

**OBSTRUCTIVE SLEEP APNEA-  
INCREASED RISK OF SURGERY  
MORBIDITY AND MORTALITY**



**INTEGRITY**

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## **OBSTRUCTIVE SLEEP APNEA- INCREASED RISK OF SURGERY MORBIDITY AND MORTALITY**

Outpatient surgery and surgery centers can provide another option from the traditional hospital setting. However, for an individual with numerous pre-existing conditions (specifically obstructive sleep apnea), these settings might not be the best or safest location.

Obstructive sleep apnea (OSA) most commonly affects middle aged and older adults, especially those who are overweight. OSA occurs when the throat muscles relax, causing either partial or total airway obstruction during sleep; the most noticeable sign including snoring and observed episodes of not breathing during sleep. Approximately 1 out of 5 individuals may suffer from OSA with up to 80% undiagnosed and untreated and 7% with moderate to severe OSA.

Obstructive sleep apnea is associated with an increased risk of peri operative morbidity and mortality; related to the administration of sedatives, pain medications and muscular relaxants. These medications routinely cause lower muscle tone, which in an individual with OSA can be devastating, contributing to airway closure, respiratory depression, low oxygen levels, cardiac issues and ultimately respiratory/cardiopulmonary arrest.

Before litigating surgery cases regarding possible bad outcome related to OSA, there are important issues to consider. These include:

- Recognition of an individual with OSA by both the surgeon and anesthesiologist. This would include identification of possible risk factors (obesity, large tonsils, history of low and frequent snoring with observable breathing pauses or increased daytime fatigue).
- Patients with diagnosis of OSA should be considered at increased risk for perioperative complications. Identifying patients at high risk for OSA before surgery for targeted perioperative precautions and interventions may help to reduce patient complications
- Best practice guideline (consensus of the SASM<sup>1</sup> Task Force) is that all perioperative providers, and the patient, should be aware that the patient has a known diagnosis of OSA, which could potentially adversely affect his or her clinical course<sup>2</sup>.
- Regardless of established diagnosis of OSA, anesthesiologists, surgeons and institutions should develop institutional protocol for patients with known or suspected OSA including types of anesthesia, choice of medications, postoperative

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<sup>1</sup> Society of Anesthesia and Sleep Medicine

<sup>2</sup> Unfortunately, at present there is limited evidence supporting the use of preoperative screening tools for OSA as a practice to reduce patient complications

- analgesic regimens, monitoring, and appropriate preoperative/postoperative referral to reduce complications<sup>3</sup>.
- For the patients at increased risk of OSA, a determination of best surgery location (as in inpatient or outpatient basis). Location can then depend on surgery and anesthesia type, patient age, presence of pre-existing conditions, adequacy of post surgical observations and capabilities of outpatient facility.
  - Provided care to include appropriate usage of monitoring during and after sedation and possible use of postoperative oxygen to maintain adequate oxygenation levels (dependent on potential respiratory diagnoses).
  - Patient positioning after surgery as in side lying, prone (face down) or sitting position as compared to supine (lying flat on back). Position dependant on surgery type and potential problems.
  - Time of scheduled surgery, especially for the individual with multiple pre-existing conditions. Was the surgery scheduled earlier in the day as compared to end of day, and possible admission to acute care hospital for continued monitoring?
  - Facility discharge when no longer risk of postoperative respiratory depression (related to medication dosing). Patient may require an overnight stay as compared to same day discharge, depending on risk factors and stability.
  - Usage of diagnostic discharge tool, (as in Aldrete Scoring System) - to determine patient overall safety and stability.
  - Patient discharge from recovery area, to an unmonitored setting (home), until no longer at risk for postoperative respiratory depression (related to medications). May require a longer stay as compared to non-OSA patient.

If you are litigating a possible wrongful death case, a thorough case review will determine if the individual was provided complete pre-operative evaluation and postoperative care and evaluation before discharge. A legal nurse can provide a case review and analysis and procure and vet appropriate testifying experts for litigation.

Source:

American Society of Anesthesiologists Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea,  
Practice Guidelines for Perioperative Management of Patients with Obstructive Sleep Apnea, *Anesthesiology* 206; 104: 1081-1093  
Society of Anesthesia and Sleep Medicine Guidelines on Preoperative Screening and Assessment of Adult Patients with Obstructive Sleep Apnea, [http://journals.lww.com/anesthesia-analgesia/Fulltext/2016/08000/Society\\_of\\_Anesthesia\\_and\\_Sleep\\_Medicine.22.aspx](http://journals.lww.com/anesthesia-analgesia/Fulltext/2016/08000/Society_of_Anesthesia_and_Sleep_Medicine.22.aspx)

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<sup>3</sup> [http://journals.lww.com/anesthesia-analgesia/Fulltext/2016/08000/Society\\_of\\_Anesthesia\\_and\\_Sleep\\_Medicine.22.aspx#R111-22](http://journals.lww.com/anesthesia-analgesia/Fulltext/2016/08000/Society_of_Anesthesia_and_Sleep_Medicine.22.aspx#R111-22)