Practical Updates in Primary Care

Obstructive Sleep Apnea in Primary Care: Practical Strategies for Diagnosis, Treatment, and Referral

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Faculty Disclosures

- **Wendy L. Wright, DNP, ANP-BC, FNP-BC, FAANP, FAAN, FNAP:** Consultant – Otsuka Pharmaceutical Development & Commercialization; Speaker's Bureau – Otsuka Pharmaceutical Development & Commercialization

- **Saurav Luthra, MD** has nothing to disclose in relation to this activity

Disclosure

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Learning Objectives

- Describe common and high-risk presentations of OSA in primary care and validated screening tools to confirm diagnosis
- Evaluate the benefits and limitations of OSA treatment options, including PAP, OAT, behavioral interventions, and surgical or device-based approaches such as HGNS
- Identify patients with OSA who may be intolerant or inadequately treated with PAP therapy, and require referral for specialist evaluation and advanced therapies
- Apply shared decision-making strategies to improve patient adherence and long-term management of OSA

OSA = obstructive sleep apnea; PAP = positive airway pressure; OAT = oral appliance therapy; HGNS = hypoglossal nerve stimulation.

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Case Study

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56-Year-Old Female Presenting for Fatigue

- Presents to primary care reporting fatigue and frequent waking at night
- Present x years but worsening
- Having difficulty functioning (staying awake) at work and is fearful of losing her employment
- PMH: hypertension, obesity, MDD, and hyperlipidemia
- Medications
  - Lisinopril 20 mg once daily
  - Escitalopram 10 mg once daily
  - Atorvastatin 10 mg once nightly
  - Multivitamin one pill daily

- Physical examination
  - VSS; BP: 122/78, BMI: 35.6, pulse: 84 bpm, RR: 16 per minute
  - Skin: normal; no cyanosis
  - HEENT: limited visualization of uvula – can only see small portion; tongue limits evaluation
  - Thyroid: normal; no nodules or goiter
  - Lungs: clear without abnormalities
  - Heart: S1, S2, RRR, no S3, murmur or S4
  - PV DP/PT: 2+ bilateral; no edema

PMH = past medical history; MDD = major depressive disorder; VSS = vital signs stable; BP = blood pressure; BMI = body-mass index; RR = respiratory rate; HEENT = head, eyes, ears, nose, throat; RRR = regular rate and rhythm; PV = peripheral vascular; DP/PT = dorsalis pedis/posterior tibial.

Insomnia: What Is it?

- Insomnia
  - Difficulty initiating or maintaining sleep; sleep that is nonrestorative despite having an adequate opportunity and no abnormal environmental circumstances; and accompanied by daytime somnolence

Sateia MJ, et al. *J Clin Sleep Med*. 2017;13(2):307-349.

DSM-5-TR Definition of Insomnia

– Difficulty initiating ***and/or***

– Difficulty maintaining ***and/or***

– Waking earlier than desired ***AND***

– Occurring at least 3 nights per week for at least 3 months ***AND***

– Dissatisfaction with sleep

Khurshid KA. *Psychiatric Times*. September 30, 2015. Accessed September 21, 2026. http://www.psychiatrictimes.com/special-reports/review-changes-dsm-5-sleep-wake-disorders.

10 Sleep-Wake Disorders

1. Insomnia disorder
2. Hypersomnolence disorder
3. Narcolepsy
4. **Sleep disordered breathing**
    a. Obstructive sleep apnea
    b. Central sleep apnea
    c. Sleep-related hypoventilation
5. Circadian rhythm sleep-wake disorders
6. Non-rapid eye movement (NREM) sleep arousal disorders
7. Nightmare disorder
8. REM sleep behavior disorder
9. Restless legs syndrome
10. Substance-/medication-induced sleep disorder

American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revisions* (*DSM-5-TR*). APA Publishing; 2022.

Sleep Disordered Breathing

- Comprised of 3 disorders
  - Obstructive sleep apnea (85-95%)
  - Central sleep apnea
  - Sleep-related hypoventilation

Kapur VK, et al. *J Clin Sleep Med*. 2017;13(3):479-504. Ho ML, et al. *Neurol Int*. 2011;3(3):e15.
Patel SR, et al. *Sleep Breath*. 2025;29(5):296.

