



Newsletter, August 2002

Australasian Sleep Association

PRESIDENT'S REPORT

Dr Michael Dodd

It is a pleasure to provide my presidential report for this newsletter.

The most important aspect to report is that the planning for the October Annual General Scientific Meeting to be held in Hobart is well underway. Whilst many people are responsible for putting the meeting together, Alister Neill deserves special mention for the amount of time and effort he has put into the job so far. I am sure the meeting will be a success, but to reach its full potential of success we need as many members as possible to attend the meeting. I would encourage you to do what you can to ensure you are in Hobart for that meeting.

Whilst speaking of meetings the World Federation of Sleep Research Societies is planning to have their next Meeting in Chicago combined with the APSS Meeting next June. The meeting will be focusing on the 50th Anniversary of the discovery of Rapid Eye Movement Sleep. As an incentive to encourage input to this meeting the WFSRS is providing a travel scholarship for one of our members. Details of this scheme are included elsewhere in the Newsletter. The WFSRS has also confirmed that it is continuing with its plan to hold the 2007 Meeting in Cairns. The Executive view of the ASA is certainly pushing for that meeting to be held in Cairns.

I am pleased to report that the discipline of sleep medicine is becoming recognised as an entity in itself both overseas

and in Australia. The Royal Australian College of Physicians has included a representative from the ASA in its special societies group, which meets twice each year. This enables us to have a direct voice at the level of the College of Physicians being completely independent from the Thoracic Society.



As I mentioned in a previous letter, the ASA has been intimately involved in the drafting of new driver guidelines for commercial vehicle drivers. Peter Solin and his Committee have done a tower of work in providing that help.

You may or may not have noticed that we have a new newsletter editor in Keith Wong. If you have any contributions that you would feel suitable for inclusion in the newsletter I am more than certain that Keith would be happy to receive them.

I look forward to seeing you all in Hobart.

Regards

MICHAEL DODD

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ANNUAL GENERAL MEETING

The Annual General Meeting of the Australasian Sleep Association will be held at 1.00pm on Sunday 13 October 2002, at the Hotel Grand Chancellor, Hobart, during the Annual Scientific Meeting.

All Members are warmly invited to attend the AGM.

DATES FOR THE DIARY

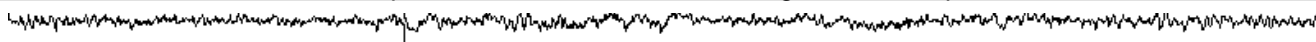
11-13 October 2002 ASA/ASTA Annual Scientific Meeting, Hobart, Tasmania
20-23 November 2003 ASRS Congress, Zhuhai (near Macao), China. See www.shisa-sleep.com

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The Fitness to Drive Guidelines.

There has been a major initiative to update the fitness to drive guidelines. Currently there are two publications, one for private drivers, and the other for commercial drivers. We have had the opportunity to combine guidelines for both these driving groups into the one publication, and update the background information. The book would be used by medical practitioners in all areas to help determine suitability for licensing of people with sleep disordered breathing and narcolepsy. Above all, the fitness to drive guidelines are guidelines, and a decision about a person's suitability for driving is a clinical decision dependent on the circumstances. I would like to thank Drs Mark Howard, Robert Pierce, and Murray Johns for enthusiastically taking on this project, and producing a clear, and I hope, a useful document. The aim of the current rewrite is to identify people with proven obstructive sleep apnoea and or narcolepsy, particularly those at high risk of motor vehicle accidents. It is clear that the knowledge base in this area still needs to grow, and the effects of intervention need to be proven to be effective in reducing motor vehicle accidents. There was considerable healthy debate around a number of issues. For example, what to do about patients who have sleep disordered breathing found on a sleep study, yet have very little daytime somnolence or no history of drowsy driving or falling asleep at the wheel. Some concerns have been raised that although the Epworth Sleepiness Scale is a reasonable marker of overall sleepiness, a better questionnaire for sleepiness related to the driving task should be utilised. Also, how to advise the sleepy patient without sleep disordered breathing or an alternative diagnosis, who has previously been labelled as being a Narcoleptic.

The current draft proposal, will be included on our web page for your perusal, and comment. I thank members who already have submitted suggestions for improvement, and most have been incorporated. Later this year, it will go into government for final approval, with the publication appearing early in 2003.

