



C-START Revision Resources

Sleep related breathing disorders and hypoventilation

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Prepared for revision purposes.



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UK-RES-2601939 September 2026



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Obstructive Sleep Apnoea/Hypopnoea Syndrome (OSAHS)

In which groups of patients is there a higher prevalence of OSAHS?

System	Conditions
Metabolic/endocrine	• Obesity or overweight • Obesity or overweight in pregnancy • Type 2 Diabetes • PCOS • Hypothyroidism • Acromegaly
Cardiovascular	• Treatment resistant hypertension • Arrhythmia (especially AF) • Stroke/TIA • Chronic heart failure
Respiratory	Moderate-severe asthma
Syndromic/structural	Down's syndrome
Ophthalmic	Non arteritic anterior ischaemic optic neuropathy (NAAION)

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How to approach patients with suspected OSAHS?

Take a sleep history from patients if they have 2 or more of the following:

- Snoring
- Witnessed apnoea
- Unrefreshing sleep
- Waking headache
- Unexplained excessive sleepiness/tiredness/fatigue
- Nocturia
- Choking during sleep
- Sleep fragmentation/insomnia
- Cognitive dysfunction or memory impairment

What is used to assess patients with suspected OSAHS?

Epworth

- Patient-completed questionnaire assessing the likelihood of dozing in eight everyday situations (e.g. sitting reading, watching TV, as car passenger, sitting talking to someone etc)
- Each item scored 0-3 (0-never doze, 3 -high chance of dozing), total 0-24
- Interpretation: 0-10 normal, 11-14 mild, 15-18 moderate, ≥ 19 severe
- NICE advises that it should not be used alone to establish if referral required, not all people with OSAHS have excess sleepiness

STOP-BANG

- Screening tool estimating probability that OSAHS is present (risk stratification, not diagnostic)
- 8 items, each 1 point (0-8):
 - **Snoring (loud)**
 - **Tiredness/daytime sleepiness**
 - **Observed apnoea**
 - **Pressure (HTN, treated or untreated)**
 - **BMI $>35\text{kg/m}^2$**
 - **Age >50**
 - **Neck circumference $>40\text{cm}$**
 - **Gender male**
- Interpretation: 0-2 low, 3-4 intermediate, 5-8 high risk of OSAHS

Important definitions:

- AHI: apnoeas and hypopneas per hour of sleep
- ODI: number of oxygen desaturations of $\geq 3\%$ or $\geq 4\%$ per hour of sleep, depending on the scoring system used

For prescribing information please refer to individual product SmPC.

Who should be prioritised for rapid assessment by sleep service?

- Drive for a living
- Occupation where vigilance critical for safety
- Unstable cardiovascular disease
- Pregnant
- Preoperative assessment for major surgery
- NAAION

How do we diagnose OSAHS?

- First line investigation: home respiratory polygraphy
 - Overnight oximetry may be used if access to polygraphy is limited (be cautious interpreting oximetry in patients with heart failure /chronic lung diseases > oximetry is less accurate at distinguishing OSAHS from other causes of nocturnal hypoxaemia)
- If results don't match the clinical picture:
- If oximetry is negative but symptoms remain significant, consider respiratory polygraphy or polysomnography
- Negative polygraphy but symptoms persistent > consider polysomnography

What is the key lifestyle advice given to patients of all OSAHS severities?

- Stop smoking
- Weight loss
- Reduce alcohol intake

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Treatment

Classification	Apnoea Hypopnoea Index (AHI)	Treatment	Follow up
MILD	5-14	• Treatment not usually needed- lifestyle modification usually effective • If symptoms affecting QOL (or if prioritisation factors listed above) can offer fixed level continuous CPAP along with lifestyle advice • Can consider auto-CPAP as alternative to fixed level CPAP if high pressure needed certain times of night/cannot tolerate fixed level/telemonitoring cannot be used/ auto CPAP available at same or lower price • Consider humidification in those with mild OSAHS and upper airway side effects • If mild OSAHS + symptoms affecting QOL + unable to tolerate/declines CPAP AND ≥ 18 with optimal dental/periodontal health >>> consider mandibular advancement splint (nb may be inappropriate if poor dentition, few/no teeth, generalised tonic/clonic seizures)	If having CPAP – telemonitoring for up to 12 months and consider beyond
MODERATE	15-29	• Fixed level CPAP + lifestyle measures • Can consider auto CPAP (as above) • Consider humidification if upper airway side effects • If unable to tolerate/declines CPAP > consider mandibular advancement splint (as above)	F2F, video or telephone consultation with initial consultation at 1 month (if CPAP), 3 months (if mandibular advancement) and subsequent follow up according to needs > once CPAP optimised, annual follow up Telemonitoring for 12 months