Obstructive Sleep Apnea (OSA)

- The most common of the sleep disordered breathing conditions
  - Believed to affect approximately 14% of men and 5% of women
    - This number may be underestimated based upon a limited definition
  - Higher numbers in certain populations such as those undergoing bariatric surgery or in those with history of TIA/CVA (~50-80%)
  - Common cause of daytime fatigue and frequent awakening
    - Many of these patients have been diagnosed with insomnia without any investigation as to the cause
    - Many are treated with various sleep medications, which may make symptoms/condition worse

TIA = transient ischemic attack; CVA = cerebrovascular accident.
Kapur VK, et al. *J Clin Sleep Med.* 2017;13(3):479-504.

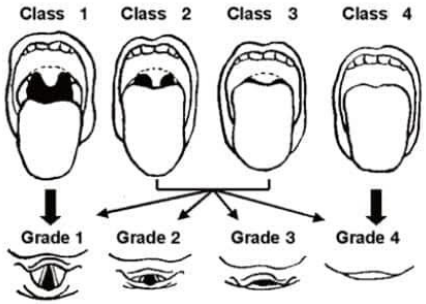
Obstructive Sleep Apnea

- Breathing disordered caused by narrowing of the upper airways during sleep, which ultimately impacts normal ventilation

- Associated with several significant health consequences
  - Atrial fibrillation
  - Pulmonary hypertension
  - CAD
  - Heart failure
- Resistant hypertension (≥3 medications and not at goal, or ≥4 medications and at goal)
  - Reduced quality of life due to daytime fatigue
  - Increased risk of occupational injuries and MVAs

CAD = coronary artery disease; MVAs = motor vehicle accidents.
Kapur VK, et al. *J Clin Sleep Med.* 2017;13(3):479-504.

Important Additional Tools



- Modified Mallampati score
  - **Class 1**: the tonsils, uvula, and soft and hard palates are visible
  - **Class 2**: the soft palate and at least part of the uvula are visible
  - **Class 3**: the soft palate is visible
  - **Class 4**: nothing beyond the tongue is visible

Class 3 and 4: higher risk of OSA and greater risk of severe disease
  - Risks of OSA double with each increase in class

- Neck circumference
  - Higher the circumference, greater the risk of OSA
  - Women: typically <15 inches (38 cm); **increased risk**: ≥15.5 inches (39 cm)
  - Men: typically <17 inches (43 cm); **increased risk**: ≥17 inches (43 cm)

Ikpeze T. SleepApnea.org. October 27, 2025. Accessed September 21, 2026. https://www.sleepapnea.org/diagnosis/mallampati-score. Chang SJ, et al. *Korean J Pediatr*. 2010;53(10):863-871.

Validated Tools





Epworth Sleepiness Scale

0-7 normal;
8-9 mild sleepiness;
10-15 moderate;
16-24 severe

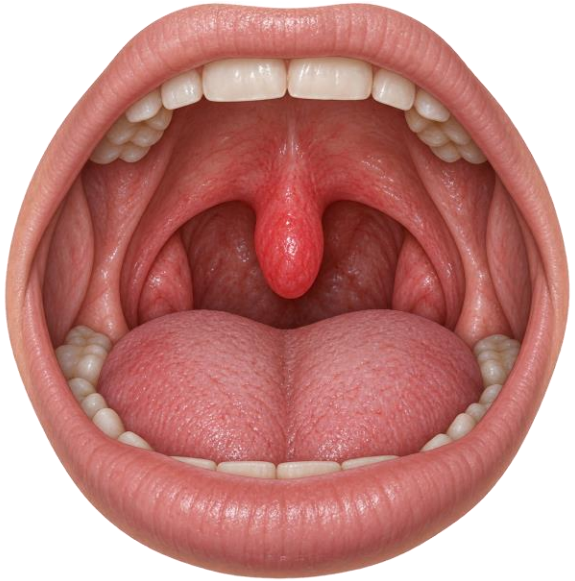
STOP-Bang Score (preferred tool)

0-2 low risk of OSA
3-4 intermediate risk (investigate)
5-8 high risk for moderate-severe OSA

Ikpeze T. SleepApnea.org. October 27, 2025. Accessed September 21, 2026. https://www.sleepapnea.org/diagnosis/mallampati-score. Pacheco D. SleepFoundation.org. June 11, 2026. Accessed September 21, 2026. https://www.sleepfoundation.org/sleep-apnea/stop-bang-score.