Dr Peter Solin

MEDICAL STANDARDS – SLEEP DISORDERS[†]

CONDITION	PRIVATE STANDARDS (Drivers of cars, light rigid vehicles or motorcycles unless carrying passengers for hire or reward or carrying bulk dangerous goods- refer definition page)	COMMERCIAL STANDARDS (Drivers of heavy vehicles, public passenger vehicles or bulk dangerous goods vehicles- refer definition page)
Obstructive Sleep Apnoea	<p>The criteria are NOT met:</p> <ul style="list-style-type: none"> For persons with proven obstructive sleep apnoea syndrome (sleep apnoea on a diagnostic sleep study and excessive daytime sleepiness) <p>A conditional licence may be recommended by the treating doctor/GP, subject to periodic review if:</p> <ul style="list-style-type: none"> The person is compliant with treatment; and The response to treatment is satisfactory; and Consideration is given to the driving requirements. (Expert opinion) 	<p>The criteria are NOT met:</p> <ul style="list-style-type: none"> If the person has established sleep apnoea syndrome (sleep apnoea on a diagnostic sleep study and excessive daytime sleepiness) until treatment is effective. Consideration should be given to how long-distance drivers will comply with treatment such as CPAP [12] [10]. (LOE-III-2) A history suggestive of sleep apnoea in association with severe daytime sleepiness, until investigated and treated. Severe sleepiness is indicated by frequent self-reported sleepiness while driving, motor vehicle crashes caused by inattention or sleepiness or an Epworth Sleepiness Scale Score of 16 to 24 [36] [37] [1]. (LOE-III-2) <p>A conditional licence may be recommended by a specialist in sleep disorders, subject to annual review:</p> <ul style="list-style-type: none"> For those with established sleep apnoea syndrome (sleep apnoea on a diagnostic sleep study and excessive daytime sleepiness) who are on satisfactory treatment. (Expert opinion)
Narcolepsy	<p>The criteria are NOT met: If narcolepsy is confirmed.</p> <p>A conditional licence may be recommended by a specialist in sleep disorders, subject to periodic review, after consideration of the response to treatment, and the nature of the driving required. (Expert opinion)</p>	<p>The criteria are NOT met:</p> <ul style="list-style-type: none"> If narcolepsy is confirmed. (LOE-III-2) <p>A conditional licence may be recommended by a specialist in sleep disorders, subject to periodic (at least yearly) review, after the following requirements are met: an clinical assessment has been made by a sleep physician and/or neurologist; cataplexy has not been a feature in the past, medication is taken regularly, there has been an absence of symptoms for 6 months, normal sleep latency present on MWT (on or off medication). (Expert opinion)</p>

[†]The above summary table is an excerpt from the draft guidelines (available from the ASA website).



THE CLINICAL PAGE.

Dr Peter Solin

In this section, we will highlight some of the 'behind the scenes' work going on by the executive and members of the society in clinical matters. We will also introduce 'Controversy Corner', whereby the membership can put up a difficult or controversial case for discussion. In the next edition, I will summarise peoples responses and advice regarding the case in question.

Controversy corner

This edition's controversial case comes from Dr Margot Davey, a Melbourne-based specialist in paediatric sleep disorders. The case carries on from the theme of fitness to drive...

Andrew is a 20 year old man who was diagnosed with Prader Willi Syndrome at 13 years of age, who wants to obtain a driving license. He lives with his family in the country several miles from the nearest town, and parents presented with him because of concerns about Andrew's daytime sleepiness and his safety driving a car. Andrew denied that there was a problem and is studying at college 4 days a week. Parents recollect that daytime sleepiness has always been a problem and during his adolescence he was prescribed dexamphetamine but he did not like taking it and

parents were unclear as to whether it made any difference. He has snored for many years.

Examination	BMI 38, BP 120/80. Rest of examination normal.	
PSG	TST 476 min., sleep efficiency 93% No evidence of OSA or PLM with normal sleep architecture	
MSLT	Mean sleep latency	2.9 mins
	Mean REM latency	5.5 mins.
	Number of REM episodes	4 out 5 naps

At the commencement of each nap Andrew said he didn't feel tired and was also unsure whether or not he had slept. HLA typing is negative.

What next? Has anyone else struck this clinical problem? I would invite the readership to send in any pearls of advice to me, so I can produce a cohesive response to the general readership in the next edition, and pass the comments on to the submitting author.

Peter Solin

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OTHER NOTICES

ASA/ASTA Annual Scientific Meeting

As you would know by now, this will be held on 11-13 October 2002 at the Hotel Grand Chancellor, Hobart, Tasmania. It looks to be an exciting programme including updates on the Sleep Heart Health Study from Prof Susan Redline, genetic aspects of sleep medicine, and a year-in-review session. Registrations are due 30 August 2002.

Accreditation of sites offering advanced training in adult sleep medicine

The SAC for Thoracic and Sleep Medicine have asked for comments from all members of ASA and TSANZ on a draft document detailing guidelines for the site accreditation for training in Adult Sleep Medicine. The 13-page document will be posted on the ASA website and also emailed to all members. The full document including Respiratory training will also be posted on the TSANZ website. Could any comments be directed to the ASA Secretariat so that it may be forwarded to the ASA Executive, the SAC of the College and the Professional Standards Subcommittee of the TSANZ. The SAC ask that responses be made within the next 6 weeks.

Funding for a trainee to attend WFSRS June 2003, Chicago

The World Federation of Sleep Research Societies will fund airfare and meeting registration for one trainee from the ASA to attend and present an abstract at their next meeting. Recipients of the funding will be encouraged to spend some time at a laboratory in the USA which interests them. Interested applicants should contact the ASA secretariat for further details. Please apply to the ASA Executive before January 2003.

