



Editorial

 [Translated article] Guidelines, recommendations and consensus on obstructive sleep apnea[☆]


Guías, recomendaciones y consensos en apnea obstructiva del sueño

Medical students are taught that the optimal management of individual and community health depends on the simultaneous use of 2 tactics: a general strategy involving evidence-based clinical practice guidelines (CPG), and a personalized strategy using precision medicine. Tools for the former are available for the vast majority of diseases in the form of CPGs that consist of national or international recommendations and consensus documents. The second approach relies on our ability to identify an individual or a subgroup of individuals whose disease presentation or specific therapeutic response differs from the “general” response of most patients. To simplify the analogy, it could be said that CPGs meet the needs of the group as a whole and are especially suited to socialized health systems, while precision medicine is more focused on the individual needs of each patient.

CPGs are considered appropriate when, after publication, they are widely followed in clinical practice. In our opinion, CPGs should meet 3 requirements: they should be short, clear and offer a number of diagnostic and treatment algorithms; they should be suitable for use by both generalists and specialists; and they should be updated as dictated by diagnostic and therapeutic advances. Not even the most perfect CPG will meet every individual need. This is the cue for the doctor to apply the old maxim: “Treat the patient, not the disease”.

Respiratory medicine specialists use 2 CPGs that are models of their kind: GINA and GOLD^{1,2}. These CPGs are successful because they not only meet the 3 essential requirements, but they are also regularly updated to build on the fundamental understanding of the diseases and to introduce new evidence, interpreting and incorporating the latest advances into their algorithms, and thereby helping clinicians to expand their knowledge with each version. This approach is clearly practical and logical, but it has not been followed by the different CPGs in obstructive sleep apnea (OSA), and to date, no CPG on OSA has been produced by a widely representative international expert group.

This issue of ARCHIVOS DE BRONCONEUMOLOGÍA contains a new CPG on OSA³, published according to the established practice in Spanish respiratory medicine: SEPAR sponsors the development of a series of CPGs that subsequently appear in ARCHIVOS DE BRONCONEUMOLOGÍA^{4–8}. On this occasion, the consensus has been devised by leading OSA experts in Spain and Latin America. The authors should be applauded for their efforts in providing the medical community with a decision-making tool in primary care and specialized medicine that is accompanied by numerous appendices, making it a comprehensive update of the state of the art and a textbook analysis of OSA.

All CPGs developed to date in Spain have contributed to the understanding of OSA and methodical patient management. However, they do not meet the 3 requirements mentioned above. Their long-term applicability is limited, while the possibility of updating them to meet the standard of good OSA guidelines is restricted. Little evidence has been generated in recent decades, and aside from the widespread use of continuous positive airway pressure (CPAP) in the 1980s and the increasing use of home-based polygraphy since 1990s, few significant diagnostic or therapeutic developments have been made that can be generally applied to OSA patients. The changing nomenclature of the disease itself is confusing: “sleep apnea”, “obstructive sleep apnea”, “sleep apnea syndrome”, “obstructive sleep apnea syndrome”, “obstructive sleep apnea-hypopnea syndrome”, etc. Severity cannot be clearly stratified on the basis of 1 (e.g. mean pulmonary arterial pressure level in pulmonary hypertension) or 2 variables (e.g. dyspnea and exacerbations in chronic obstructive pulmonary disease), making it impossible to establish a clear therapeutic algorithm. In this latest CPG, in particular, different diagnostic algorithms have been developed, depending on whether the patient is managed by a generalist or a specialist, and different apnea-hypopnea index cut-offs and daytime sleepiness criteria are used, creating some confusion.

Nevertheless, the new consensus document addresses and clarifies important aspects in the management of OSA, such as indications for each diagnostic tool and the rational management and follow-up of CPAP, and guides the clinician and patient on alternative options for this measurement. Over the next few years we hope to be able to determine the extent to which this new CPG has been implemented in the different areas of clinical practice.

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