Primary Care: Clinical Pearl

- Recurrent uvulitis
  - Beefy / edematous uvula
  - Recurrent sore throats
  - Often seen with obstructive sleep apnea



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Diagnosis

- **History and physical examination create suspicion**
  - Snoring, gasping, witnessed apnea, daytime sleepiness, or frequent choking at night
  - Obesity, abnormal Mallampati score, cardiac risk factors

- **Home sleep apnea test (HSAT)**
  - Uncomplicated adults with high probability of moderate-severe OSA
  - Must be interpreted by a sleep clinician
  - If negative or technically inadequate, proceed to PSG

- **Polysomnography (PSG) – gold standard**
  - Indicated when
    - Comorbidities (CHF, COPD, neuromuscular disease, opioid use, suspected CSA)
    - Complex sleep complaints
    - Negative/inconclusive HSAT despite high suspicion

CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; CSA = central sleep apnea; HSAT = home sleep apnea test.

Kapur VK, et al. *J Clin Sleep Med.* 2017;13(3):479-504.

Interpreting a Sleep Study: What Do the Results Mean?

- **Apnea-hypopnea index (AHI)**
  - **Normal:** AHI <5
  - **Mild OSA:** AHI 5-14
  - **Moderate OSA:** AHI 15-29
  - **Severe OSA:** AHI ≥30

- **Oxygen saturation metrics**
  - Normal: 90% or higher
  - Minimum SpO2 (lowest recorded): <88-90% concerning
  - Mean SpO2 (average O2 while sleeping)
  - T90 (time spent below 90%)
  - ODI (Oxygen Desaturation Index): number of 3-4% drops in oxygen per hour

Kapur VK, et al. *J Clin Sleep Med.* 2017;13(3):479-504.

Interpreting a Sleep Study: What Do the Results Mean?

- HSAT additional data
  - **Supine vs non-supine AHI** – OSA frequently worsens while sleeping on back
  - **Snoring metrics** – intensity and frequency of snoring
  - **Heart rate trends** – tachycardia during desaturations

- **Respiratory Event Index**
  - Respiratory events per hour of recording time
  - Some home sleep tests will report this out instead of AHI
  - However, this can underestimate the severity of the condition

Kapur VK, et al. *J Clin Sleep Med.* 2017;13(3):479-504.

Case Study (Continued)

- Patient undergoes HSAT, which shows severe obstructive sleep apnea
- Discussed options with patient, who has elected for CPAP option
- Would like to consider tirzepatide in the future, but it is not covered by her insurance
- Patient is referred to sleep specialist for further evaluation
- Primary care clinician counsels patient regarding
  - Reducing alcohol
  - Weight loss and exercise
  - Sleep hygiene strategies
    - Cool bedroom
    - Consistent bedtime
    - Quiet room
    - Minimize distractions
    - Limit electronic use
  - Positional therapy



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Evolving OSA Treatment Options: CPAP and Beyond

Saurav Luthra, MD

PAP Therapy: What it Delivers and How it's Chosen

- Early, structured follow-up predicts long-term use; AASM does not mandate an exact window; a common approach pairs an early check around 1-2 weeks with an in-person visit around 4-6 weeks
- Dose-response data: outcomes improve past the minimum, with thresholds around 6 hrs/night for objective sleepiness and 7.5 hrs/night for daily functioning

Modality	How it Works	Best Fit
CPAP	One fixed pressure all night	Most patients; simple and effective
APAP	Auto-adjusts pressure breath-to-breath within a range	Pressure needs that vary across the night
BPAP (bilevel)	Separate inspiratory and expiratory pressures	High fixed-pressure intolerance or coexisting hypoventilation

AASM = American Academy of Sleep Medicine; CPAP = continuous PAP; APAP = automatic PAP; BPAP = bilevel PAP.