For prescribing information please refer to individual product SmPC.

SEVERE	≥30	• Fixed level CPAP + lifestyle measures • Can consider auto CPAP (as above) • Consider humidification if upper airway side effects • If unable to tolerate/declines CPAP > consider mandibular advancement splint (as above)	F2F, video or telephone consultation with initial consultation at 1 month (if CPAP), 3 months (if mandibular advancement) and subsequent follow up according to needs > once CPAP optimised, annual follow up Telemonitoring for 12 months
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Monitoring treatment efficacy:

- Monitor with: Epworth sleepiness scale, severity of OSAHS using AHI/ODI, adherence, telemonitoring
- Consider stopping treatment for OSAHS if things resolved (i.e. significant weight loss)
 - After at least 2 weeks without treatment re-evaluate symptoms and consider sleep study

Other treatments available for OSAHS:

- Positional modifiers:
 - Considered mild/moderate OSAHS if other treatments not tolerated or suitable
 - Unlikely effective in severe OSAHS
- Surgery:
 - Tonsillectomy can be considered if BMI >35kg/m² and large obstructive tonsils
 - If severe OSAHS + not able to tolerate CPAP/mandibular advancement splint > can consider assessment for oropharyngeal surgery

Rhinitis and OSAHS

Why does it matter?

- Rhinitis can affect tolerance to CPAP (switching from nasal to orofacial mask + humidification can help)
- CPAP can worsen nasal congestion/ rhinitis

How to approach?

- Assess for underlying allergic or vasomotor rhinitis in those with OSAHS and nasal congestion
 - If allergic rhinitis -> topical nasal corticosteroids / antihistamines
 - If vasomotor rhinitis -> topical nasal corticosteroids
- If no improvement with treatment or anatomical obstruction suspected → refer to ENT

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Obesity Hypoventilation Syndrome (OHS)

- Obesity (BMI $>30\text{kg/m}^2$) + raised arterial pCO_2 when awake + Breathing abnormalities when asleep (apnoea/hypopnoea/hypoventilation/combination)
- OHS is a specific form of ventilatory failure

When do we suspect OHS?

BMI $\geq 30\text{kg/m}^2$ AND

- features of OSAHS
- features of nocturnal hypoventilation
 - waking headaches
 - peripheral oedema
 - hypoxaemia (sats $<94\%$ on air)
 - unexplained polycythaemia

What are assessment scales for suspected OHS?

- Epworth sleepiness scale for initial assessment of sleepiness – don't use alone (remember as with OSAHS, not all patients with OHS have excess sleepiness)

Who should be prioritised for rapid assessment by sleep service?

Nb – same as OSAHS + hypercapnia/hypoxaemia/acute ventilatory failure

- Severe hypercapnia $\text{PaCO}_2 > 7\text{kPa}$ when awake
- Hypoxaemia (sats $<94\%$ on air)
- Acute ventilatory failure
- Drive for a living
- Occupation where vigilance critical for safety
- Unstable cardiovascular disease
- Pregnant
- Preoperative assessment for major surgery
- NAAION

How do we diagnose OHS?

- Diagnosing OHS and assessing ventilatory failure
 - If pre-test probability of OHS is LOW: serum venous bicarbonate; if levels $<27\text{mmol/l}$ OHS unlikely
 - To assess chronic ventilatory failure: ABG or arterialised capillary blood gas when awake
- Diagnosing OSAHS or nocturnal hypoventilation in people with OHS
 - Respiratory polygraphy, can consider adding transcutaneous CO_2
 - Avoid oximetry alone to determine OSAHS in those with OHS

Treatment

Lifestyle advice:

- Stop smoking
- Reduce alcohol

For prescribing information please refer to individual product SmPC.

