

ARTP SLEEP: S-NEWS

Dreaming of a better night's sleep

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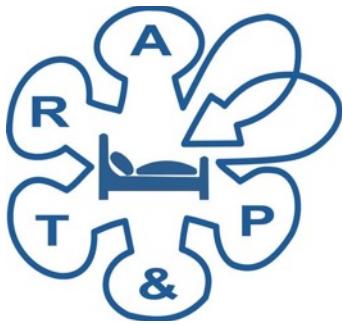
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Send your articles to S-NEWS@artp.org.uk



Editor's Welcome

Welcome to another issue of S-NEWS, and thank you for joining me once again! Another busy year is drawing quickly to a close.

However, we still have some exciting articles for you to read. We have an interesting article from Dr Tim Quinell, Consultant in Respiratory & Sleep Medicine, and President of the British Sleep Society (BSS), on his route into the profession. Gavin is also updating us on new and upcoming research into sleep.

I hope you enjoy reading this edition! Remember to contact me if you have any research or information to post in our next edition in 2019, or if there is anything in particular you would like to see featured. We are always happy to hear from you!

Best wishes,

Alison

S-NEWS@artp.org.uk



Dates for your diary:

- 31st January - 1st February 2019, [ARTP Annual Conference](#), Glasgow.
- 11th - 13th April 2019, [Sleep & Breathing](#), Marseille, France - Abstracts accepted August - October 2018.
- 17th - 22nd May 2019, [ATS Conference](#), Dallas TX.
- 20th - 25th September 2019, [World Sleep](#), Vancouver, Canada.
- 28th September - 2nd October 2019, [ERS Annual Congress](#), Madrid



ARTP Sleep People:

Dr Tim Quinell, Consultant Respiratory & Sleep Disorder Physician

My first glimpse of sleep medicine was as a Senior House Officer working at the London Chest Hospital in 1997. We looked after patients on NIV but also some with OSA. I remember being shown print-outs of desaturations on ancient graph paper and a brief discussion about the scoring system. However my focus was on trying to pass my MRCP physician's exam and, in between working and studying, doing my best to enjoy London life in my 20s.

Fortunately my work life balance was for once spot on. I managed to pass the exam and still find time to get to know my Australian girlfriend well enough to up sticks and travel with her to her native Melbourne when I finished at the Chest.

My first year in Australia was spent as a Care of the Elderly Registrar in a DGH on the South-Eastern outskirts of Melbourne. During that year I learnt 3 things: 1. that I wanted to stay longer; 2. that I greatly preferred Chest Medicine; 3. that I greatly preferred my girlfriend enough to propose.

I managed to get a general medical and respiratory registrar job at the Western Hospital in the Western suburbs of Melbourne- Not easy for a foreign Dr competing with home grown trainees. I bided my time in the first year there, doing the grunt work and only knowing of 'the lab' as somewhere the senior respiratory registrar disappeared to after the ward round while I tackled the ED. By that stage I had discovered that in order to gain further respiratory training in Oz I would have to do another exam, this time the FRACP (Oz equivalent of MRCP), known to those taking it as the 'F-CRAP'. I passed it that year, which allowed me to take over from the senior registrar when he moved on. For the next 2 years I immersed myself in acute respiratory medicine but also came across the sleep lab. This was new, state of the art, and a bit of a coup for my boss to achieve at what was a slightly peripheral teaching hospital. That was when I got to know OSA and the amazingly effective tool that is CPAP. As part of the sleep training curriculum (they're ahead of us in Sleep Down-under) I had to learn to score polysomnograms (PSGs). I found this fascinating, although when I left the Western after 4 years in Oz I was under the mistaken impression that the only appropriate sleep study was a PSG. During my time there I also managed the respiratory HDU, becoming very familiar with the use of acute NIV for COPD. Like for CPAP, I was impressed by how useful it was when used correctly.

