Comparing the criteria that we used with the 2007 manual, there is no difference regarding the definition of apnea. However, there are some episode of hypopnea was defined as a reduction of nasal air flow ≥ 50% with a drop in pulse oxygen saturation ≥ 3% which last more than 10 s. In the 2007 manual, either a drop of pulse oxygen saturation ≥ 4% with a decrease of nasal air flow ≥ 30% or a drop of pulse oxygen saturation ≥ 3% with a decrease of nasal air flow ≥ 50% which last ≥ 10 s will be defined as 1 episode of hypopnea. The definition in the 2007 manual for hypopnea is broader than the definition we used for our study.

In our 177 study patients for validating the STOP questionnaire, the severity classification based on the AHI and number of patients in each group can be found on page 817: 

\[ \text{AHI} \leq 5.55, \text{AHI} > 5 \text{ and} \leq 15.52, \text{AHI} > 15 \text{ and} \leq 30.31, \text{AHI} > 30.39. \]

When doing the analysis of predictive parameters, we had to classify patients into either smaller or bigger than the cutoff value and use this classification to evaluate the screening tools. That is the reason why we combined patients with moderate and severe obstructive sleep apnea (OSA) in one group to evaluate the capacity of screening tools to identify this group of patients.

We agree with Dr. Overdyk and colleagues that the duration of oxygen desaturation, apnea and hypopnea, rate of desaturation, adequacy of ventilation recovery, and level and stability of the arousal threshold are very important factors in evaluating the severity of OSA, especially as assessing the potential to trigger other perioperative adverse events. However, there is no agreement yet on how to incorporate these factors into the severity classification of OSA patients.

Our main focus was to develop and validate a concise and easy-to-use screening tool for preoperative clinics. We agree with Dr. Overdyk and colleagues that the STOP questionnaire is a practical step forward in identifying patients with OSA, and it bears the same limitations as other questionnaires. To more accurately stratify the perioperative risk, guide postoperative monitoring, and predict outcome, we need to combine the score of the STOP questionnaire with the other information such as the need for narcotics and the invasiveness of the surgery.

These points were illustrated in the American Society of Anesthesiologists guideline on the perioperative management of OSA patients. 

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