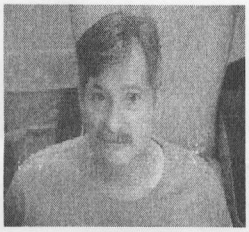
James A. Haley VA Medical Center
Department of Veterans Affairs
13000 Bruce B. Downs Boulevard
Tampa, Florida 33612

Patient Name:	**MCINTOSH,** SCOTT M
Study Date:	10/17/2012
Report Date/Time:	11/8/2012 1:29 PM
Scoring RPSGT:	L COPELAND RPSGT
Patient Number:	120464294
Testing Tech.	R. SMITH RPSGT

Split Study Report



Indications:

Mr. MCINTOSH was referred for evaluation of possible Obstructive Sleep Apnea (OSA). The patient presents with a history of snoring, irregular respiratory efforts during sleep, and daytime fatigue or sleepiness (Epworth Sleepiness Scale 11). BMI is 28.1.

Procedure: Please refer to Appendix #1

Findings:

EEG / Sleep Staging- Lights Out occurred at 21:39 p.m.
Sleep Latency was 7.5 minutes.
No REM sleep was observed during the study.
Sleep Efficiency during the initial part of the evening was 81.8%.
Positive Airway Pressure improves sleep continuity.
Ancillary EEG findings- Alpha Intrusion was not noted. Atypical spindles were not noted.

Respiratory Events- The initial Obstructive AHI was 51.7
5.2% of the initial portion of the evening was spent below a saturation of 90%,
The saturation nadir during the initial portion of evening was 83%.
These events are ameliorated by Positive Airway Pressure.
The following mask interface was used for PAP titration: **SMALL COMFORTGEL**

Cardiac Summary- No significant dysrhythmias were noted. Baseline Heart Rate during sleep was 74 and 78.5 during wake. After PAP therapy was initiated Heart Rate duri ng sleep was 69 and 64.5 during wake.

Parasomnias- LMs' (13.6/hr) and PLMs (13.4/hr) were noted.
The clinical significance thereof would need to be correlated with the presence and severity of any symptoms of Restless Limb Syndrome
Other Parasomnias (Bruxism, Somniloquy, were not noted)

Impression:

1. Severe obstructive sleep apnea (327.23) with mild associated nocturnal hypoxia.
2. Mild underlying central sleep apnea (327.29) with worsening demonstrated while on PAP therapy.
3. Inability to correct sleep related breathing disorder on CPAP due to the significant appearance of central events while on CPAP and Bilevel therapy.

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General Recommendations:

Individuals with untreated OSA have an increased risk for cardiovascular consequences (heart attack, stroke, and sudden death), and neuro-cognitive consequences (daytime sleepiness, fatigue, inattentiveness, reduced vigilance, reduced mental acuity, reduced job performance, increased risk for accidents or injuries associated with those activities requiring vigilance such as driving or operating machinery). There is also evidence to suggest that untreated OSA may have an adverse effect on hypertension and diabetes.

In this regard the patient is advised to:

1. Avoid Alcohol, Sedatives, and Muscle Relaxants prior to retiring for bed as these agents may exacerbate sleep apnea.
2. Use all due diligence with regard to the operation of a motor vehicle and or any other activities that might require vigilance until such time as any hypersomnolence or impaired attentiveness has abated.
3. Efforts at weight loss and reconditioning might be of value, especially if the Body Mass Index is >27.
4. The patient should inform their physicians, and in particular, the anesthesiologist, of a diagnosis of OSA, before considering any surgical procedure, or before the use of any sedating medication.
5. The patient's own CPAP unit and mask should be brought with them to the hospital when confined, and should be carried with them when away from home.

Specific Recommendations for Mr. MCINTOSH

1. One could consider trial of PAP therapy with Auto PAP, followed by overnight pulse oximetry study while on PAP therapy once he is acclimated to the device- to determine whether or not he experiences a subjective benefit. Overall however, in the lab, he did best on oxygen alone at 2 LPM, and this may be sufficient and appropriate treatment for him until he is able to eliminate the medications which may be contributing to these findings.
2. Suggest to attempt to wean off narcotics and other CNS depressants. He has been seen by pain management in the past.
3. Counseling, education, and follow up through the PAP clinic.
   Consider follow up through the Complex Sleep Clinic as needed.

Alfonso Castro, MD

INTERPRETING FELLOW

I verify that this test was interpreted under my supervision and I agree with the findings:

Daniel J Schwartz, MD

ATTENDING INTERPRETING PHYSICIAN