Case Report

OBSTRUCTIVE SLEEP APNEA HYPOPNEA SYNDROME (OSAHS): A CASE REVIEW

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OSAHS is syndrome of sleep apnea characterized by intermittent closure/collapse of pharyngeal air way which causes apneic episode during sleep manifesting as brief arousals our case who was diagnosed as OSAHS presented to Emergency Department with CO2 narcosis owing to non-compliance with the treatment (CPAP). He had occult Hypothyroidism and improved significantly after treatment with Thyroxine. Our case highlights has two important issues of OSAHS (1) compliance with CPAP which patient needed to be counselled/ regularly and revived appropriately. (2) Occult hypothyroidism which compounded the problem. Treating culture illness can have marked effect on the condition.

Keywords: OSAHS, Sleep apnea, CO2 narcosis, Occult hypothyroidism

INTRODUCTION

Obstruction sleep apnea Hyponea syndrome OSAHS is defined as the co-existences of unexplained excessive day time sleepiness with at least five obstructed breathing events per hour of sleep. It is a major cause of morbidity, a significant cause of mortality and the most common medical cause of daytime sleepiness. It occurs in around 1-4% of middle aged males and is about half as common in female (mostly post menopausal) it occurs in childhood usually associated with tonsils or adenoid enlargement and in elderly, although the frequency in slightly lower in old age.

CASE REPORT

A 66 years old retired Central Govt. Employee presented with working shortness of breath since 5 days and Altered Sensorium since 1 day patient was a known case of OSAHS, since 1 year on CPAP treatment, who discontinued CPAP, since last 1 week because he was not comfortably with it. Patient had a old cerebellar bleed which was evacuated by craniotomy post-surgery, patient recovered and was able to walk.

On Examination

Patient is obese BMI 33 in Respiratory Distress, Drowsy GCS – E2 V2 M4 Blood Pressure: 130/
90 mm of Hg, Pulse Rate: 96/min, Temperature: Normal, Bilateral, Lower limb cellulites SPO$_2$: 93% in Emergency Room, Heart / Lungs: S1 S2 clear, NS: Moving 4 limbs on Deep Painful Stimulus, Per Abdomen: Soft. ABG on presentation (on 28% O$_2$) Ph 7-141 PCO$_2$ 99 PO$_2$ – 101 HCO$_3$ – 32.6. Patient immediately intubated and connected to mechanical ventilator and shifted to ICU. CT Brain- No fresh changes CBP – Hg 17 mg/dl. HCT – 56% RBC 6-5 m/mm$^3$ TLC – 8-8103/mm$^3$ Platelet count – 250 x 10$^9$/mm$^3$ ESR – 6 / 1 h CUE – 1+ protein. TSH, LFT planned. ECHO – EF 60% Trivial TR. CXR – Left CP obliteration – pleural effusion. Patient followed up in ICU regularly by ICU team, Chief Physician, Pulmonologist, Anaesthesiologist, Intensivist next day TSH – 6-12, LFT – Albumin 2.1. Thyroid profile report next day suggested Hypothyroidism. Patient was started on Tab. Thyroxin 50 mg BBF and gradually weaned of ventilator and Kept on minimal CPAP support.

The case was diagnosed OSAHS secondary to obesity and occult. Hypothyroidism presenting with type 2 Respiratory Failure and CO$_2$ Narcosis leading to Metabolic Encephalopathy. Patient improved significantly on treating occult Hypothyroidism, Patient was counselled regarding with reducing weight, exercise and diet modification. Advice was given regarding compliance with the treatment.

**DISCUSSION**

Obstructive Sleep Apnea Hypo apnea syndrome is characterized by intermittent closure/collapse of the Parenchymal airway which causes apnoeic episodes during sleep. There are Hypothyroidism, Acromegaly, adenoids, tonsils, obesity.

Common clinical presentation of OSAHS snoring loudly in sleep, Daytime somnolence, poor sleep quality, morning headache, decreased libido, decreased cognitive performance.

Simple studies like pulse oximetry, video recording may all be that is required for diagnosis. Polysomnography is diagnostic treatment should focus on treating primary cause weight reduction, avoidance of Alcohol and tobacco, treatment of Hypothyroidism treatment of acromegaly and CPAP via Nasal Mask – Tonsillectomy, Uvuloplasty may occasionally needed.

**REFERENCES**