Patil SP, et al. *J Clin Sleep Med.* 2019;15(2):335-343. Weaver TE, et al. *Sleep.* 2007;30(6):711-719.

Common PAP Concerns: Ask Early, Fix Specifically

- “The mask leaks or feels claustrophobic”
  - Refit the interface; try nasal vs full-face; check for mouth leak
- “The pressure feels too strong”
  - Pull download data to confirm the pressure is actually elevated; adjust ramp, humidification, or nasal patency, or consider an APAP or bilevel evaluation if it truly is high
- “My mouth, nose, or sinuses feel dry or irritated”
  - Optimize heated humidification; treat nasal congestion or sinus issues that are amplifying the dryness
- “My stomach feels bloated” (aerophagia)
  - Usually swallowed air at higher pressures; try a lower ramp, review pressure settings, and consider positional changes before assuming intolerance
- “I take it off after a few hours”
  - Normalize the adjustment period; structured troubleshooting; reassess objective data instead of waiting for the annual visit

Patil SP, et al. *J Clin Sleep Med.* 2019;15(2):335-343.

PAP Adherence: A Primary Care Opportunity

- Know the benchmark before calling a patient “nonadherent”: adequate use is defined as at least 4 hours/night on at least 70% of nights over a 30-day window (Medicare/AASM definition)
- Most nonadherence emerges early; checking in within the first 1-2 weeks, not at the annual visit, is the single highest-yield intervention
- A 2024 RCT found that once structured early follow-up is already in place, adding remote telemonitoring did not further improve adherence or outcomes at 10 weeks or 1 year; the follow-up itself is what matters, not necessarily the technology
- Persistent symptoms despite reported use warrant a look for residual OSA, insufficient sleep, insomnia, medication effects, or an unrecognized second sleep disorder

RCT = randomized controlled trial.
van der Kleij S, et al. *Sleep Breath*. 2024;28(4):1715-1721.

Behavioral Interventions as Adjunctive Therapy

- Weight management, regular activity, reduced evening alcohol, and avoiding sedating medications support OSA care and cardiometabolic risk, but don't replace effective therapy in clinically significant disease

- "Sleep hygiene" treats neither OSA nor chronic insomnia; keep these framed as separate problems for your patients

- Comorbid insomnia and OSA (COMISA) is common and changes the plan: unrecognized insomnia blunts PAP adherence and leaves residual sleepiness; treating both together, typically CBT-I introduced before or alongside PAP, outperforms treating either alone

- Reassess OSA objectively after any substantial weight change or major treatment shift; don't assume resolution

CBT-I = cognitive behavioral therapy for insomnia.

Araghi MH, et al. *Sleep*. 2013;36(10):1553-1562. Zhang Y, et al. *Sleep Med Rev*. 2026;88:102301. Cruz MME. *Med Clin North Am*. 2026;110(5):707-720.

Weight Management and Tirzepatide

- December 2024: FDA approved tirzepatide as the first medication for moderate-to-severe OSA with obesity, alongside diet and activity changes; the same molecule for type 2 diabetes does not carry this OSA indication

- SURMOUNT-OSA (2 phase 3 RCTs): AHI fell 20.0 events/hr vs placebo in PAP-naïve patients, and 23.8 events/hr vs placebo in patients already on PAP (both *P*<.001), with significant gains in hypoxic burden, hs-CRP, systolic BP, and patient-reported sleep impairment

- Can be used with or without concurrent PAP; weight loss reduces severity but doesn't guarantee resolution; repeat testing before discontinuing other therapy

- Most adverse events were GI-related, mild-to-moderate

hsCRP = high-sensitivity C-reactive protein; GI = gastrointestinal.
Malhotra A, et al. *N Engl J Med*. 2024;391(13):1193-1205.