- Lose weight

Diagnosis	Treatment
OHS and severe OSAHS	CPAP first line >> if symptoms not improving /hypercapnia persisting/ AHI or ODI are not sufficiently reduced/CPAP poorly tolerated>> NIV
OHS and nocturnal hypoventilation	NIV
OHS and acute ventilatory failure	NIV >> if hypercapnia persists, consider continuing and optimising, if hypercapnia resolves, consider stopping NIV and monitor response If subsequently stabilised on NIV with control of hypercapnia, consider stopping NIV, respiratory polygraphy and trial of CPAP in patients with frequent episodes of obstructive apnoea and minimal hypoventilation >> if decompensates, restart NIV

Other:

- Oxygen
 - Consider supplemental O2 with CPAP/NIV for those with OHS who remain hypoxaemic despite optimal control of nocturnal hypoventilation and AHI on CPAP/NIV
- Rhinitis
 - Same as treatment in OSAHS
- Follow up
 - Follow up within 1 month of starting NIV/CPAP
- Monitoring
 - OHS symptoms and Epworth sleepiness
- Severity – using AHI/ODI
 - Oxygenation/hypercapnia
- Adherence
 - Telemonitoring information

COPD-OSAHS Overlap syndrome

When do we suspect COPD-OSAHS overlap?

- COPD + features of OSAHS + features of nocturnal hypoventilation

What is used to assess patients with suspected COPD-OSAHS overlap?

- Epworth sleepiness scale
 - Don't use alone (not all people with COPD-OSAHS have excessive sleepiness)
- STOP-BANG

For prescribing information please refer to individual product SmPC.

- Spirometry to assess severity of COPD

Who should be prioritised for rapid assessment by sleep service?

Nb – same as OHS

- Severe hypercapnia $\text{PaCO}_2 > 7\text{kPa}$ when awake
- Hypoxaemia (sats $< 94\%$ on air)
- Acute ventilatory failure
- Drive for a living
- Occupation where vigilance critical for safety
- Unstable cardiovascular disease
- Pregnant
- Preoperative assessment for major surgery
- NAAION

How do we diagnose COPD-OSAHS overlap?

- Diagnosing ventilatory failure:
 - ABG or arterialised capillary blood gas when awake
- Diagnosing OSAHS/nocturnal hypoventilation in those with suspected COPD-OSAHS overlap syndrome:
 - Respiratory polygraphy, can consider adding transcutaneous CO_2
 - Avoid oximetry alone to determine the presence of OSAHS in people with suspected COPD-OSAHS overlap syndrome

Treatment

Lifestyle advice:

- Stop smoking
- Reduce alcohol
- Lose weight

COPD-OSAHS overlap syndrome	CPAP – first line, if do not have severe hypercapnia ($\text{PaCO}_2 \leq 7\text{kPa}$) If severe hypercapnia ($\text{PaCO}_2 > 7\text{kPa}$) consider NIV
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- Oxygen
 - Consider supplemental O_2 with CPAP/NIV for those with COPD-OSAHS who remain hypoxaemic despite optimal control of nocturnal hypoventilation and AHI on CPAP/NIV
- Rhinitis
 - Same as treatment in OSAHS/OHS
- Follow up
 - Follow up within 1 month of starting NIV/CPAP
- Monitoring
 - OSAHS symptoms and nocturnal hypoventilation including Epworth sleepiness
- Severity – using AHI/ODI
 - Oxygenation/hypercapnia
- Adherence
 - Telemonitoring information

For prescribing information please refer to individual product SmPC.

