

## Re: Health Technology Appraisal: Consultation Document

Thank for forwarding me details of this document. I have shared this with my colleagues whom I represent at the Royal Society of Medicine Sleep Section. My responses are as follows:

1.3 I do not think it should only be the monitoring of the “initial” response and it should be the whole response both initially and subsequently: “initial” should be removed.  
We need to ensure that the definition of sleep specialists is something that is robust and exists in the outline description.

2.2 I am pleased that we are using the sleep apnoea/hypopnoea **syndrome** which associates clinical symptoms together with abnormal physiology. Sometimes the diagnosis is made by using a more “limited” sleep study that involves respiratory monitoring but not full EEG. While I appreciate the severity of OSAHS is determined by the apnoea/hypopnoea index this is only one factor. Frequent arousals as noted by other physiological methods of assessment or EEG changes may be as important.

For example a person may snore loudly because of upper airway collapse but may not have a “significant” number of episodes of apnoea/hypopnoea. However if you record brainwave activity you will see that they are waking up frequently. I therefore think we need some “opt out” to ensure that patients who are very symptomatic from their upper airway collapse and have disturbed sleep patterns and an element of daytime sleepiness associated with it but do not fulfil the magic AHI index can still receive treatment.

I appreciate that I am trying to get over a somewhat of a complex concept and in essence I didn’t want to through the baby out with the bathwater i.e. if an individual is very symptomatic and just has a few episodes of sleep apnoea they are still worthy of a trial of therapy.

2.3 I think I would remove the word abnormalities and perhaps use the word features or better characteristics.

2.4 There is quite a lot of research to say witnessed apnoeas are an important feature of OSAHS, as is nocturnal choking. A common reason for referral is passing urine at night and I think nocturia should be included.

2.5 Penultimate paragraph there is a gap between s\_urgery.

3.5 I accept we need some timing for how long a CPAP machine works and this does dramatically affect the costings that you have put forward. Whilst some machines do last for 7 years few go on beyond that, some break down earlier. I am not certain how much evidence that really exists for using 7 years and whether 6 is a better figure but realise this too is arbitrary.

4.0 The evidence of interpretation on the whole was satisfactory and I understand in 4.1.11 that we have used quality of life. It is the patient’s clinical response that is so obviously “overwhelming” to clinicians.

4.1.14 This should be a greater number of “healthcare workers” or perhaps better “workforce resources” as it is not purely scientists, although scientists are important in delivering sleep services.

- 4.2.5 I am disappointed about the issue that road traffic accidents have not really been factored in. Whilst I appreciate that we are looking in part at the “direct” costs of provision of CPAP there is literature to say that healthcare utilisation is greater before CPAP is utilised and, perhaps more importantly, is the large impact on indirect costs of road traffic accidents.

I think there is good evidence to say that people with sleep apnoea are excessively sleepy and do have an excess of road traffic accidents. It is therefore valid, though I appreciate perhaps not scientifically as rigorous as you would like, to infer that if you are preventing road traffic accidents and CPAP is also going to reduce general costs of healthcare by reducing accidents. Furthermore I think we are not only looking at the impact on healthcare of preventing a road traffic accident but there is no “financial model” that can take into account the loss of a life and the impact on loved ones as a consequence of a road traffic accident which, via CPAP, we can probably prevent.

In summary I understand why driving has not featured however I think this is a say omission from both a financial cost base and from a sociological impact.

- 4.3.11 Issue of driving as above.

- 4.3.13 I take note that sleep apnoea is thought to be rare in children and adolescents, this is not so. However there is not much epidemiological data to support this conclusion. There are many children with very large tonsils who have sleep apnoea and tonsillectomy can clearly improve these individuals. In addition however there are a large number of children with cranio-facial changes which may or may not alter as the face/body alters with age. However such individuals may have sleep apnoea and do benefit hugely from CPAP. The phrasing of this implies as if we are saying CPAP in children and adolescents is rare and therefore the recommendation of NICE should only apply to adults. This is wrong as many children will be denied what is an effective therapy.

- 5.0 Implementation. This is my major concern and the one I have left until last. For reasons, clearly that I understand, the technological appraisal is only that of CPAP. However it is essential that in the pre-ambule that goes with the document there is a clear statement that PCT's/hospitals need to provide adequate facilities for the investigation of patients with suspected sleep apnoea. What may be a very good appraisal and of benefit for patients/carers may not be utilised if PCT's do not allow/fund investigations for sleep problems.