and outside the OR, Anesthesiologists are at a great advantage to experience and evaluate the increased susceptibility of OSA patients under various levels of sedation and opioid administration. Any indication that the patient may be at a higher risk of airway collapse or opioid induced respiratory side effects should be identified as high-risk. It is known that with timely preoperative CPAP therapy and appropriate monitoring led to reduced incidence of postoperative complications in a bariatric surgical population with OSA.29

There are two more dimensions to the role of Anesthesiologists in identifying patients at risk or with formal diagnosis of OSA. Firstly, apart from the clinical setting, the implications for OSA diagnosis exist for future research. Adverse outcomes are very rare in line with the current advances in perioperative care. Population based prospective or retrospective cohort studies thus are more suitable at this point as there is paucity of published large trials. However, a high percentage of undiagnosed OSA corrupts the true control group and makes comparison difficult. This measurement bias is a major limitation of these studies and calls for a proper diagnosis of OSA.

Secondly, the role of a perioperative physician does not stop within the confines of the operating room or the PACU. Specialist sleep physician referral and appropriate therapy are crucial in long term cardiac and cerebrovascular outcomes, espe-
Undiagnosed Obstructive Sleep Apnea in the Surgical Setting: A Challenge and an Opportunity for the Anesthesiologist continued from previous page

Finally, as one of Albert Einstein’s famous quotes states, “In the middle of difficulty lies an opportunity”. We should be hopeful that as perioperative physicians and researchers we shall live up to this challenge and deliver solutions aiming to increase the precision and accuracy of OSA diagnosis perioperatively.

References
Introduction

One of the key goals in performing a preoperative assessment is the identification of risk factors that can be mitigated to reduce perioperative risk and improve patient safety. Obstructive sleep apnea (OSA) has become increasingly recognized as an important co-morbid condition for surgical patients.\(^1\) Once OSA is diagnosed, appropriate treatment including utilization of continuous positive airway pressure (CPAP) can be instituted in the postoperative period in an effort to reduce pulmonary complications. The gold standard for diagnosing OSA is an overnight sleep study. Thus, identification of patients at risk for OSA is essential to determine which patients might benefit from further evaluation. Without a structured risk assessment, the diagnosis is frequently missed.\(^2\)

The STOP-Bang OSA screening tool has become an accepted instrument for identifying patients at risk of OSA.\(^3,4\) The mnemonic represents snoring loudly, daytime somnolence, observations of apnea during sleep, elevated blood pressure, body mass index above 35, age greater than 50, neck circumference greater than 40 cm and male gender. Risk factors are evaluated as binary conditions and added together to produce a score that ranges from 0 to 8. An electronic version of this screening tool is available online (http://stopbang.ca). Integrating this questionnaire into clinical practice, however, requires bringing together data from multiple parts of the visit: vital signs, history, and physical examination.

Implementation

At Vanderbilt University Medical Center, we have internally developed and maintain a suite of applications called the Vanderbilt Perioperative Information Management System (VPIMS). These applications give us the ability to implement custom features into our perioperative workflow without the constraints common with 3rd party commercial systems; rather, we are able to modify all portions of our electronic documentation system to meet our needs for patient care.

A subcommittee was tasked with determining how to build the STOP-Bang score into our preoperative evaluation clinic workflow. While height, weight and blood pressure were already captured during our intake process, neck circumference was not and was subsequently added to the vital signs module of our VPIMS preoperative application. Age and gender were already available through baseline demographics, and structured documentation of hypertension was an existing portion of our cardiovascular history module. The screening questions for snoring, daytime somnolence, and observed apneas were added to our pulmonary history module (Figure 1).

In addition to building in individual components of the STOP-Bang screening tool, we incorporated the score into the initial screen of our VPIMS preoperative application. Age and gender were already available through baseline demographics, and structured documentation of hypertension was an existing portion of our cardiovascular history module. The screening questions for snoring, daytime somnolence, and observed apneas were added to our pulmonary history module (Figure 1).

Implementation of the STOP-Bang Screening Tool within a Perioperative Information Management System

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included in individual patient’s calculation. While a threshold score of 3 out of 8 was suggested as a positive screen, our system used a threshold score of 5 to flag patients as high risk since a threshold of 3 would have been overly inclusive given our patient population. No distinction in the threshold is made between genders.

**Evaluation**

Our VPIMS-based STOP-Bang screening implementation has been successful at capturing risk factors for OSA. Since the inception of the program 8 months ago, we have record neck circumference on over 12,500 patients. Identification of high-risk patients has provided broad input on patient risk assessment. Due to the high number of patients at-risk without prior screening, implementing an automatic referral program for preoperative sleep study has not been feasible, but in several instances, surgeries have been postponed for preoperative workup of OSA.