References and suggested reading:

1. National Institute for Health and Care Excellence. Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s [NG202]. London: NICE; 2021.
 2. Johns MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. *Sleep*. 1991;14(6):540-545.
 3. Chung F, Yegneswaran B, Liao P, Chung SA, Vairavanathan S, Islam S, et al. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. *Anesthesiology*. 2008;108(5):812-821.
 4. Chung F, Subramanyam R, Liao P, Sasaki E, Shapiro C, Sun Y. High STOP-Bang score indicates a high probability of obstructive sleep apnea. *Br J Anaesth*. 2012;108(5):768-775.
 5. Ramar K, Dort LC, Katz SG, Lettieri CJ, Harrod CG, Thomas SM, et al. Clinical practice guideline for the treatment of obstructive sleep apnea and snoring with oral appliance therapy. *J Clin Sleep Med*. 2015;11(7):773-827.
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For prescribing information please refer to individual product SmPC.

DVLA Guidance: Excessive sleepiness, including obstructive sleep apnoea syndrome

	Group 1 car and motorcycle	Group 2 bus and lorry
Excessive sleepiness due to a medical condition (see relevant chapter) including mild obstructive sleep apnoea syndrome (AHI below 15) or medication.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in 3 months DVLA must be notified.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in 3 months DVLA must be notified.
Excessive sleepiness due to obstructive sleep apnoea syndrome – moderate and severe: ■ AHI 15 to 29 (moderate) ■ AHI 30 or more (severe) on the apnoea-hypopnoea index or equivalent sleep study measure	● Must not drive and must notify DVLA. Subsequent licensing will require: ■ control of condition ■ improved sleepiness ■ treatment adherence DVLA will need medical confirmation of the above, and the driver must confirm review to be undertaken every 3 years at the minimum.	● Must not drive and must notify DVLA. Subsequent licensing will require: ■ control of condition ■ improved sleepiness ■ treatment adherence DVLA will need medical confirmation of the above, and the driver must confirm review to be undertaken annually at the minimum.
Excessive sleepiness due to suspected obstructive sleep apnoea syndrome.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in 3 months DVLA must be notified. See 'Excessive sleepiness due to obstructive sleep apnoea syndrome' above when diagnosis is confirmed.	● Must not drive. Driving may resume only after satisfactory symptom control. If symptom control cannot be achieved in 3 months DVLA must be notified. See 'Excessive sleepiness due to obstructive sleep apnoea syndrome' above when diagnosis is confirmed.

Additional points from 2026 BTS Position statement on Driving and OSA:

- OSA ≠ OSAS
 - only OSA + excessive sleepiness needs DVLA
 - High AHI alone, if asymptomatic → no notification
- New single form with a filter question ("does sleepiness affect your driving?")
 - protects non-sleepy drivers from unnecessary licence loss. SL1 (Group 1) / SL1V (Group 2)
- Never give blanket "stop and notify" advice without assessing sleepiness
- Professional drivers
 - fast-track diagnosis and treatment within 4 weeks
- Duty to notify = the patients
 - If they drive against advice while sleepy → doctor may notify DVLA (GMC): last resort, no consent needed, inform patient in writing first

For prescribing information please refer to individual product SmPC.

- ESS alone insufficient - identify the high-risk driver by direct questioning (esp. MVC/near-miss)
- Notify DVLA in writing

References and suggested reading

1. DVLA Assessing fitness to drive – a guide for medical professionals (<https://assets.publishing.service.gov.uk/media/690c6d0a68ffdd77951aab0/assessing-fitness-to-drive-november-2025.pdf>)
2. BTS 2026 - BTS Position statement Driving and Obstructive sleep apnoea ([file:///Users/k2585006/Downloads/Position%20Statement%20on%20Driving%20and%20Obstructive%20Sleep%20Apnoea%20\(1\).pdf](file:///Users/k2585006/Downloads/Position%20Statement%20on%20Driving%20and%20Obstructive%20Sleep%20Apnoea%20(1).pdf))
3. British Thoracic Society. Position statement on driving and obstructive sleep apnoea. London: BTS; 2026.

Central Sleep Apnoea (CSA)

What is the core distinction from OSAHS?

- Apnoeas occur with absent respiratory effort - the problem is drive, not upper-airway obstruction (in OSAHS effort continues against a closed airway). Look for absence of thoraco-abdominal effort on the sleep study

What are the causes/associations?

