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LETTER TO EDITOR/LED REPLY

Response to Dr. Friel's Letter to the Editor

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Dear Dr. Friel:

Thank you very much for your letter submitted to the editor. In your letter, you highlighted the high incidence of obstructive sleep apnea (OSA) in bariatric surgical candidates and the significant challenge in identifying those at risk. In addition, you emphasized the clinical consequences of failing to identify and treat these high-risk patients.

While bariatric surgery does have a positive effect on the treatment of OSA [1], many patients have a 6- to 12-month lag before bariatric surgery due to surgical wait times and the extensive time needed to safely prepare a patient for bariatric surgery. The cardiorespiratory and metabolic consequences of untreated OSA exist during this time of preparation. In addition, sleep apnea may not resolve immediately postoperatively, requiring time for substantial weight loss to occur in order for OSA to improve or resolve. For some patients, moderate to severe OSA may still exist up to 1 year after surgery [2]. Equally as important, years after gastric surgery, there may be a recurrence of more severe OSA, independent of significant weight regain [3].

The aims of our study were to determine the incidence of undiagnosed OSA in all bariatric surgical candidates and to evaluate the utility of the STOP BANG Questionnaire, Berlin Questionnaire, and Epworth Sleepiness Scale (ESS) as screening instruments for OSA. Statistically, our study did not support the STOP BANG or the Berlin Questionnaire as an effective tool for detecting moderate- or high-risk patients with OSA undergoing bariatric surgery.

Your opinion that routine polysomnography (PSG) be undertaken for all patients undergoing bariatric surgery who have not been previously investigated with a PSG is supported by others [4]. The cost of performing this test and available resources are significant considerations. For those individuals in our study undergoing bariatric surgery who previously had never been evaluated for OSA with a formal level 1 sleep study, nearly half of the sample (48.5%) had moderate/severe OSA (43.6% of females and 76.9% of males) and over a quarter (26.9%) had severe OSA (22.7% of females and 51.3% of males) [5]. Other studies report the incidence as high as 77% [4]. Furthermore, the recognition of the diagnosis of OSA is even more challenging as there may be no correlation between the severity of OSA and BMI [4].

More effective screening tools are needed to identify and diagnose OSA in bariatric surgical candidates. Until that time, the gold standard in diagnosing OSA remains the level 1 PSG and should be considered to be integrated into the preoperative management of patients undergoing bariatric surgery.

Stephen A Glazer

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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This study is a retrospective review and formal consent is not required. This study was approved by the Research and Ethics Board at Humber River Hospital.

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