Suggestions welcome

This is my first attempt at putting the newsletter together. I would appreciate suggestions on what you would like included and how it could be improved. You could contact me via my email address kwkh@tpg.com.au... Keith Wong



HONORARY SECRETARY Dr David Joffe

Dear Membership, following the meeting in Cairns, at which many issues regarding the ASA were canvassed, there have been some important points to communicate.

Peter Solin has completed the new "Fitness to Drive" guidelines with much thanks to him and the many members who had input to the paper. It is included in the newsletter for your perusal.

Keith Wong (Sleep Fellow, RNSH) has been approached and has accepted the offer to take over the editorial role of this newsletter. He will work closely with Peter Solin, Stephanie and myself to improve the content and make-up of this important publication. Changes will include a "Clinical Dilemma" corner where difficult cases can be canvassed and discussed. I urge you to please send us your problem cases so we can share the experiences around!

The latest news of Modafinil is that it is up for discussion with the PBAC and may become available in July. The budget reforms hold-up in the Senate may however compromise its listing. The latest news with respect to Pramipexole is the probable listing for the indication of early Parkinson's Disease in January 2003. Again, there will be no listing at this stage for RLS and as with Cabaser the cost will thus be borne by the user.

The planning for the Annual Scientific meeting is well underway and the program looks fabulous. Alister Neill has outdone himself in

terms of content and design and it really promises to be one of our best meetings yet. Details should have reached you by now, if not, the information is on the home page for downloading.

Respiroics USA in conjunction with Anaesthetic Supplies and the Department of Respiratory Medicine RNSH will be running a weekend course in non-invasive ventilation in August 2002, for advanced trainees in respiratory medicine. The course will take place in Terrigal. Speakers will include, Arthur Teng, David Barnes, David Berlowitz, Amanda Piper, and Richard Totaro. Topics will include a wide range of areas from paediatric to clinical controversies, spinal disease and new ventilation strategies. The course has been approved by the TSANZ SAC and will be advertised to all current trainees.

On behalf of the Executive, I remind you to get your registration for the meeting in early so that we can assess numbers and ensure everyone has the best possible time. See you all in Hobart!

Regards,

Dave Joffe
djoffe@mail.usyd.edu.au



Announcement Regarding Sleep Med Services

The Executive of the ASA for sometime now has been aware of the activities of an organisation known as Sleep Med Australia operating in Gosford. Sleep Med Australia is a member of the Resmed group of companies. It is a service to which general practitioners and other medical practitioners are encouraged to refer patients for home (partial PSG) assessment of sleep apnoea. Physicians qualified in the interpretation of sleep studies provide a report on these tests and the report is then sent to the referring practitioner. If they wish the referring practitioner then decides on the mode of treatment without the patient having a direct line of communication with a qualified Sleep Physician. The Executive of the ASA is aware that there is a significant unmet clinical need for sleep apnea investigations and management in Australasia. Home sleep studies or limited sleep studies may be one of the strategies that can be employed to address this need, but there is uncertainty about the reliability and utility of these methods for diagnosing and managing patients with sleep disorders. The Association is presently involved in an independent assessment of the value of home monitoring being conducted in the United States jointly by the American Academy of Sleep Medicine, American Thoracic Society and American College of Chest Physicians. We have sent one of the members of the Executive to meetings in the United States but that task force is yet to present its report

The Executive has requested the Professional Standards Subcommittee of the Thoracic Society of Australia and New Zealand to provide its opinion on the Sleep Med Australia model. The reply to the Australasian Sleep Association is as follows:

"It is our carefully considered opinion that this model of care does deviate, in undesirable ways, from the currently accepted model for such patients. Most importantly, the initial assessment is made using a relatively new device, and a diagnosis of sleep apnoea either suggested or refuted, without the patient having the benefit of a more thorough assessment of their sleep disordered breathing by a specialist. This is contrary to currently accepted practice where, although a patient may be referred directly for a 'sleep study', the reporting physician (qualified in the interpretation of sleep studies) is charged with the responsibility of determining the appropriateness of the testing procedure. The currently accepted model, we believe, does offer the patient appropriate care in a relatively new area of specialised practice and is designed to minimise possibly incorrect and undesirable management practices in a rapidly expanding area of medicine."

The Executive has also asked the Ethics Committee of the Royal Australian College of Physicians to provide comment but no reply has yet been received.

The Executive of the Sleep Association wishes to ensure that patients with sleep disorders receive the best possible standard of care. The use of new home-based diagnostic devices to establish diagnosis and the failure to involve sleep physicians in the management of the patients may not satisfy these aims. The Executive welcomes the introduction of new methodologies for the diagnosis of sleep disorders or new clinical pathways if they can be demonstrated to enhance patient care. However, any new methods must first be carefully and methodically evaluated to show that the outcomes for patients are at least equivalent and hopefully better than outcomes achieved using current diagnostic and management pathways.

Your Executive will continue to review any new methods in order to ensure these aims are achieved.

Michael Dodd

President