After 2 years I had gained a good grounding in General Respiratory Medicine and particularly OSA/PSG/NIV. I was at the stage of my hybridised Anglo-Australian training where I needed to seek further subspecialty experience and consider research. We also had a baby son and it was time to introduce him to the English family. I was pondering my options and realising how disconnected I had become from the UK medical scene when the hospital librarian asked me one day, as the 'Sleep Reg', to have a look at a new sleep textbook they were thinking of

ordering. I skimmed through it, quite liked it and then looked at the author biography on the flyleaf. John Shneerson, Respiratory Support and Sleep Centre (RSSC), Papworth Hospital, Cambridge – Bingo!

I managed to secure an interview to discuss a research fellowship, which I combined with a family holiday. The interview was going well with John Shneerson until his young colleague, Ian Smith (an ARTP favourite), joined us. When he asked me what I wanted to research I answered 'I dunno, I just like sleep' (I could blame jet-lag but I was basically underprepared). However, I somehow managed to convince them I wasn't a complete waste of space. Either that or they were just short staffed, because they offered me a year's clinical post to give me 'a chance to develop your research ideas'. I was in!

In truth I was more than happy with having secured a clinical post. The RSSC has so much to offer. There is a sizeable home NIV service, patients are weaned from invasive ventilation *and* large numbers of patients presenting with a wide range of respiratory and non-respiratory sleep disorders are seen. However when I first saw how patients were assessed for OSA I thought I'd made a mistake. Home oximetry was the entry level test. Having been brought up on PSG I thought I had gone back to the Dark Ages! I soon learned the 'right way' to assess for OSA. The first choice of home oximetry was deliberate. It allows large numbers of patients to be assessed, cheaply, at home. The emphasis is on the clinical context...SYMPTOMS. Even though I joined the RSSC in 2002 our entry level OSA test is still oximetry. This is still deliberate. Research has not yet shown us that not treating non-sleepy (oximetry-negative) OSA is wrong. Of course oximetry has to be good quality and you can't run a sleep service with it alone. It only works if combined with experienced clinical assessment and access to more sophisticated tests when symptoms are compelling but oximetry is negative; so the RSSC also runs a polygraphy service and a fully functioning PSG lab. The other delight I had during my RSSC training was to be introduced to the fascinating world of non-respiratory sleep disorders. This helped me to develop into a well-rounded sleep physician and attain Australian sleep accreditation, and it continues to give me a buzz to this day.

After a brief sojourn in the CF unit I returned to the RSSC as a research fellow and studied genetic and electrophysiological aspects of narcolepsy. My research time finished after a year because the RSSC was getting busier and I was lucky enough to secure a consultancy position in 2004. It has been a blur since then. Completing my MD thesis around a 1 in 3 on call and a growing family (kids = 4) was challenging but I got there with strong mentorship and an even stronger wife.

I have thoroughly enjoyed my clinical work and honing my skills in sleep and ventilation. Other highlights have included running an NIHR trial (TOMADO), leading our sleep lab's British Sleep Society (BSS) accreditation, teaching people about sleep and getting involved in the BSS – an eclectic bunch of sociable sleep enthusiasts. Even though the balance may have tipped a bit so that I feel like I'm in a constant whirlwind of work, work and play, I'm managing to maintain good enough sleep hygiene that should allow me to stay energised for another 15 years...or so.

Do you know someone who may benefit from being an ARTP Sleep member?

"ARTP Sleep" was designed to represent and support all healthcare professionals in the delivery of care, training and development of sleep services.

Who Should Join ARTP Sleep?

ARTP Sleep represents and supports all healthcare professionals in the delivery of care, training and development of sleep physiology measurement and therapeutic services. This includes but is not limited to:

- ATOs and HCAs working in oximetry clinics
- Sleep physiologists and technologists involved in PSG units
 - Sleep and NIV nurses
 - Physiotherapists involved in sleep apnoea services
 - Physicians in sleep medicine
- Orthodontists and maxillofacial technicians who support sleep and snoring clinics
- General Practitioners with an interest in sleep medicine (GPwSI & non-GPwSI)

Registration forms and FAQs can be viewed here

Pillow Talk:

Manufacturers news, new equipment and a bit of gossip!



