SleepNews

Wisconsin Sleep Society

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Words from the President

Dear Wisconsin Sleep Society Members and Colleagues,

It is a great honor for me to serve as the Wisconsin Sleep Society President. I have the great fortune to assume the leadership role of this Society at a time when we will all be seeing significant changes in the field of sleep medicine. I thank the past Officers and Board of Directors for their time and dedication to the Society and look forward to working with the newly elected Officers and Board of Directors who are all very eager to serve the members of the Wisconsin Sleep Society.

Although the new Officers and Board members come from many diverse backgrounds and institutions, we are united in our passion for sleep and we bring a wide array of interests and talents and it is because of this diversity that the Wisconsin Sleep Society has the potential to soar to new heights.

Some of the initiatives on which the Board will be working in the coming year include education, communication and increasing membership. We have formed several committees to accomplish these initiatives; including the Education/Scientific Committee, Conference Committee, Communications Committee, Political Action Committee, Website Committee, and the Social Media/Membership/Recruitment Committee. If you have thoughts about these initiatives—or thoughts about other issues we should be addressing—please share them with a Board member. The Board and I welcome any suggestions that will further the mission of the Wisconsin Sleep Society in general.

The Board of Directors is very excited to be implementing an updated website, upcoming newsletters, and the second annual Wisconsin Sleep Society Conference. Information about this year's annual conference will continue to be posted on our website at www.wisleep.org.

The entire Board looks forward to providing the stewardship to keep our Wisconsin Sleep Society healthy and thriving and we look forward to serving all of our members. Sincerely,

Craig A. Muri

RPSGT, RST, REEGT
President, Wisconsin Sleep Society
Clinical Director, The Sleep Wellness Institute

Inside this issue:

Sleep hygiene in the Sleep Lab

With 13 years and three different sleep labs, I have noticed that many of my patients do not practice very good sleep hygiene while in the lab. I really believe our profession could use Sleep Hygienists to promote good sleep behavior. In lieu of not carrying around that title, I would like to promote the idea that we as sleep technologists are in a position to begin the educational process of correcting poor sleep hygiene.

At our lab, the scheduling lead tech attempts to curtail some of the poor sleep hygiene by telling patients to try and avoid caffeine after 2 -3p.m., try not to take a nap and try not to consume too much alcohol before the study. Many of the in lab list of sleeping tools I have observed are MP3 players, IPAD's, DVD players, laptop computers, electronic readers, a smorgasbord of food, cellphone's, and of course every lab I have worked in has contributed by providing a TV. You could probably list many more "sleep aids" that patients bring to the lab. We normally say that the bed is for sleep and sex, at home that is.

As polysomnography technologists, we have to balance the goal of getting enough sleep data versus making the patient comfortable to achieve that goal. One of the first things I tell the patient on my walk from the reception area to the lab is that the more sleep data we can get, the greater chance the physician will have of finding out what is making you feel tired during the day. That information will be followed up with a conversation of what to expect during the study. Briefly walk them through what you will be doing, i.e. set-up, biocals, sleeping positions, treatment, etc. I am sure all of you have a strategy to try and relax your patients prior to the study. I usually ask them if they know anybody that has had a study. More often than not patient's know someone that has had a study or that is on CPAP. From there I usually get patient's talking about themselves and their families during set-up. I think it is very important to avoid talking about politics, taxes, religion or any conversation that might get a patient's mind racing. Think calmness. Think of your conversation as a bedtime story.

In order to get a good study with enough information, we need to set some boundaries for our patients. I usually tell my patients that we would like to have lights out by 11p.m., and normally I get patients up between 6 and 6:30a.m. Reinforce the idea that more data the better. What about the TV that your lab provides for the patient? Think TV sleep timer. I am more lax in this area than my lead tech, but she has taught me to use the TV sleep timer. My lead tech might set the timer for 30 minutes, while I might do 45 minutes to an hour. By the time you get to this point in the night, you probably have a good read on the patient. A yawning patient might get 15 minutes versus a high energy patient might get closer to an hour of TV time.