Heart Failure	Cheyne-stokes respiration (crescendo-decrescendo breathing with central apnoeas)
CNS lesions	Stroke, brainstem pathology
Opioids	Common cause
High altitude	Periodic breathing with central apnoeas
Treatment emergent CSA/ 'complex sleep apnoea'	Central events appearing once CPAP is started for OSAHS; often resolve over weeks to months

How is it managed?

- Treat the underlying cause
 - Optimise heart failure
 - Reduce or discontinue opioids
 - Treat neurological disease where appropriate
- Positive airway pressure therapy: CPAP may improve CSA, particularly treatment-emergent CSA or some patients with heart failure
- Adaptive servo-ventilation (ASV) may be considered for selected patients with CSA except in symptomatic heart failure with reduced ejection fraction

For prescribing information please refer to individual product SmPC.

- Important point: do not use ASV in symptomatic HFrEF (LVEF $\leq 45\%$) after the SERVE-HF trial showed increased mortality

References and suggested reading

1. Oxford handbook of respiratory medicine 4th Edition
 2. Cowie MR, Woehrle H, Wegscheider K, Angermann C, d'Ortho MP, Erdmann E, Levy P, Simonds AK, Somers VK, Zannad F, Teschler H. Adaptive Servo-Ventilation for Central Sleep Apnea in Systolic Heart Failure. N Engl J Med. 2015 Sep 17;373(12):1095-105. doi: 10.1056/NEJMoa1506459. Epub 2015 Sep 1. PMID: 26323938; PMCID: PMC4779593.
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Other sleep disorders:

Narcolepsy

Definition

- Central disorder of hypersomnolence - excessive daytime sleepiness is the cardinal feature; a differential for "sleepy patient" alongside OSAHS.

What is the classic tetrad for narcolepsy?

1. Excessive daytime sleepiness - always present. Irresistible sleep attacks despite adequate sleep
2. Cataplexy - sudden bilateral loss of muscle tone triggered by emotions (especially laughter, excitement or surprise), without loss of consciousness. Defines type 1 narcolepsy
3. Sleep paralysis - transient inability to move or speak when falling asleep or waking
4. Hypnagogic/hypnopompic hallucinations- vivid dream like hallucinations occurring when falling asleep (hypnagogic) or waking (hypnopompic)

What types are there?

- Type 1
 - Cataplexy OR low CSF hypocretin (orexin-1) levels
 - Strong association with HLA-DQB1*06:02
 - Thought to result from autoimmune loss of hypocretin producing neurons
- Type 2
 - No cataplexy
 - Normal CSF hypocretin
 - Less well understood than type 1

For prescribing information please refer to individual product SmPC.

How do we diagnose narcolepsy?

- Overnight polysomnography first to exclude other sleep disorders and confirm adequate sleep
- Multiple Sleep Latency Test (MSLT) performed the following day:
 - Mean sleep latency (≤ 8 min)
 - ≥ 2 sleep-onset REM periods (SOREMPs)
- CSF hypocretin (orexin 1) low in type 1 narcolepsy

How do we manage narcolepsy?

- Non-pharmacological:
 - Good sleep hygiene
 - Scheduled daytime naps
 - Avoid shift work and sleep deprivation
 - Driving advice where appropriate (see DVLA)
- If excessive day time sleepiness:
 - Modafinil (first-line)
 - Alternatives: Pitolisant, Solriamfetol, Methylphenidate
- Cataplexy
 - Sodium oxybate for cataplexy (also improves excessive daytime sleepiness)
 - Pitolisant
 - Venlafaxine or other SSRIs/SNRIs (reduce cataplexy by suppressing REM sleep)

Insomnia

Definition

- Persistent difficulty with sleep initiation, maintenance, or early waking despite adequate opportunity to sleep, resulting in daytime impairment
- Chronic insomnia: symptoms occur ≥ 3 nights/week for ≥ 3 months.

Key point: insomnia is a clinical diagnosis; a sleep study is NOT routinely indicated

How to assess?

Identify and treat contributing factors:

- Depression and anxiety
- Chronic pain
- Caffeine/alcohol/nicotine/stimulants
- Medications (corticosteroids, stimulants, SSRIs)
- OSAHS (screen if symptoms suggestive)
- Restless legs syndrome/periodic limb movement disorder
- Poor sleep hygiene
- Shift work or circadian rhythm disorders

For prescribing information please refer to individual product SmPC.

