Provincial Adult Obstructive Sleep Apnea Primary Care Clinical Pathway

1. History & Assessment

Suspect OSA in adult patients (≥18) with:

- Snoring
- Witnessed apneas
- Nocturnal choking/gasping
- Restless sleep
- AM headache
- Excessive daytime sleepiness
- BMI ≥ 30kg/m²
- Hx HTN/CVA/CHF

Complete:

- Physical exam of upper airway (Mallampati classification and neck circumference)
- STOP-BANG to assess OSA probability. Add 1 point for each "yes" answer

If excessive daytime sleepiness present or the patient has a safety critical occupation, counsel on driving safety

STOP-BANG

Snoring	**B**MI >35kg/m²
Tiredness	**A**ge >50 years old
Observed apnea	**N**eck size ≥17in/43cm (M), ≥16in/41cm (F)
High Blood **P**ressure	**G**ender = Male

STOP-BANG may underestimate risk in some groups (e.g. females); clinical correlation is required.

score 0-2

Low probability OSA

- Home Sleep Apnea Test (HSAT) not indicated
- Consider other causes of sleepiness
- See STOP-BANG link above for details

score 3-8

Intermediate/high probability OSA. See STOP-BANG link above for details

2. Red Flags

- Neuromuscular disease
- Home oxygen use

Home Sleep Apnea Test (HSAT) is recommended only for patients at increased risk of moderate-to-severe OSA and without red flags present

Yes → **5. Refer** to respirologist or sleep specialist. See referral guideline tab for instructions.

No →

Other Considerations

- Chronic/regular opiate medication use
- Significant cardiopulmonary disease
- Inability to complete HSAT (e.g. physical, cognitive barriers)
- Equivocal testing attempts with high clinical suspicion

Consider if HSAT or referral will best meet patient needs

Acronyms
AHI – Apnea Hypopnea Index
RDI - Respiratory Disturbance Index
PSG - Polysomnography

3. Investigations: HSAT must be completed through an accredited facility

4. Management after HSAT

HSAT negative

Normal
AHI or RDI <5/hr

Consider other causes for symptoms

HSAT positive

Discuss healthy behaviours including weight loss, alcohol use and sleep positions, if indicated

Mild
AHI or RDI 5-14/hr

Moderate
AHI or RDI 15-29/hr

Severe
AHI or RDI ≥30/hr

Red Flag: Sustained or severe hypoxemia/suspected hypoventilation. **Do not initiate treatment**

Yes → 5. Refer to respirologist or sleep specialist (include HSAT results and CPAP download). See referral guideline tab for instructions.

No →

No treatment required if asymptomatic

If symptomatic and patient interested:

- 1st line – CPAP trial
- 2nd line – Oral appliance, if patient prefers or CPAP not tolerated

Treatment options:

- 1st line – CPAP trial
- 2nd line – Oral appliance, if patient prefers or CPAP not tolerated

CPAP trial recommended to address significant OSA risks

Minimum therapy target: 4 hours of CPAP use for 70% of nights and symptoms have improved. Follow-up with CPAP provider or physician in 2-4 weeks.

Assess treatment effectiveness

Not Effective

- **Causes:** Non-adherence, intolerance, good adherence but patient not improving
- **Solutions:** Troubleshoot CPAP, if appropriate, consider oral appliance (fitted by certified sleep dentist), consider other sleep disorders

Effective (resolution of symptoms, adequate use of therapy)

- Continue CPAP
- Re-test only if change in clinical status

Funding
Is a PSG test required for government funding?

Yes → 5. Refer to respirologist or sleep specialist (include HSAT results and CPAP download). See referral guideline tab for instructions.