Think creating the best sleep environment for that person on that night. Make sure cellphones are turned off. Make sure the room temperature is to the patient's liking. Provide a fan for those that request one. Make sure that the patient is feeling no pain from wires pulling on them. I like to turn the lights down in the room as soon as I get the patient in bed. Be sensitive to claustrophobic patients when it comes to providing low light or keeping a door open. Don't deny phone calls to family members, but encourage brevity. Sometimes these conversations can hinder sleep. Reinforce to the patient that if they need anything to just talk. Let them know how easy it is to contact you and also how easy it will be for them to use the bathroom at night.

Once biocals are done and the patient prepares for sleep, I think we need to identify what the patient is doing, especially if it's behavior that could be detrimental to sleep. If I feel strongly that poor sleep hygiene is contributing to the patient's sleep issues, I might identify it in my tech note with the phrasing that "it appears the patient has poor sleep hygiene secondary to……". The interpreting doctor then can decide whether or not to address the issue. In our fast paced, need to be connected world, I feel we as sleep professionals are in a good position to educate and steer patients toward good sleep hygiene. In my experience, people in general are not allowing enough time to get a good nights sleep. We should be getting 7-9 hours of sleep a night. The American Academy of sleep medicine has a good brochure to give to patients titled "How To Sleep Better". The words caffeine, stressful, anxiety, alcohol, schedule, diet, relaxing activities, fitness, environment, dark quiet room and sound sleep are on the cover. Patient's that don't have sleep disordered breathing or OSA, but are tired, could be suffering from poor sleep hygiene. We need to reinforce good sleep behavior with our patients. Please contact the WSS with any feedback that you might have on this subject. Good ideas will be published in the next newsletter.

Steve Collins, RPSGT, RRT

St. Clare Sleep Lab, Baraboo, Wisconsin

Keeping up with the Journals

Skimming through "The Journal of Sleep Medicine" is not as easy as it used to be, since it is no longer in paper form. It used to be easy to look through the journal during the night and keep up to date. I did that for years, adding to my knowledge. Once the journal became available only on line, it was more of a hassle. Who wants to take the time to access it on line when you're running sleep studies, right? I didn't, until just recently, and was reminded of what I was missing. Here are some snippets from the last couple of journals.

Experienced scorers at different laboratories have very good agreement in hypopnea and AHI results when good-quality PSGs are scored using AASM-recommended criteria. (Results were not so good using alternative definitions of hypopneas, particularly that proposed for research) Also, AASM guidelines for PSG scoring are increasingly being adopted worldwide. Experienced scorers internationally also have very good agreement in scoring respiratory events.

There was a study done comparing a new automated scoring system with the usual computer assisted manual scoring. The results stated that the automatic system yielded results that were similar to those obtained by experienced techs. It goes on to say that this automated scoring software, particularly if supplemented with manual editing, may increase laboratory efficiency and standardize PSG scoring results within and across sleep centers. My take on this: I've heard claims like this over the years, so am skeptical. BUT, would like to check it out and see for myself.

A study showed that short sleep duration and OSA are independently associated with visceral-obesity in adults. This association is particularly strong in short sleepers with OSA. Another study showed that moderate to severe OSA is an independent risk factor for cerebral white matter change in middle aged and older individuals. Therefore, early treatment of OSA could reduce the risk of stroke and vascular dementia.

Older adolescents can really just be more tired, even if they are getting plenty of sleep. So, cut your kid some slack when you ask him or her to help with something around the house and they say "I can't; I'm just TOO TIRED." Maybe they can't help it. Maybe.

The AAST's publication A2Zzz also switched to on line only awhile back. That's one I did keep up with , since if you're an AAST member you can get 2 CEUs quarterly for reading the articles. 8 CEUs per year! That's a good deal, plus interesting and educational to boot. I learn something from every issue.