Positional Therapy, Exercise, and Alcohol Reduction

- These are adjuncts or phenotype-specific options after objective testing, not substitutes for first-line therapy in unselected patients

Positional Therapy	Exercise Training	Alcohol Reduction
For clearly positional OSA (events concentrated supine); vibrotactile devices reduce supine sleep time and improve AHI	Improves fitness, sleepiness, and OSA severity through mechanisms beyond weight loss alone	Alcohol relaxes upper-airway muscles and worsens AHI, especially near bedtime

AlQarni AS, et al. *Thorax*. 2023;78(11):1126-1134.

When CPAP Is Not Enough: Failure vs Intolerance vs Nonacceptance

PAP failure:
persistent events/symptoms despite adequate use and correctly titrated settings

PAP intolerance:
can't sustain consistent use despite reasonable troubleshooting

PAP nonacceptance:
patient declines PAP after a fully informed discussion

Before escalating: confirm the diagnosis, pull download data, and address every modifiable barrier first

- A single-night sleep study (HSAT or PSG) has real night-to-night variability; a negative or borderline result doesn't always settle the question if clinical suspicion stays high (multi-night home testing is emerging but not yet standard)

Kent D, et al. *J Clin Sleep Med*. 2021;17(12):2499-2505. Manners J, et al. *Sleep Adv*. 2026;7(1):zpag023.

Oral Appliance Therapy

- Custom, titratable mandibular advancement devices, fitted and followed by a qualified dental sleep specialist, are the guideline-endorsed approach, not an over-the-counter “boil and bite” device
- Best supported for mild-to-moderate OSA; select severe patients may benefit when PAP isn’t feasible
- Confirm efficacy with follow-up sleep testing after fitting; symptom improvement alone doesn’t confirm adequate control

Bottom line: mild-to-moderate OSA, custom-fitted, follow-up sleep testing required to confirm control

Ramar K, et al. *J Clin Sleep Med*. 2015;11(7):773-827.

Surgical Approaches: What to Know Before You Refer

- Surgery is anatomy-driven, not a single intervention; options range from nasal surgery and tonsillectomy to palatal, tongue-base, and jaw-advancement procedures, depending on where the airway collapses
- You don’t need to know the technique; drug-induced sleep endoscopy at the surgical/ENT level determines which procedure fits, after referral, not in primary care

Referral trigger: PAP-intolerant or PAP-declining adults with BMI <40 are guideline-appropriate for a sleep surgery evaluation

ENT = ear, nose, and throat.

Kent D, et al. *J Clin Sleep Med*. 2021;17(12):2499-2505.

Hypoglossal Nerve Stimulation: Mechanism and Patient Selection

- HGNS activates the genioglossus muscle in sync with breathing to keep the tongue from collapsing into the airway during sleep
- Standard system: implanted pulse generator, stimulation lead, respiratory sensing lead, and patient remote, activated nightly by the patient
- What you can screen for before referring: AHI in range, BMI, and a genuine trial of PAP; DISE and surgical risk are determined by the sleep surgery team

Criterion	FDA-Labeled Threshold
AHI	15-100
BMI	<40
DISE finding	No complete concentric palatal collapse
PAP history	Documented failure or intolerance

DISE = drug-induced sleep endoscopy.
FDA. June 8, 2023. Accessed September 21, 2026.
https://www.accessdata.fda.gov/cdrh_docs/pdf13/P130008S090b.pdf.

HGNS Outcomes: Efficacy, Safety, and Quality of Life

74%
3-yr surgical success (STAR)

75%
5-yr AHI responder rate (STAR)

20.9
events/hr AHI drop, real-world (ADHERE)

76.7% vs 29.5%
sham-controlled responder rate

- STAR 5-year data also showed Epworth sleepiness normalization rising from 33% to 78%, and quality-of-life normalization rising from 15% to 67%; serious device-related events occurred in 6%, mostly lead/device adjustments
- The ADHERE registry (n=1,849) confirmed similar real-world gains, with mean nightly use of 5.6 hours and serious adverse events in 2.3%
- Bottom line for your patients: effective for carefully selected, PAP-intolerant patients; not a universal PAP replacement

Woodson BT, et al. *Otolaryngol Head Neck Surg*. 2016;154(1):181-188. Woodson BT, et al. *Otolaryngol Head Neck Surg*. 2018;159(1):194-202. Suurna MV, et al. *Laryngoscope*. 2021;131(11):2616-2624. Heiser C, et al. *J Clin Med*. 2021;10(13):2880.

