A. Screening for OSA risk

If the patient meets **2 or more** of the following criteria, a STOP-BANG questionnaire should be done

- Snoring
- Witnessed apnoea
- Choking sensation which causes patient to wake from sleep
- Two or more anti-hypertensives
- BMI > 30

Or any patient in whom there is a suspicion of SDB based on clinical judgement.

***Further simple investigations include**

CBC

Renal function

HbA1c

Venous bicarbonate. ≥27 should prompt consideration of obesity hypoventilation syndrome (OHS)

ECG – looking for arrhythmias or right heart strain

S	When sleeping: do you **SNORE** loud enough to be heard through closed doors or does your partner elbow you for snoring
T	During the day: Do you often feel **TIRED**, sleepy, fatigued or fall asleep while driving or talking to someone
O	When you are asleep: Has anyone **OBSERVED** you stop breathing, choke or gasp
P	Do you have, or are you being treated for high BLOOD **PRESSURE**
B	Is your **BMI** greater than 35
A	Are you older than 50 years of **AGE**
N	Is your **NECK** measurement bigger than 40cm
G	**GENDER** – are you male

A STOP-BANG score of ≥5* indicates increased probability of moderate to severe OSA – **go to step B**

B. Assessment of perioperative OSA (pOSAr) risk score to guide perioperative care

Patient risk factors

Procedural risk factors

Add the **single** greatest patient risk factor score, to the **single** greatest procedural risk factor score.

If > 3 patient is at **elevated risk** of perioperative events – **go to step C**

OSA severity*		Comorbidities
Severe OSA or OHS	3	Severe cardiorespiratory comorbidity
Moderate OSA	2	
Mild OSA	1	

***Undiagnosed OSA:** If STOP-BANG ≥5, assume MODERATE OSA unless clinical judgement suggests otherwise.

***Diagnosed OSA:** Grade according to AHI (5-15 mild, 15-30 moderate, >30 severe) If compliant with CPAP severity can be downgraded 1 point.

Surgery & anaesthesia risk		Post op opioid requirement
Major surgery under GA	3	IV, neuraxial or high dose oral opioids
Peripheral surgery under GA	2	
Peripheral surgery under LA/RA with sedation	1	Low dose oral opioid morphine <10mg q4h/codeine <60mg q4h
Peripheral surgery without sedation	0	No opioid

C. Recommended perioperative care in patients with elevated perioperative OSA risk (pOSAr)

Calculate **risk score** from chart A. If >3 the following elements beyond standard care should be applied.

pOSAr	Postoperative Risk	Anaesthesia*	PACU	Postoperative care
5-6	**Significantly increased**	Anticipate difficult airway: intubation and extubation Local/Regional anaesthesia where possible Avoid or minimise long acting opioids and sedatives	Anaesthetist led analgesia plan Consider PAP in PACU and inform staff early if required. Modified PACU discharge criteria ** Apply oximetry in PACU prior to ward transfer. Set alarm limit (default >90%)	OSA monitored bed† Airvo2 overnight if no CPAP Prescribe O2 to SpO2 target overnight.
4	**Increased**		Standard Care	Ward
2-3	**Not increased**		Standard Care	Home

*see full guideline for comprehensive list

†continuous alarmed oximetry, hourly observations (SpO2, RR, pain and sedation scores) 1st night post op

pOSAr ≥5 must be documented on cortex at the earliest opportunity to allow appropriate ward staffing.

The following conditions in PACU increase pOSAr by one point

- Evidence of upper airway or ventilatory compromise
  - Loud snoring
  - Apnoea > 10 seconds
  - Recurrent bradypnoea <8 breaths/min
  - Recurrent hypoxaemia < 90%
  - Hypercapnia $PaCO_2$ >50
- Pain-sedation mismatch

**** Any patient with a pOSAr ≥5 should remain in PACU postoperatively until the following criteria are met**

- 60min after PACU discharge criteria are met
- Until spinal anaesthesia has regressed below the surgical incision