ResMed UK are pleased to announce that Anna Young has joined the Commercial Team as a new Account Manager covering Scotland. Anna started on the 2nd July 2018 and joins Fenella Connell and Larissa Cottington in looking after our Scottish customers. We have also been joined by Kirsty Hunt our new Business Development Manager, Market Access. Kirsty joined us on 23rd July.

We have now completed our move to new premises; our offices moved from the temporary site at Thomson Ave, Harwell Campus to Quad 1, Becquerel Ave, Harwell Campus in March and our Warehouse and Technical Services team moved to their purpose built facilities just across the road in May. The Warehouse & Technical Services address is Unit 3 Zephyr Building, Eighth St, Harwell Campus, OX11 0RL.

Motor neurone disease (MND) is a progressive and ultimately fatal disease that results in degeneration of the motor neurones, or nerves, in the brain and spinal cord.

GPs and others in the primary care team can make a great difference to the quality of life of people with MND, with timely care, support and symptom management.

These online courses are designed to help you support people affected by MND. Below is a link to the MNDA / RCGP e learning for MND. There are 2 courses. They are easy to register and free of charge, with a CPD certificate.



<https://www.mndassociation.org/forprofessionals/information-for-gps/online-learning-for-gps/>



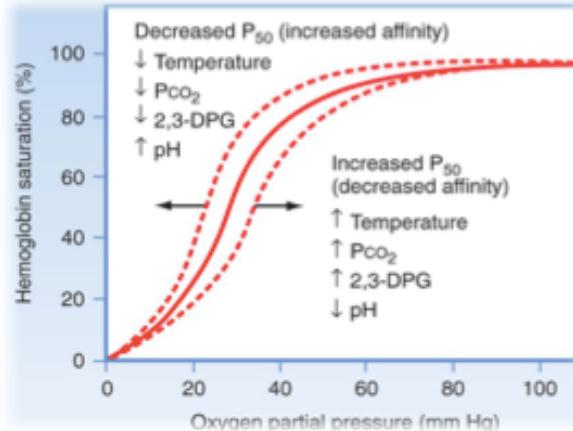
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Research in Sleep:

By Gavin Comber, Respiratory Clinical Scientist

Welcome back to the latest round up of what research has been published in the last six months.

Carter et al (2018) have performed a double blind randomised trial to assess the effects of a one month prescription of Zopiclone on patients with OSA. They found no significant impact on OSA severity, sleepiness or alertness in selected patients.

With technology playing more and more of a role within diagnostic services, Scott et al (2018) investigated the accuracy of a popular iPhone app compared to PSG in estimating sleep onset. It was found that the app is a viable option for estimating sleep onset in the home with the potential to be used in sleep retraining or optimising power naps.

Whilst Adaptive Servo Ventilation (ASV) is not usually recommended in patients with Left Ventricular Ejection Fraction (LVEF) <45%, Oldenburg et al (2018) assessed the outcomes of 550 patients in this category with Central Sleep Apnoea (CSA). It was found that whilst long-term ASV improved Heart Failure symptoms, there was no significant improvement in survival, LVEF or blood gases compared to control patients.

Furthermore, Damy et al (2018) have released interim results from the FACE cohort study assessing the prognosis of patients with varying degrees of heart failure who are treated with ASV. From the assessment of 391 patients, a better prognosis was observed in patients with a preserved LVEF, non-ischaemic aetiology and high level of oxygen desaturation during sleep.

Prasad et al (2018) set out to try and answer the age old question of what factors causes sleepiness in patients with OSA above and beyond AHI alone. Ethnicity, sleep duration, chronotype and pro-inflammatory cytokine IL-3 levels were all found to impact on daytime sleepiness.

Wang et al (2018) have investigated the impact of moderate sleep restriction on patients undergoing a calorie restrictive diet. Following an 8-week period, although weight loss was similar across groups, proportional fat loss and body composition was adversely effected in those with sleep restriction.

For full details of all studies please see the references noted on the next page.