How do you manage insomnia?

- First-line:
 - Cognitive behavioural therapy for insomnia (CBT-I) + sleep hygiene
 - most effective with best long-term outcomes
- Short term pharmacological treatment:
 - Consider only if insomnia is acute, severe and disabling
 - Consider a short course of a Z-drug (zopiclone, zolpidem) or short-acting benzodiazepine
 - Use the lowest effective dose $\leq 2-4$ weeks, because of tolerance, dependence and rebound insomnia
- Other options:
 - Melatonin: prolonged release melatonin is licensed for short term insomnia in adults ≥ 55 years; it is also used for some circadian rhythm disorders
 - Daridorexant: dual orexin receptor antagonist, NICE approved for selected adults with chronic insomnia when symptoms have persisted for ≥ 3 months despite sleep hygiene measures

References and suggested reading:

1. NICE Clinical Knowledge Summary (CKS): Narcolepsy
2. NICE 2023- Daridorexant for treating long term insomnia [TA922]
3. NICE Clinical Knowledge Summary (CKS): Insomnia
4. Bassetti CLA, Kallweit U, Vignatelli L, Plazzi G, Lecendreux M, Baldin E, et al. European guideline and expert statements on the management of narcolepsy in adults and children. J Sleep Res. 2021;30(6): e13387.
5. National Institute for Health and Care Excellence. Narcolepsy. Clinical Knowledge Summary. London: NICE; updated periodically.
6. National Institute for Health and Care Excellence. Insomnia. Clinical Knowledge Summary. London: NICE.
7. National Institute for Health and Care Excellence. Daridorexant for treating long-term insomnia [TA922]. London: NICE; 2023.

Glossary of terms

ABG	Arterial Blood Gas
AF	Atrial Fibrillation
AHI	Apnoea-Hypopnoea Index
ASV	Adaptive Servo-Ventilation
BMI	Body Mass Index
BTS	British Thoracic Society
CBT-I	Cognitive Behavioural Therapy for Insomnia
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
CSA	Central Sleep Apnoea
CSF	Cerebrospinal Fluid
CNS	Central Nervous System
CKS	Clinical Knowledge Summary
CO ₂	Carbon Dioxide
DVLA	Driver and Vehicle Licensing Agency
ENT	Ear, Nose and Throat

For prescribing information please refer to individual product SmPC.

ESS	Epworth Sleepiness Scale
F2F	Face-to-Face
GMC	General Medical Council
HFrEF	Heart Failure with Reduced Ejection Fraction
HLA	Human Leukocyte Antigen
HTN	Hypertension
kPa	Kilopascal
LVEF	Left Ventricular Ejection Fraction
MVC	Motor Vehicle Collision
MSLT	Multiple Sleep Latency Test
NAAION	Non-Arteritic Anterior Ischaemic Optic Neuropathy
NG	NICE Guideline
NICE	National Institute for Health and Care Excellence
NIV	Non-Invasive Ventilation
O ₂	Oxygen
ODI	Oxygen Desaturation Index
OHS	Obesity Hypoventilation Syndrome
OSA	Obstructive Sleep Apnoea
OSAS	Obstructive Sleep Apnoea Syndrome
OSAHS	Obstructive Sleep Apnoea/Hypopnoea Syndrome
PaCO ₂	Partial Pressure of Arterial Carbon Dioxide
PCOS	Polycystic Ovary Syndrome
QOL	Quality of Life
REM	Rapid Eye Movement
SL1	DVLA Sleep Disorder Questionnaire (Group 1 Licence)
SL1V	DVLA Sleep Disorder Questionnaire (Group 2 Licence)
SNRI	Serotonin-Noradrenaline Reuptake Inhibitor
SOREMP	Sleep-Onset REM Period
SSRI	Selective Serotonin Reuptake Inhibitor
TIA	Transient Ischaemic Attack
TV	Television

OSAHS is the preferred term used throughout this document and encompasses obstructive sleep apnoea with associated symptoms.

For prescribing information please refer to individual product SmPC.

UK-RES-2601939 September 2026

