Parasomnias Require Thorough Evaluations

Tips for Making Bedrooms Safer

- Removing weapons such as guns and knives from the bedroom is a given when people present with parasomnias that put them and their bed partners in harm’s way.

- Dr. Teofilo L. Lee-Chiong Jr. said in an interview that he knows of no cases in which these weapons have caused injury during a parasomnia. Other, less obvious changes are at least as important, he said, offering the following recommendations for a safe bedroom:
  - Keep the floor very clean. There should be no object on the floor that could cause a person to slide or trip.
  - Make sure nothing breakable is within reach of the person. Glasses and mirrors might have to be removed from the bedroom.
  - Ensure sharp objects, including pens.
  - Pad sharp edges of bedroom furniture.
  - Close the bathroom door—a barrier, if necessary—to keep out a person having a parasomnia. The floor is harder, and fixtures can create a dangerous obstacle course for a person who is not fully awake.
  - Sleep on the first floor if possible. Stairs and upper story windows are hazards.
  - Use heavy curtains to prevent cuts to the hand and forearm, if a person strikes out and breaks the glass.

Obstructive Sleep Apnea Hypopnea Raises Risk of Crashes

Patients with obstructive sleep apnea hypopnea had a greater rate of motor vehicle crashes than did matched controls, and they were three times more likely to be involved in crashes involving personal injury, according to researchers in British Columbia.

“Our data indicate that the increased risk of motor vehicle crash occurs at all levels of OSAH severity,” Dr. Alan T. Mulgrew, of the University of British Columbia, Vancouver, and his colleagues wrote in the January 30 (Epub) J Clin Psychiatry. “Our data indicate that the increased risk of motor vehicle crash occurs at all levels of OSAH severity,” Dr. Alan T. Mulgrew, of the University of British Columbia, Vancouver, and his colleagues wrote in the January 30 (Epub) J Clin Psychiatry. “Our data indicate that the increased risk of motor vehicle crash occurs at all levels of OSAH severity,” Dr. Alan T. Mulgrew, of the University of British Columbia, Vancouver, and his colleagues wrote in the January 30 (Epub) J Clin Psychiatry.

The study involved 783 adult patients who were referred for overnight polysomnography for suspected sleep-disordered breathing. Patients were excluded if they had symptoms of another sleep disorder known to cause daytime sleepiness (periodic limb movement disorder), or if they had another serious medical condition or overt psychiatric disease. They were also excluded if they were already being treated for OSAH.

Overnight polysomnography was performed using conventional instrumentation, and analysis was performed according to the American Academy of Sleep Medicine’s recommendations on syndrome definition and measurement techniques. Patients completed a number of surveys on the night of their sleep study, including the Epworth Sleepiness Scale. All motorists in British Columbia are insured by a single insurance corporation: the Insurance Corporation of British Columbia (ICBC). Objective crash data for patients—including crash severity type—was obtained for 3 years prior to the sleep study.

All patients were matched with an individual control from the ICBC database based on age, gender, type of license, driving experience, and postal region, Dr. Mulgrew said.

Patients were categorized by OSAH severity based on the apnea hypopnea index (AHI): normal polysomnography (AHI of 5 or fewer events per hour), mild OSAH (AHI greater than 5 and up to 15), moderate OSAH (AHI greater than 15 and 30 events per hour), and severe OSAH (AHI of 30 or more per hour).

Most patients (71%) were men, and the average age was 50 years. The average AHI was 22.6 events per hour, and the average Epworth Sleepiness Scale score was 10. The mean body mass index (BMI) was 31.8 kg/m². The average distance driven each week was 236 km (147 miles).

In terms of OSAH severity, 18% of patients had normal polysomnography, 30% had mild OSAH, 26% had moderate OSAH, and 26% had severe OSAH.

In all, there were 374 crashes, of which 231 (63%) happened to patients. In the patient group, 94 of 251 crashes caused minor property damage, 83 crashes caused major property damage, and 74 crashes caused injuries. This compared with 48, 52, and 23 in the control group.

When compared with controls, patients with OSAH had a significantly increased rate of motor vehicle crashes, with relative risks ranging from 1.9 to 2.6. In comparison, patients without OSAH (AHI 0–5 events per hour) were at lower risk of motor vehicle crashes than were patients with OSAH.

The presence of OSAH was linked with a 3.0– to 4.8-fold increase in the rate of more severe motor vehicle crashes.

Within the patient group, there appeared to be a dose-response relationship between OSAH severity and the rate of motor vehicle crashes involving personal injury. In patients with an AHI of 0–5, motor vehicle crashes involving personal injury accounted for 25% of crashes, compared with 37% in those with an AHI greater than 30.

Compared with patients with an AHI of 0–5, patients with severe OSAH were 6.1 times more likely to be in a crash involving personal injury, the researchers reported.