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In Reply: Are Clinical Features and Severity Vital While Deciding the Treatment in Sleep Apnea Syndrome?

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We appreciate your interest in our recently published study entitled "Five-Year Subjective Outcomes of Obstructive Sleep Apnea Surgery: A Multi-Institutional Study" [1]. We received 3 comments which we will address and are summarized as follows: (1) there were some insufficiencies in the clinical and demographic characteristics of the study population including sleep endoscopy; (2) the severity of obstructive sleep apnea (OSA) was not presented in the article; and (3) healthy control group was more suitable than untreated control group and follow-up polysomnographic tests were better than telephone inquiries.

The objective of this research was to perform a retrospective, multi-institutional study to assess potential long-term effects of OSA surgery and positive airway pressure (PAP) on sleep disordered breathing (SDB) symptoms via a chart review and telephone survey. Being a retrospective study, we could not evaluate the effectiveness of specific treatments using broad patient selection criteria. Similar in design to our research, Goh et al. [2] evaluated long-term quality of life after uvulopalatopharyngoplasty. In their study and ours, surgical treatment was performed at the doctor's discretion based on the patient's clinical features, severity of disease, and preference. Because our data was accumulated from 10 different institutions, there was substantial heterogeneity in available demographic information, clinical features, and measured outcomes other than age, sex, body mass index, and baseline apnea-hypopnea index (AHI). We agree with the comment that sleep endoscopy and follow-up polysomnograms would have provided more important information. Unfortunately, postoperative polysomnograms were not routinely performed in our clinical setting and therefore could not be included in the analysis. Regarding the second comment, the mean AHI scores with ranges are provided in Table 1 [1]. Patients with the highest AHIs were included in the PAP group (mild:moderate:severe=2:15:51), followed by the surgery (mild:moderate:severe=16:30:41) and control (mild:moderate:severe=23:17:34) groups.

The last comment warrants an interesting discussion on study design. We agree that healthy control patients would have provided additional information, including a reference to compare treatment success between PAP and surgery. However we designed this study to provide clinicians with long-term outcome data on the effects of upper airway surgery or PAP versus those patients with OSA that select no-treatment. We feel that this objective is also of value to the literature, as we demonstrated that patient-reported SDB symptoms were significantly improved after surgery or PAP, compared to those that had no intervention in a 5-year period.

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CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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