If anyone has any comments on the above please do get in touch and don't forget to follow us @ARTP_Research

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Sleep In the News:



Rise in Sleep Disorders linked to Obesity

BBC News reports a 30% rise in people receiving inpatient care for sleep disorders in Wales over the last 5 years. Dr Jose Thomas notes the close link between obesity and Obstructive Sleep Apnoea (OSA). Therefore as obesity levels rises so does the rate of OSA. It is also important to note the increased awareness of OSA by both medics and the general public, leading to higher levels of diagnosis.

Dr Thomas further notes good provision in Wales for treatment of OSA, unfortunately the provision for neurological sleep disorders is not as complete. It is important to be aware that chronic insomnia and restless-leg syndrome can effect around 10% of the population.

To read more please click [here](#).

Need a good nights sleep?

There are many recommendations of what food and drink to avoid before going to bed- but what is truth and what is myth. The Express speaks to Nutritionists to establish the best way to get a good sleep.

The following food and drink should be avoided:

Coffee and caffeinated products (including chocolate): Caffeine can stay in the system for up to 8 hours after it is consumed, so intake should stop after late afternoon.

Alcohol: This can make you feel sleepy but reduces sleep quality, by interfering with neurotransmitter balance. It is recommended that consumption is kept to a minimum at night.

Greasy/Fried foods: These foods take longer for your body to digest and if this process takes place over night it can result in you feeling sleepy on waking.

Cheese: The tale about cheese giving you nightmares may not be a myth. Cheese is high in fat. This can cause indigestion and interrupt sleep, resulting in nightmares.

To read more please click [here](#).

Go2Sleep Tracker detects Sleep Apnoea

Verdict Medical Devices looks at one of the newest sleep trackers on the market- the “Go2Sleep” by SleepOn. This is a unique wearable monitor which sits on the finger, like a ring, is said to monitor blood flow through capillaries in the finger. It is therefore able to monitor heart rate, pulse strength and blood oxygen saturations. This information is then inputted into an app or email.

It does however note that despite measuring these parameters this device cannot distinguish between types of sleep apnoea so consultation with a healthcare provider is recommended.

For more information please click [here](#).

Essential Oils for a good nights sleep

Mens Health Magazine suggests that smells can help you to drift off to sleep and wake up in the morning.

Lavender: According to research, participants using this essential oil woke feels more alert.

Chamomile: This is proven to combat insomnia by reducing feelings of anxiety and stress.

Mint: This oil can reduce symptoms of sickness and nasal blockage, which in turn can help with sleep quality.

Lemon: This oil is invigorating and is said to wake you up if feeling groggy. It can also regulate your sleep schedule and relax you.

Rose: This floral scent is said to have healing benefits and aid restful sleep.

For more information please click [here](#).

Sleep Deprivation on the small screen

15 years ago Channel 4 aired a reality TV show called “Shattered”, in which contestants competed to stay awake as long as they could for the chance to win £100,000.

At the time this show was controversial with many complaints to Ofcom and would most likely not meet rules and regulations that would allow for airing today.

With the winner of the show being sleep deprived for 178 hours The Guardian looks at where the contestants are now and the effects they have had from completing this challenge.

For more information please click [here](#).

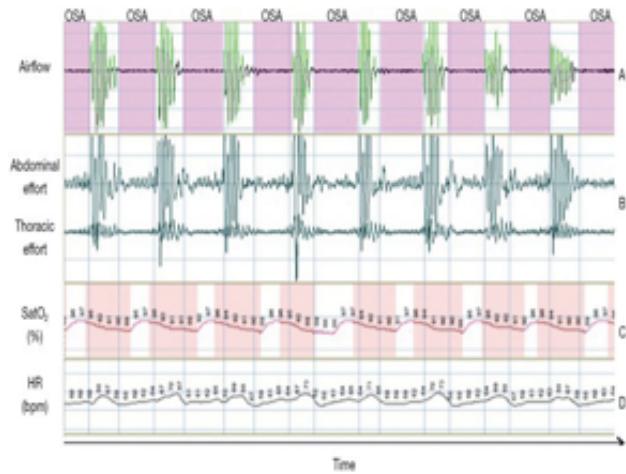


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