

SLEEP NEWS

January 2016

www.surgicalsleepp.org

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Next ISSS Meeting

April 15-16, 2016

Sao Paulo, BRAZIL

Eric Kezirian, MD, MPH President
Michel Cahali, MD and Denilson Fomin, MD
Program Chairs

Pertinent topics for your daily practice in the treatment of Obstructive Sleep Apnea and Snoring!

Come Join Us!

The meeting with focus on:

- Thoughtful, lively discussions about the latest technological innovations, and discoveries
- The latest in cutting-edge treatment options from around the globe
- Translational research and how that affects your patients and your practice
- Join your colleagues in lively discussions about the latest advances in surgical and medical treatment for adults and children with OSA
- AND MORE...

Explore the exhibits and latest technological advancements with of our industry partners.

www.forl.org.br/ISSS2016

Note: Citizens of the United States, Canada and many other countries will need a visa to travel to Brazil, so please consult online resources or your local Brazilian consulate/embassy for more information. Obtaining a visa requires some time for processing the application, so please plan in advance.



PRESIDENT'S MESSAGE

Welcome to the second issue of the ISSS Sleep News!

On behalf of the entire Board, I am excited to announce that we now have over 120 ISSS members from around the world! With your support and continued involvement, we are maintaining our dedication to being the world's major organization dedicated to the surgical treatment of sleep disordered breathing through education of members, other medical professionals, and the public about sleep surgery.



The cornerstone of the ISSS has been our scientific meetings, and the next one will be held in Sao Paulo, Brazil on April 15-16, 2016. Details and registration information are available at www.forl.org.br/ISSS2016. This will be the seventh ISSS scientific conference and will build on the tremendous successes of previous meetings. Some of the highlights of the upcoming meeting are:

- Outstanding faculty from around the world, including both the speakers and moderators leading the discussion in each session
- Two lecture rooms running simultaneously, enhancing the diversity in the program and enabling substantial time for discussion
- Expanded coverage of a full spectrum of topics in sleep surgery, including airway evaluation, surgical techniques, pediatrics, oral appliances, and oral and maxillofacial surgery
- Oral and poster research presentations: abstract submissions through the course website (<http://gforl.forl.org.br/Site/iss2016/289>). Deadline February 3, 2016

Please join us in our commitment to sleep surgery by joining or renewing your ISSS membership. Your \$100 membership dues for 2016 entitles you to all member benefits, including receipt of the ISSS newsletter, discounted registration fees for ISSS scientific meetings, and member listing on the ISSS website. Membership fee information is available on the ISSS website at <http://surgicalsleepp.org/membership/>. Fees can be paid through PayPal or by mail (US Applicants only).

Do not hesitate to direct any questions to me at eric.kezirian@med.usc.edu.



ISSS Supports the Position Statement on Surgical Procedures for OSA/SDB

We support the following statement, which can be accessed on our website with the full list of references, at: <http://surgicalsleepp.org/iss-position-statement-on-sleep-surgery>

The following surgical treatments and procedures have been shown to be effective in the treatment of sleep disordered breathing/obstructive sleep apnea syndrome in adults (and/or children) when applied to selected patients based on their anatomy, physiology, body mass index and neck size, prior therapy and co-morbidities. Patient should have undergone an appropriate evaluation(s) prior to treatment, which may include polysomnography, home sleep testing, awake or drug induced sleep endoscopy, and possible cephalometric or other radiographic evaluations.

The list of effective surgical procedures and their synonyms, variations and modifications, are listed below including selected publications supporting the procedures efficacy for treatment. References may focus on a single procedure or a combination of procedures. When listed as a combination of procedures, the reference may be listed under multiple procedure headings.

- Tonsillectomy
- Adenoidectomy
- Septoplasty
- Turbinate reduction (submucous resection of the turbinates, partial turbinectomy, radiofrequency ablation of the turbinates)
- Nasal valve repair
- Uvulopalatopharyngoplasty (UPPP) [Z-palatoplasty (ZPP), uvulopalatal flap (UPF), lateral pharyngoplasty, expansion sphincter pharyngoplasty]
- Transpalatal advancement pharyngoplasty
- Hyoid advancement/suspension (either to mandible or thyroid cartilage)
- Genioglossus advancement/suspension
- Tongue suspension
- Maxillomandibular advancement (MMA)
- Tongue Radiofrequency ablation
- Midline glossectomy/lingualplasty
- Lingual tonsillectomy
- Base of tongue reduction
- Epiglottoplasty (partial epiglottectomy)
- Cranial nerve (hypoglossal nerve) stimulation
- Tracheotomy

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We look forward to seeing you at ISSS meetings in Sao Paulo in 2016 and Los Angeles in 2017!



