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COMORBID INSOMNIA AND SLEEP APNEA (COMISA)

What is insomnia?

- Insomnia occurs when an individual has difficulty initially falling asleep, returning to sleep after waking during the night, or wakes too early in the morning.
    - It is generally held that "difficulty" means taking 30 minutes or more
- Chronic Insomnia involves frequent (3+ nights per week) and persistent (>3 months) difficulty with insomnia symptoms, producing impairments in daytime functioning (e.g., mood, fatigue, memory/concentration).
- 30-50% of people with obstructive sleep apnea (OSA) have co-morbid chronic insomnia.
- Compared to either insomnia or OSA alone, co-morbid insomnia and sleep apnea (COMISA) is associated with greater morbidity for patients, complex diagnostic decisions for clinicians, and reduced response to otherwise effective treatment approaches.

What treatments are effective for Chronic Insomnia?

- Once insomnia becomes chronic in COMISA, treating OSA may not fully eliminate the insomnia as well (e.g., with CPAP) and will likely require its own, targeted treatment.
- Cognitive-behavioral therapy for insomnia (CBT-I) with a trained behavioral health provider is considered the gold standard of treatment for chronic insomnia, and is effective in COMISA as well.
- Sleep hygiene education is not an effective stand-alone treatment for chronic insomnia, but healthy sleep practices can help prevent chronic insomnia from developing in the first place.
- Sleep aids for the treatment of chronic insomnia might be recommended if CBT-I or other nonpharmacologic interventions are unavailable, unsuccessful, or declined by patients. However, this should be strongly considered as some sleep aids may worsen sleep-disordered breathing.

Considerations for Insomnia – Screening patients for OSA

- In addition to OSA screening questions, you might ask if any of the following insomnia symptoms are also present?
    - Takes longer than 30 minutes to fall asleep most nights?
    - Awake for more than 30 mins during the middle of the night?
    - Wakes up 60 or more minutes before desired wake time and cannot return to sleep?
    - Are they currently or have they ever taken a prescribed or over-the-counter sleep aid?
        - If yes, what is/was the effect?

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Considerations for Insomnia – Referring for a Sleep Study

- If you think insomnia is also present, can you refer to a behavioral health provider for CBT-I or other therapies *prior to* or *simultaneously* with ordering a sleep study?
    - Treating insomnia *before* further evaluation might offer some benefits, such as improved sleep during the night of the sleep study.
    - However, do not delay referral for a sleep study just because insomnia is present, *unless you strongly suspect* the patient will not be able to tolerate the evaluation (at home or in the sleep clinic).
- Consider potential impact of insomnia on diagnostic testing for OSA via sleep study when selecting where to complete the testing (i.e., at home versus in a sleep clinic).
    - Some patients may sleep better in an environment away from home, where their insomnia is worst.
    - Some patients may prefer to sleep in their own bedrooms, where they are most comfortable.

Considerations for Insomnia – Diagnosing OSA

- Insomnia may impact the results of the sleep study and whether or not sleep-related breathing events occur frequently enough to diagnose OSA.
    - A sleep study that is negative for OSA, but where insomnia was present, might be repeated when insomnia is better controlled—after targeted insomnia treatment or in a different setting (e.g., an in-lab PSG study after a negative home sleep apnea test [HSAT]).
- While insomnia may be identified on the night of the sleep study, this is not enough to diagnose chronic insomnia. Rather, a pattern of poor sleep for several weeks/months is needed.
    - This pattern of insomnia is often captured during a longer clinical interview in addition to a daily sleep diary, which patients complete as part of CBT-I.

Considerations for Insomnia – Treatment of OSA

- In COMISA, consider offering treatments to target insomnia as soon as possible.
    - *Unless* you feel strongly that the other symptoms of OSA would interfere or contraindicate an insomnia therapy to start (e.g., unable to follow behavioral recommendations due to severe and excessive daytime sleepiness, risk of worsening OSA if prescribed sleep aids).
- When risk for OSA and clinical insomnia are identified together, ask patients how they might want to proceed with referrals to target OSA (via CPAP), insomnia (via CBT-I or medications), or both (if available).
    - Collaborative discussion and treatment planning can increase acceptance of—and adherence to—treatment for OSA and insomnia.

- COMISA can impact tolerance and adherence of therapies for OSA such as CPAP.
    - The symptoms of insomnia may only be apparent after starting on CPAP.
    - Patients may report “sleeping worse” with CPAP, resulting in longer times to fall asleep or more frequent awakenings during the night.
    - Coordinating with the sleep clinic to make adjustments to treatment settings that are more tolerable (e.g., reducing pressure settings, increasing “comfort” features like humidification) may help patients better adjust to CPAP early in treatment.
- Treating insomnia before starting treatment for OSA (e.g., CPAP) might provide improvement in insomnia symptoms and better tolerance of therapies for OSA (e.g., CPAP).
- Many patients designated as “failing CPAP” or exhibiting low usage may have untreated insomnia.
    - Continually monitor for symptoms of insomnia and offer evidence-based treatments as deemed appropriate.
    - Document issues of co-morbid insomnia and potential impact on adherence to treatments for OSA.
        - This may impact DME and/or CMS/insurance coverage of treatment if adherence is not demonstrated during the first 30-90 days after receiving a CPAP.

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