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LETTERS TO THE EDITOR

Pulmonary artery dilatation and obstructive sleep apnea

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We read with great interest the article by Nokes et al[1] reporting a high incidence of sleep- disordered breathing [SDB] in patients with scleroderma as evaluated by overnight pulse oximetry. It is interesting to note that the authors report in their study that in scleroderma patients, the only predictive variables for abnormal overnight oximetry [defined as [ODI >5/h or a mean oxygen saturation < 90%] were advancing age and pulmonary artery diameter >3.0 cm.

Pulmonary artery dilatation can occur from many causes, including abnormal pulmonary hemodynamics, hypoxemia, trauma, and vasculitis.[2–4] During last few years, there has been significant improvement in the understanding of the link between SDB, pulmonary hypertension,[5] and interstitial lung diseases.[6]

There is also a suggestion that obstructive sleep apnea is associated with enlargement of the main pulmonary artery.[7,8] The current study,[1] although retrospective, again highlights that in patients with SDB, repetitive nocturnal hypoxemia, and large intrathoracic negative pressure swings attributable to recurrent upper airway obstruction could affect pulmonary hemodynamics and may lead to pulmonary artery dilatation, although we agree that this concept needs to be studied further.

Patients with scleroderma report features of sleepiness and fatigue, usually attributed to the scleroderma disease process itself rather than to underlying SDB. As clinicians, we believe the presence of an enlarged pulmonary artery in scleroderma patients should not only rule out pulmonary hypertension but also remind ourselves about the possibility of underlying SDB.

CITATION

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DISCLOSURE STATEMENT

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