Complete data capture for patients who are not evaluated in our preoperative evaluation clinic was one of the challenges of rolling out our STOP-Bang screening tool. Altering medical assistant and nurse practitioner workflows in the clinic was straightforward, but changing our anesthesia providers’ workflow has not yet been successful. While some of the variables can be derived from demographics and patient history, obtaining neck circumference measurements and asking the additional screening questions adds extra time to the immediate preoperative assessment. Without a systematic change in management based on the screening results, completion of the screen is not yet a mandatory portion of the day-of-surgery preoperative evaluation.

**Future directions**

In an effort to improve patient satisfaction and improve workflow efficiency, some centers have experimented with telemedicine preoperative evaluations. To this end, we have incorporated patient airway images into our evaluation. These images may permit us to develop an equivalent measurement to neck circumference, obviating the need to perform a physical measurement to complete the screening process on the day-of-surgery.

Implementation of the STOP-Bang screening tool within a perioperative information management system continued from previous page
may also permit the development of a tool with better sensitivity and specificity. The tool’s current approach is to use simple binary thresholds, set to aid in provider recollection rather than maximize tool performance (Frances Chung, personal communication, September, 2013). Some of the relationships between risk factors and OSA risk, particularly age, appear to be non-linear, and thus may be used to estimate risk more effectively if not dichotomized. Use of restricted cubic splines, for instance, can improve model performance by accurately representing non-linear relationships.\(^6\) While these statistical techniques are time prohibitive for a paper tool, they could easily be implemented within an electronic system and thus provide more accurate results compared with the present tool.

**Conclusion**

Integration of screening tools such as the STOP-Bang questionnaire into an existing workflow requires careful planning and adaptation at an institutional level to ensure success. Once implemented, the resulting screening tool score can be used to trigger decision support and prompt clinicians to have appropriate risk conversations with patients. Additionally, electronic versions of screening tools offer the ability to develop more precise assessments by incorporating complex statistical methods that are not practical for bedside, paper questionnaire-based approaches. Future iterations of the STOP-Bang and other perioperative screening tools can be added to the existing perioperative information management system without disruption of workflow.

**References**

Encountering a morbidly obese surgical patient in the preoperative area without any assessment for obstructive sleep apnea (OSA) is a common dilemma faced by all anesthesiologists. For me this is frustrating because OSA often goes undiagnosed despite its substantial implications to anesthetic and postoperative management. Anesthetic agents, sedatives and opioids exaggerate airway obstruction and hypoventilation in patients with OSA, and subsequent, tragic postoperative respiratory complications such as hypercapnic respiratory arrest have been well documented.(1) Surgical patients with OSA have a several-fold higher risk of postoperative tracheal intubation and mechanical ventilation than those without OSA.(2) Surgical patients with unrecognized OSA are even more concerning and have higher rates of postoperative complications, intensive care unit admissions, and longer hospital stays.(3) Worrisome is that only 15% of bariatric surgical patients carry the diagnosis of OSA but if they undergo overnight sleep studies with polysomnography, approximately three quarters are found to have OSA!(4,5) When the diagnosis of OSA is known the perioperative management can be tailored to mitigate the impact of OSA on the postoperative course. At the Mayo Clinic we demonstrated that when bariatric surgical patients were preoperatively assessed with polysomnography and subsequently diagnosed patients with OSA were optimally managed with perioperative noninvasive ventilation devices combined with vigilant monitoring, the postoperative complication rate was low and not associated to the presence or severity of OSA.(5,6)

The major impediment to preoperative evaluation for OSA in the bariatric surgical population is that for many patients preoperative polysomnography is impractical because of its expense and limited availability. Some patients have overnight oximetry to screen for OSA(7), but this assessment tool lacks diagnostic accuracy and if a high index of suspicion for OSA remains, patients still need confirmatory polysomnography.(8) A variety of assessment tools that screen for OSA at the bedside are available such as STOP BANG(9,10), American Society of Anesthesiologist’s sleep apnea screening tool(6), and Flemons criteria or sleep apnea score (SACS) (11). These can help the anesthesiologist to increase the level of suspicion for the presence of OSA, but like overnight oximetry, they have limitations of accuracy.(12) Equivocal screening test results can leave the anesthesiologist in a bind as how to best manage and postoperatively triage bariatric or other morbidly obese surgical patients with a high clinical suspicion for OSA.

