

Evaluation and management of obstructive sleep apnea in adults hospitalized for medical care: an American Academy of Sleep Medicine clinical practice guideline.

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Publication year: 2025

Journal: Journal of clinical sleep medicine : JCSM : official publication of the American Academy of Sleep Medicine

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Society: European Respiratory Society

Origin country: International (Europe)

Target countries: Europe

DOI: 10.5664/jcsm.11864

PMID: 40838698

Source: <https://pubmed.ncbi.nlm.nih.gov/40838698/>

J Clin Sleep Med J Clin Sleep Med 368 jcsleepmed 101231977 JCSM Journal of Clinical Sleep Medicine : JCSM : Official Publication of the American Academy of Sleep Medicine 1550-9389 1550-9397 Springer PMC12670605 PMC12670605.1 12670605 12670605 40838698 10.5664/jcsm.11864 JC2500520 1 Special Articles Special Articles special-articles Obstructive Sleep Apnea obstructive-sleep-apnea Health Care Delivery health-care-delivery Clinical Practice Guideline clinical-practice-guideline Evaluation and management of obstructive sleep apnea in adults hospitalized for medical care: an American Academy of Sleep Medicine clinical practice guideline Evaluation and management of OSA in adults hospitalized for medical care Mehra Reena MD, MS, FAASM 1 Auckley Dennis H. MD, FAASM 2 Johnson Karin G. MD, FAAN, FAASM 3 Billings Martha E. MD 1 Carandang Gerard MS 4 Falck-Ytter Yngve MD 5 6 Khayat Rami N. MD, FAASM 7 8 Mustafa Reem A. MD, MPH, PhD 9 10 Pena-Orbea Cinthya MD 11 Sahni Ashima S. MD, FAASM 12 Sharma Sunil MD, FAASM 13 Patil Susheel P. MD, PhD, FAASM 14 15 1 Division of Pulmonary, Critical Care and Sleep Medicine, University of Washington, Seattle, Washington 2 Division of Pulmonary, Critical Care, and Sleep Medicine, MetroHealth Medical Center, Case Western Reserve University, Cleveland, Ohio 3 Department of Neurology, Baystate Medical Center, University of Massachusetts Chan Medical School-Baystate, Springfield, Massachusetts 4 American Academy of Sleep Medicine, Darien, Illinois 5 Case Western Reserve University, Cleveland, Ohio 6 Department of Gastroenterology and Hepatology, Veterans Affairs Northeast Ohio Healthcare System, Cleveland, Ohio 7 Department of Medicine, Division of Pulmonary, Allergy, and Critical Care Medicine, Penn State University College of Medicine, Hershey, Pennsylvania 8 Penn State Sleep Services, Milton S. Hershey Medical Center, Hershey, Pennsylvania 9 Department of Internal Medicine, University of Kansas Medical Center, Kansas City, Kansas 10 Department of Health Research Methods, Evidence, and Impact, McMaster University, Hamilton, Ontario, Canada 11 Cleveland Clinic, Sleep Disorders Center, Neurologic Institute, Cleveland, Ohio 12 Division of Pulmonary, Critical Care, Sleep and Allergy, Department of Medicine, University of Illinois at Chicago, Chicago, Illinois 13 Division of Pulmonary, Critical Care, and Sleep Medicine, West Virginia University School of Medicine, Morgantown, West Virginia 14 Sleep Medicine Program, University Hospitals of Cleveland, Cleveland, Ohio 15 Case Western Reserve University School of Medicine, Cleveland, Ohio Address correspondence to: Reena Mehra, MD, MS, FAASM; Email: mehrar@uw.edu 1 12 2025 1 12 2025 21 12 501683 2193 2203 19 8 2025 19 8 2025 01 12 2026 03 12 2025 03 12 2025 © 2025 American Academy of Sleep Medicine 2025 Introduction: The purpose of this guideline is to establish clinical practice recommendations for the management of obstructive sleep apnea (OSA) in medically hospitalized

adults.

The American Academy of Sleep Medicine (AASM) commissioned a task force of experts in sleep medicine to develop recommendations and assign strengths based on a systematic review of the literature and an assessment of the evidence using Grading of Recommendations, Assessment, Development and Evaluation methodology. The task force provided a summary of the relevant literature and the certainty of evidence, the balance of benefits and harms, patient values and preferences, and resource use considerations that support the recommendations. The AASM Board of Directors approved the final recommendations.

