

Guidelines for Obstructive Sleep Apnea Patients Established

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Obstructive sleep apnea (OSA), a relatively common disorder in post-polio people, is now recognized to be associated with increased morbidity and mortality during and after anesthesia and surgery. The American Society of Anesthesiologists (ASA), the national organization for anesthesiologists, approved consensus guidelines on management of OSA patients at its annual 2005 meeting. Although the guidelines' purpose is to focus on which OSA patients might be safely done in an outpatient facility, they are also helpful in planning for OSA patients having surgery in a hospital.

The new guidelines rate a particular OSA patient's risk using a numeric score. A patient with a high score should be treated in a hospital. Rated are the severity of the OSA as determined on a sleep study (or the clinical history if a sleep study is not available), coexisting diseases, invasiveness of the operation, the type of anesthesia needed, anticipated postoperative narcotic requirements and how the patient would be observed post-operatively. The guidelines also define requirements for the facility, such as on-site radiology service for chest X-rays and the ability to do arterial blood gases.

The guidelines also discuss use of CPAP intraoperatively and postoperatively. The need to measure adequacy of ventilation during sedation by continually measuring expired CO₂ (the waste respiratory gas) is emphasized; continuous monitoring of CO₂ is always done during general anesthesia.

The important postoperative period is also discussed. In addition to use of CPAP, especially for those on it preoperatively, OSA patients should be monitored for at least 3 hours longer than non-OSA patients. Monitoring should continue for about 7 hours after the last episode of airway obstruction or hypoxemia while the

patient is breathing room air and is not stimulated.

Discharge guidelines are also defined. The oxygen saturation on room air should return to baseline, and the patient should not become hypoxic or obstructed when left undisturbed. CPAP use should continue at home for those who used it preoperatively.

The guidelines were developed by a consensus process, using experts in this area and careful analysis of the medical literature. They are not practice standards, do not guarantee a successful outcome and are not yet validated.

Over time, we will learn more about how satisfactory they are and perhaps change them, again using the expert consensus process. However, their development is of great help for those who might be pushed into a procedure at an outpatient facility (a free-standing out-surgery center or even a physician's office) by their insurance company. The guidelines can be "ammunition" when fighting the insurance company about where an operation will be done. They are also helpful to anesthesiologists because they help organize thinking about a difficult problem, defining the many factors to consider. ▲

The September 2005 issue of *Anesthesiology* (Vol. 103, No. 3, pp. 638-644) featured "Postpolio Syndrome and Anesthesia" by David A. Lambert, MD, Elenis Giannouli, MD, and Brian J. Schmidt, MD, from The University of Manitoba, Winnipeg, Canada.

The guidelines are available at www.asahq.org/publicationsandservices/sleepapnea103105.pdf.