A possible solution to this dilemma is to supplement preoperative screening or testing for OSA with structured respiratory assessments during Phase I recovery from anesthesia. Gali et al described a distinctive, 2-phase evaluation process that combines a preoperative OSA screening assessment with structured recovery room nursing assessments of patients for four specific respiratory abnormalities or events during Phase I recovery from anesthesia.(13,14) These respiratory events are: hypoventilation (defined as three episodes of < 8 respirations/min), apnea (single apneic spell of ≥ 10 seconds), oxyhemoglobin desaturation (three episodes of pulse oximetry readings < 90% or < preoperative oxyhemoglobin saturation with or without supplemental oxygen), or “pain/sedation mismatch” (Richmond Agitation-Sedation Scale(15) score ≤ -2 with a numeric pain scale rating > 5 of 10). In those studies, surgical patients without a prior diagnosis of OSA were screened continued on next page
for OSA. Patients who had respiratory specific events during any two 30-minute periods during Phase I recovery were categorized as having had recurrent respiratory events. Following discharge from Phase I recovery; patients were monitored for oxyhemoglobin desaturation events or meaningful postoperative respiratory complications. Patients who had either a positive screen for OSA or recurrent respiratory events had more frequent episodes of desaturation events and the likelihood of respiratory complications was 3.5-fold greater in patients suspected OSA and was 21-fold greater in patients with recurrent respiratory events. Thirty-three percent of patients with a positive OSA screen and who had recurrent respiratory events during Phase I recovery had postoperative respiratory complications such as admission to the intensive care unit for respiratory failure, unplanned use of noninvasive ventilatory support, or development of pneumonia.(14)

At Mayo Clinic, we have incorporated assessments of respiratory specific events as part of our discharge criteria from Phase I anesthesia recovery (in addition to using a modified Aldrete discharge criteria(16)). Patients who have respiratory-specific events 30 minutes after extubation must subsequently have two 30-minute evaluation periods free of recurrent events before discharge from Phase I recovery. In addition, any patient who has a positive screen for or known diagnosis of OSA and has recurrent respiratory events but is identified as appropriate for discharge to a standard postsurgical ward is monitored remotely with continuous pulse oximetry for the first 48 postoperative hours. Though this approach has not been validated in prospective studies, we feel this 2-phase assessment strategy has been an important component of our successful management strategy for our bariatric surgical patients and may be the key as why we have not found associations between OSA and postoperative complications in this patient population.(5)  

References
The Society of Anesthesia and Sleep Medicine (SASM) is announcing guidelines for a grant application to be selected on Friday, October 10th, 2014 (the SASM Annual Meeting). The grant is scheduled for funding starting on January 1st, 2015. The award is for up to $20,000 for a study to be conducted over a maximum of one year.

The Society of Anesthesia and Sleep Medicine grant program supports research directed towards areas in anesthesia, sleep and pulmonary medicine. Submissions are due online no later than July 1st, 2014.

Please see www.SASMhq.org for grant outlines and additional information.

Frances Chung, MBBS
President, Society of Anesthesia and Sleep Medicine
SASM Membership Benefits at a Glance…

These are exciting times for SASM. While we are a new and growing organization, we feel our collaborative efforts will give rise to unlimited opportunities. You have the ability to make an impact from the very start. Please consider joining SASM today!

The mission of SASM is to advance standards of care for clinical challenges shared by Anesthesiology and Sleep Medicine, including perioperative management of sleep disordered breathing, as well as to promote interdisciplinary communication, education and research in matters common to anesthesia and sleep.

Benefits of SASM Membership include:

- Significantly Reduced Registration Fees at SASM Sponsored Scientific Meetings
- SASM Newsletter
- "Full Voting Rights in Electing SASM Board of Directors and SASM Officers ("Dependent on membership category")
- Regular Receipt of "Literature Updates" and "Featured Articles," Allowing All Members to Stay Current on New Developments in the Area
- Enhances Your Network of Regional, National and International Colleagues
- Learn of Collaborative Research Projects
- Educational Material Posted on SASM Website for Members
- Access to a "Discussion Forum" to Evaluate and Discuss the Latest Research, Education and Clinical Practices Pertaining to OSA and Patients with Other Sleep-Disordered Breathing
- Get Advice and Counsel from Other Members Regarding Various Practice Paradigms

The easiest and quickest route to join as a member of SASM is to visit our website, www.SASMhq.org, and pay by credit card by clicking on the Membership Information tab. You can also mail check payment to our office at the address provided below.

SASM Classes of Membership:

- **Gold Patron Member - $250**
  - Showing special support for SASM
  - This donation is inclusive of annual membership and available for all classes of membership.

- **Active Member - $100**
  - Physicians and Scientists. Active Members have voting rights, can hold office and serve on the Board of Directors.

- **Associate Member - $50**
  - Non-Physicians and Non-Scientists. Associate Members do NOT have voting rights.

- **Educational Member - $50**
  - Fellows, Residents, Medical Students or other undergraduates. Educational Members do NOT have voting rights.

Please consider joining as a “Gold Patron” for 2014

The additional donation beyond general membership will be used to promote scholarly activity in the area of anesthesia and sleep medicine and promote patient care programs in areas common to anesthesia and sleep medicine. Gold Patrons will be recognized on our website for their extraordinary support of SASM efforts and will be invited to special events highlighting the programs made possible with their donations, including a keynote speaker dinner at the Annual Meeting.

SASM - NEW OFFICE LOCATION!

6737 W Washington Street, Suite 1300
Milwaukee, Wisconsin 53214

SASM is a 501(C)(3) non-profit organization. Membership dues may be deductible as a business expense. **SASM Tax ID number is 27–4613034**