The following Good Practice Statement is based on expert consensus, and its implementation is necessary for the appropriate and effective management of hospitalized adults with sleep-disordered breathing: For medically hospitalized adults with an established diagnosis of sleep-disordered breathing and on active treatment, existing treatment should be continued rather than withheld, unless contraindicated.

The following recommendations are intended as a guide for clinicians in managing medically hospitalized adults with OSA. Each recommendation statement is assigned a strength ("Strong" or "Conditional"). A "Strong" recommendation (ie, "We recommend...") is one that clinicians should follow under most circumstances. A "Conditional" recommendation (ie, "We suggest...") is one that requires that the clinician use clinical knowledge and experience and strongly consider the patient's values and preferences to determine the best course of action. For medically hospitalized adults at increased risk for OSA, the AASM suggests in-hospital screening for OSA as part of an evaluation and management pathway that incorporates diagnosis and treatment with positive airway pressure (PAP) rather than no in-hospital screening. (Conditional recommendation, low certainty of evidence) Remarks: Screening may include validated questionnaires and/or screening with overnight high-resolution pulse oximetry. When considering in-hospital screening as part of a management pathway, (1) patients who place a lower value on the potential reduction of clinically meaningful outcomes (eg, cardiovascular events) and place a higher value on the possible downsides associated with the use of PAP (eg, sleep disruption, discomfort), or (2) clinicians who perceive that the diagnosis or management of OSA may interfere with medical care, would reasonably decline OSA screening or PAP during the hospitalization. High risk for OSA is defined by signs and symptoms that suggest moderate-to-severe OSA (eg, excessive daytime somnolence plus 2 of the following: diagnosed hypertension; habitual loud snoring; witnessed apnea, gasping, or choking; and/or association of high-risk comorbidities as outlined in the Figure 1 caption). Diagnostic testing for OSA should ideally be conducted after a patient has been medically stabilized during the hospital stay or postdischarge.

For medically hospitalized adults with newly diagnosed OSA, or with a prior established diagnosis of moderate-to-severe OSA but not currently on treatment, the AASM suggests the use of inpatient treatment with PAP rather than no PAP. (Conditional recommendation, low certainty of evidence) Remarks: When considering in-hospital OSA treatment, (1) patients who place a lower value on the potential reduction of clinically meaningful outcomes (eg, cardiovascular events) and place a higher value on the possible downsides associated with the use of PAP (eg, sleep disruption, discomfort), or (2) clinicians who perceive that the diagnosis or management of OSA may interfere with medical care, would reasonably decline OSA screening or PAP during the hospitalization.

For medically hospitalized adults at increased risk for or with an established diagnosis of OSA, the AASM suggests that sleep medicine consultation be available as part of an evaluation and management pathway, rather than no sleep medicine consultation. (Conditional recommendation, very low certainty of evidence) Remarks: It is recognized that there will be variability of the availability of hospital-based expertise and resources specific to sleep medicine consultation; therefore, we provide specific guidance as follows. Oversight by a board-certified sleep medicine clinician and/or an AASM-accredited sleep center is preferable. However, elements of this consultation, including education and follow-up plan, can be provided by those with requisite expertise, including advanced practitioners, nurses, sleep technologists, respiratory therapists, care

coordinators, case managers, health educators, or other available resource personnel. Given the variability of expertise and resources available, creative consultation models of care such as teleconsult/telehealth, E-consult, and/or nursing or respiratory therapist care can be considered. Availability of inpatient diagnostics and treatment as part of the consultation should be taken into consideration in terms of feasibility of implementation of this recommendation.

For medically hospitalized adults at increased risk for or with an established diagnosis of OSA, the AASM suggests a discharge management plan to ensure timely diagnosis and effective management of OSA, rather than no plan. (Conditional recommendation, very low certainty of evidence) Remarks: Consider ordering postdischarge testing or sleep medicine evaluation prior to discharge. Inpatient sleep testing prior to discharge and/or telehealth medicine may be an option to reduce barriers to care. Consider care coordination to ensure appropriate follow-up and postdischarge care.

Mehra R, Auckley DH, Johnson KG, et al. Evaluation and management of obstructive sleep apnea in adults hospitalized for medical care: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med* . 2025;21(12):2193–2203.