Emerging Neurostimulation and Device Therapies

- Bilateral HGNS: FDA-approved August 2025 for AHI 15-65; leadless, externally powered, no chest-wall generator; pivotal DREAM trial: 63.5% AHI responder rate, 70.8% median AHI reduction, 82% reached AHI <15
- Prescription nasal EPAP device for mild-to-moderate OSA: not an over-the-counter product; requires a prescription and appropriate patient selection
- Daytime tongue neuromuscular stimulation via mouthpiece, 20 min/day for 6 weeks, then weekly maintenance: FDA-authorized (De Novo) for snoring and mild OSA (AHI <15)
- None of these substitute for PAP, OAT, surgery, or unilateral HGNS in patients who qualify for those; they fill specific gaps

FDA. August 8, 2025. Accessed September 21, 2026. https://www.accessdata.fda.gov/cdrh_docs/pdf24/P240024B.pdf. FDA. March 24, 2020. Accessed September 21, 2026. https://www.accessdata.fda.gov/cdrh_docs/reviews/DEN200018.pdf. Baptista PM, et al. *J Clin Med*. 2021;10(9):1883.

Emerging Pharmacotherapy Pipeline

- AD109 (aroxybutynin/atomoxetine): targets neuromuscular tone, not anatomy; phase 3 SynAIRgy trial (n=646, PAP-intolerant/refusing): AHI improved 4.0 events/hr vs placebo (44% vs 18% reduction, *P*=.001); about 1 in 5 discontinued for dry mouth, nausea, insomnia, or urinary hesitancy; not yet FDA-approved
- Sulthiame: a carbonic anhydrase inhibitor under investigation; early trials show it reduces AHI and related respiratory-control biomarkers through a mechanism distinct from PAP or neuromuscular agents; not yet FDA-approved
- Orexin agonists (eg, danavorexton): target residual daytime sleepiness in patients already adequately treated with PAP, a different problem than reducing AHI, and an important distinction for patient counseling
- Watch this space: oral GLP-1/incretin agents (eg, orforglipron) are now in phase 3 trials for OSA with obesity, following tirzepatide's approval

GLP-1 = glucagon-like peptide-1.

Strollo Jr PJ, et al. *Am J Respir Crit Care Med*. 2026;212(7):1569-1584. Bogan RK, et al. *Sleep Med*. 2023;107:229-235.

Referral Pathways and Long-Term Coordination

Sleep Medicine	Dental Sleep Medicine	ENT / Sleep Surgery
Uncertain diagnosis, discordant PAP data or symptoms, suspected central events, or alternative-therapy selection	Best for mild OSA without other complicating factors; typically, better after sleep medicine has confirmed diagnosis and severity	Anatomic assessment, surgical options, or HGNS candidacy in PAP-intolerant patients

Primary care coordinates the referrals and keeps the plan current

- Primary care's ongoing role: reinforce adherence, manage cardiometabolic comorbidities, track weight, review meds and alcohol use, and stay the coordination hub as the patient moves across specialists

Kent D, et al. *J Clin Sleep Med.* 2021;17(12):2499-2505. Ramar K, et al. *J Clin Sleep Med.* 2015;11(7):773-827.

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Case Study (Continued)

- 6 months later
  - Has stopped using CPAP; cannot get used to it, and feels it is making things worse
  - Wants to know about other options?
    - Dental device
    - Surgical options

- Escalation and outcome
  - Sleep medicine referral for CPAP intolerance; pressure settings reviewed and adjusted
  - Mask still poorly tolerated; concomitant insomnia identified
  - Referred for CBT-I and to ENT for HGNS evaluation; HGNS implanted
  - Follow-up: AHI 9/hr, 6.5 hrs/night usage, much more rested