The last A2Zzz had an article in the Technical Corner called "The Evolving Definition of Hypopnea: Desaturations, Arousals, Both or Either?" We all know the Medicare definition of a hypopnea: 10 second airflow reduction with 30% airflow reduction and a 4% O2 desaturation. (Does anyone remember when Medicare didn't even count hypopneas? You had to have 30 apneas to qualify for CPAP. Period.) The 2007 AASM Scoring Manual allowed an alternative definition for a hypopnea. Rule 4B was added allowing the possibility of scoring a hypopnea without oxygen desaturation. The latest revision of the AASM Scoring Manual defines a hypopnea in adults as "a 30% drop in nasal pressure excursion for 10 seconds or greater associated with at least a 3% desaturation OR an arousal". Awesome. It was always a pet peeve of mine to have to sit there all night watching your patient's obstructing airflow, followed by a snort and an arousal, but not enough of a desaturation to count the event as a hypopnea. Your patient's sleep could be a total fragmented mess, but they didn't qualify for CPAP because they didn't have the required desaturations. The new hypopnea definition will help some of these patients get the treatment they need.

There was also an interesting article called "Neurodiagnostics and Sleep Science: The World's First Bachelor Degree". This program was created because of a need across the country in filling leadership roles in education, clinical practice, research, industry and government. It's offered through the University of North Carolina via distance education. For more information, check out www.med.unc.edu/ahs/ndss or contact Mary Ellen Wells at mwells@med.unc.edu or (919) 843-4673. This could prove to be an interesting development, especially for anyone interested in teaching at the community college level in the electrophysiological areas. This could also be an asset for anyone interested in participating in sleep research. I haven't checked it out, but the "via distance education" makes it sound doable no matter where you live.

Mary Lowenberg, BS, RPSGT

I hope you have enjoyed the first edition of the WSS newsletter. Our goal is to educate and to create discussion. We are looking for a name for this newsletter. Send your suggestions to www.wisleep.org. We will post them on our website and give the members a chance to vote for their favorite.

I would love to hear any comments about the newsletter and suggestion from you on what you would like to read about.

Thanks to those who contributed to the newsletter.

Don't forget to visit the website and become a member of WSS.

Jody Scherr

Changes to AASM Scoring Manual

In October of 2012 the AASM (American Academy of Sleep Medicine) published the *AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications Version 2.0*. The WSS will publish a series of articles in our subsequent newletters discussing changes to the scoring rules. The following is a timeline for implementation of the new rules:

All AASM accredited sleep centers will be required to follow the new manual by October 1, 2013.
The AASM interscorer reliability program will begin using the updated criteria on the June 2013 exam
The BRPT will implement the updated rules on the July of 2013 exam.

Most notable of the changes are changes to the scoring of hypopneas. The new recommended rule for hypopneas is as follows:

The peak signal excursions drop by ≥30 percent of pre-event baseline using nasal pressure (diagnostic study), PAP device flow (titration study) or an *alternative* hypopnea sensor (diagnostic study).
The duration of the ≥30 percent drop in signal excursion is ≥ 10 seconds.
There is a ≥3 percent oxygen desaturation from pre-event baseline or the event is associated with an arousal."

Notice the duration of the event must meet the decreased flow signal criteria for 10 seconds or greater rather than the old rule of 90% of the event meeting the reduction in airflow. The addition of PAP device flow for airflow clarifies the criteria for scoring hypopneas during a titration.

A number of payers, including Medicare, still require ≥4 percent desaturation for reimbursement. In such cases, Version 2.0 of the *AASM Scoring Manual* recommends reporting of hypopneas according to **both** definitions in order to comply with both accreditation and payer requirements. Complying with payer requirements is critical for initial coverage of diagnostic testing and continued coverage of PAP therapy and supplies.

The WSS would like to hear ideas of how you are addressing the issue of scoring according to the AASM recommendation vs. scoring to comply with Medicare guidelines in your lab. Please email us at marla.vanlanen@gmail.com

For more information on the new AASM scoring rules, go to http://www.aasmnet.org/scoringmanual/default.aspx Marla Van Lanen, RRT, RPGST