CPAP May Lower Stroke Risk for Apnea Patients

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SALT LAKE CITY — Studies consistently show a link between obstructive sleep apnea and stroke, although the mechanisms by which sleep apnea is an independent risk factor for stroke and death.

The cumulative data in regard to sleep apnea and stroke suggest that patients with sleep apnea should be treated with continuous positive airway pressure (CPAP) or other measures. Dr. Vahid Mohsenin said at the annual meeting of the Associated Professional Sleep Societies (APSS) the evidence supporting the efficacy of CPAP is overwhelming—with good compliance, efficacy is about 90%—and the expectation is that treatment will reduce the risk of stroke, although research is needed to confirm this, said Dr. Mohsenin, professor of medicine and director of the Yale Center for Sleep Medicine, Yale University, New Haven, Conn.

In fact, a guideline from the American Heart Association/American Stroke Association Stroke Council for the primary prevention of ischemic stroke was updated earlier this year to incorporate new information about stroke prevention, including data on the role of sleep-disordered breathing in stroke. The guideline was initially published in 2001.

Although the guideline stops short of making specific treatment recommendations, and instead states that treatment should be individualized, it does address patient evaluation. It is reasonable that patients and their bed partners be questioned about symptoms of sleep-disordered breathing and that appropriate patients be referred to a sleep specialist for further evaluation, the guideline states.

Insomnia is particularly important if the patient has drug-resistant hypertension or certain risk factors for stroke, such as abdominal obesity and hypertension (Stroke 2006;37:1583-633).

In making its recommendations, the AHA/ASA Stroke Council cited data from several studies, including a case-control study of 181 patients, which showed a significant association between excessive daytime sleepiness and stroke (hazard ratio of 1.91) after adjustment for numerous factors, including age, sex, race, smoking status, alcohol consumption, body mass index, diabetes, hyperlipidemia, atrial fibrillation, and hypertension.

A trend analysis also showed a significant dose-response relationship between sleep apnea severity at baseline and development of a composite end point of stroke or death from any cause (N. Engl. J. Med. 2005;353:2034-41).

While randomized controlled trials are needed to firmly establish a causal link between sleep apnea and stroke—to “put the last nail in the coffin and say, ‘OK, sleep apnea is indeed a cause of stroke in a high-risk patient population’,” as Dr. Mohsenin put it, the findings increasingly suggest this is the case. Also, sleep apnea occurs as commonly in transient ischemic attack as it does in stroke, further underscoring the need for sleep apnea treatment in affected patients, he noted.

Additionally, a number of studies have shown that sleep apnea is associated with worse functional outcomes in stroke patients, Dr. Mohsenin said.

Patients with stroke who have sleep apnea have been shown to have more delirium, depression, impaired functional capacity, longer rehabilitation time, and longer hospitalization, he said.

“Sleep apnea does affect the outcome of stroke,” he said, noting that in some studies the functional outcomes have been shown to take 12 months.

Patients who have had a stroke should be evaluated for sleep disordered breathing, he advised.

In addition, patients using long-term CPAP should be reevaluated for residual symptoms of the disorder to ensure adequate treatment and compliance, he added.

The probability of diagnosing a sleep disorder increases among patients who complain of insomnia (Sleep Med. 2005;6:549-53). In this study, a survey of 200 general hospital patients indicated 57% reported insomnia and 50% reported at least one psychiatric disorder. Insomnia can make sleep apnea worse, except ramelteon or the tricyclic antidepressants.

Ramelteon (Rozerem, Takeda Pharmaceuticals) targets the melatonin receptors MT1 and MT2. The agent is approximately 10 times more potent than melatonin. Other approved drugs promote sleep by increasing gamma-aminobutyric acid (GABA), which is normally released by the suprachiasmatic nucleus in the brain.

“Ramelteon is a very interesting drug. It is the first on the market for sleep that does not work on the GABA system,” Dr. Wa- lace B. Mendelson said. The melatonin receptor agonist is a very potent sedative,起到acting drug with a half-life of 1 to 2 hours. “It is very potent for helping people fall asleep but not as effective for those who wake up early. So it’s for a subset of patients.”

The Food and Drug Administration approved ramelteon for treatment of insomnia characterized by difficulty with sleep onset. “It is not a DEA classified substance, only a hypnotic without potential for dependence,” said Dr. Mendelson, psychopharmacology consultant for many pharmaceutical companies, including Takeda Pharmaceuticals North America Inc.

A delay to peak therapeutic effect is another distinction of ramelteon, compared with benzodiazepines and newer, nonbenzodiazepine GABA agonists such as zolpidem (Ambien, Sanofi-Aventis) or eszopiclone (Lunesta, Sepracor). “It can take up to a week for full effect, so caution patients that they may not feel tired right away,” said Dr. Mendelson, who is also a consultant, an adviser, and on the speakers’ bureau for Sanofi-Aventis and Sepracor Inc.

People with shift-work sleep disorder can experience excessive daytime sleepiness because their body rhythm stays the same but the world changes around them, Dr. Mendelson said. “No one knows why some people are more susceptible to this, except it is harder to adapt to night-time shift work as you get older.”

Pharmacotherapy with a sleep aid might be sufficient for shift worker who complains only of sleepiness or trouble going off to sleep, Dr. Mendelson said. However, “if they are having trouble with both sleep and waking, it might make sense to try to help them shift to the new time. One way is to use melatonin.” Enogenous melatonin can shift circadian rhythms. Melatonin taken in the evening can shift a person’s circadian rhythm earlier while melatonin in the morning can shift it later, he said.

“I have a real issue with the quality and standardization of melatonin. Here is why I prefer a drug like Rozerem,” Dr. Mendelson said. “Rozerem is not indicated for this, but some research indicates it can shift circadian rhythm with off-label use similar to melatonin.”

Another option for circadian rhythm adjustment is bright light therapy: “I like bright light therapy better,” Dr. Mendelson said. “It works— but it works the opposite.” In the morning, the therapy pushes circadian rhythm phase earlier, and at night, it pushes it later.

Insomnia rarely occurs alone, Dr. Mendelson said. “About 80% of insomnia patients you see have some other disorder. The old name was secondary insomnia. US sleep guys are now calling this co-morbid insomnia.”

Ramelteon might be an appropriate choice for patients with sleep apnea, Dr. Mendelson said. A significant minority of sleep apnea will present with insomnia as the primary complaint. “We need to carefully diagnose because most of the agents we prescribe for insomnia can make sleep apnea worse, except ramelteon or the tricyclic antidepressants.”