Key Learning Points



- PAP is highly effective, but early, specific troubleshooting determines whether patients stay on it
- Treatment should match the patient's phenotype, anatomy, comorbidities, and preferences; not a one-size-fits-all algorithm
- CPAP intolerance is a trigger for reassessment and an evidence-based alternative discussion, not for abandoning treatment
- Primary care's job: identify barriers early, coordinate the right referral, and keep the plan current as new options and evidence emerge



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Patient-Centered OSA Management and Shared Decision-Making

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Barriers to Effective, Patient-Centered Care

- Practical barriers: short visit times, insurance and cost barriers to alternatives, and limited access to sleep medicine, dental sleep, or ENT specialists in many communities
- Patient-level barriers: unaddressed side effects, claustrophobia or body-image concerns, bed-partner dynamics, and unrecognized insomnia or mental health comorbidity
- Clinician-level barriers: defaulting to “try harder with CPAP” instead of exploring alternatives, and not recognizing intolerance as distinct from simple nonadherence
- The fix starts with naming the barrier out loud with the patient, not assuming it away

Patil SP, et al. *J Clin Sleep Med.* 2019;15(2):335-343.

Differentiating Modifiable PAP Adherence Barriers from Intolerance

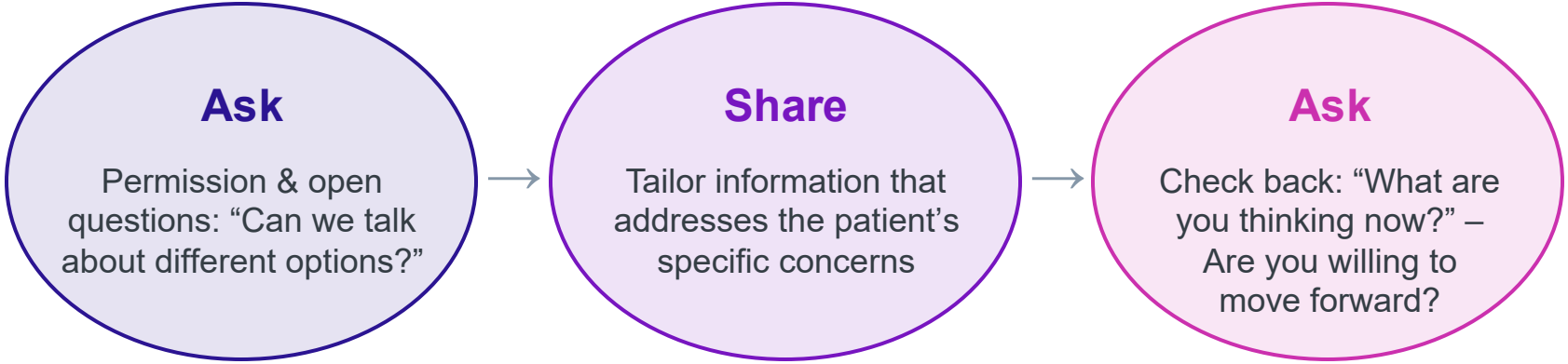
- Modifiable barriers respond to troubleshooting: mask fit, pressure settings, humidification, nasal obstruction, ramp settings, and education gaps typically improve within days to weeks of targeted fixes

- True intolerance looks different: claustrophobia or anxiety that doesn't respond to desensitization, persistent skin breakdown, unresolved aerophagia, or a patient who has had a genuine, well-supported trial and still cannot use the device

- Practical test: has the patient had structured troubleshooting, refit, pressure review, humidification, coaching, for at least 2-4 weeks? If not, it's premature to call it intolerance

- Getting this distinction right determines the next step: more troubleshooting, or a referral for an oral appliance, surgery, or HGNS evaluation

The Best Intervention Is the One the Patient Is Willing to Do



Motivational interviewing and shared decision-making is evidence-based and fits a brief primary-care visit

Evolving Treatments over Time

- This is not an all-or-none condition
- Treatments can be augmented with lifestyle modification, or can be modified in the future should the patient become less adherent with current treatment

Key Learning Points



- Screening for sleep disorders is essential in primary care
- Sleep apnea is associated with significant adverse consequences
- There is a toolbox full of treatments for this condition, and CPAP is not the only option
- Tailoring treatment to the patient and their desire is essential