RESEARCH INITIATIVES

Based on preliminary discussions at the 2014 ISSS meeting in Detroit, two multicenter studies are being developed with the support of the ISSS. No ISSS financial resources will be used for the studies, but the meeting was an opportunity to discuss exciting new directions for research in the surgical evaluation and treatment of obstructive sleep apnea. Multicenter collaborations will enable the development of larger studies that are the key to answering many important research questions.

Drug-Induced Sleep Endoscopy and Surgical Outcomes

This is a retrospective cohort study of adults undergoing preoperative drug-induced sleep endoscopy (DISE) and pharyngeal surgery for the treatment of obstructive sleep apnea. The objective of the study is to examine the association between preoperative DISE findings and surgical outcomes, although the database will be available for additional studies to those who contribute patients. The principal investigator is Eric J. Kezirian, MD, MPH at the University of Southern California, and the study has already received funding from the [American Sleep Medicine Foundation](#). Please contact Dr. Kezirian at eric.kezirian@med.usc.edu if you are interested in becoming a study center.

Prospective Study of Surgical Outcomes

This prospective study is based on a group discussion and consensus for a core set of patient evaluation and outcome measures in obstructive sleep apnea surgery. The principal investigator is M. Boyd Gillespie, MD, MS at the Medical University of South Carolina. Please contact Dr. Gillespie at gillesmb@musc.edu if you are interested in becoming a study center.

CLINICAL CONTROVERSIES

Case: A 9 year old obese male with has a 6 month history of snoring, restless sleep, nighttime awakenings and choking episodes. He has difficulty getting out of bed in the morning after sleeping for 9 hours. Since starting aripiprazole (Abilify) 9 months ago, he has had significant weight gain. On examination, BP 120/90, BMI% for age =97%. Nose is patent. Tonsils 3 +, modified Mallampati = 3.

Should a sleep study be obtained?

Pro: This 9 year old obese child is at risk of having severe OSA, respiratory problems and persistent OSA after T&A. A diagnostic polysomnogram (PSG) will diagnose and quantify OSA, will allow for post-surgical planning (observation versus ICU) and indicate if a PSG is needed after T&A. The clinical practice guidelines from the American Academy of Otolaryngology, Head and Neck Surgery (AAO/HNS), American Academy of Sleep Medicine (AASM) and American Academy of Pediatrics (AAP) would all recommend a PSG in this child. His symptoms may also be related to other factors. For example, choking may be caused by reflux; sleepiness by insufficient sleep and a mood disorder may be an intrinsic problem. The diagnosis of OSA is more common in obese children but is not certain thus supporting PSG as a diagnostic test to avoid unnecessary surgery. The CHAT study reported that in obese children with mild OSA OSA, 30% of cases will resolve without surgical intervention within a 7-month observation period. Thus PSG may indicate the severity of OSA and allow for surgery to be postponed while a weight reduction option is explored. This specific child has several factors that suggest that surgery is less likely to be effective (obesity and age > 7 years). Furthermore, If this child has severe OSA, the surgeon may discuss and familiarize the child and family with non-invasive ventilation such as CPAP.

Con: Sleep studies are expensive, time consuming, burdensome and often unavailable. This child has nighttime and daytime symptoms together with enlarged tonsils that result in clinically significant sleep disordered breathing and are likely to improve with a T&A. PSG diagnoses and quantifies OSA but does not measure daytime symptoms, quality-of-life, behavior or school performance. It is known that the severity of OSA does not correlate with quality of life scores in children. This is especially relevant as the majority of T&A's are performed to improve the quality-of-life of the child and their caregivers. Although 30% of obese children in the CHAT study had spontaneous resolution of OSA without T&A, less than 20% of these children also had resolution of symptoms. Furthermore, obese children are often admitted for observation after T&A regardless of PSG findings and can be moved to an ICU setting if they need more intensive monitoring. PSG can be obtained post-T&A either routinely or in selected children who remain symptomatic. In an era when healthcare utilization and costs are under increasing scrutiny this approach is more likely and cost-effective and safe.

So what should you do?

We have provided compelling arguments both for and against obtaining a sleep study in an obese child with symptoms of sleep-disordered breathing. For each child a risk/benefit assessment is performed. For those children that have multiple comorbidities (e.g., Down syndrome, obesity, craniofacial deformities) and an elevated risk for general anesthesia it is prudent to obtain a sleep study. For other children, one should have a discussion with the parents and weigh their preferences and the mitigating circumstances (shared decision making). If a decision is made to proceed without a preoperative sleep study, we would recommend a period of overnight observation.

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IN CLOSING

Take a moment to explore the ISSS Website

Surgicalsleep.org