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Sleep-related breathing disorders in idiopathic pulmonary fibrosis: A new hidden perspective

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Dear Editor,

We have read the original article entitled "*The spectrum of sleep-related breathing disorders (SRBDS) in idiopathic pulmonary fibrosis (IPF)*" by Vayısoğlu Şahin et al.[1] and would like to congratulate the authors for this original analysis. However, we believe that certain aspects require further clarification for their clinical implications.

First, the authors reported that the mean STOP-Bang scores (Snoring, Tiredness, Observed apnea, high blood Pressure, Body mass index, Age, Neck circumference, and Gender) differed significantly between the two groups: patients with SRBD scored 4.2±1.4, while those without SRBD scored 3.2±1.1 (p=0.032). However, STOP-Bang scores between 3 and 4 indicate an intermediate risk for obstructive sleep apnea (OSA), which places both groups in the same risk category for developing OSA. Clarification of this point could provide more valuable insight for clinical practice.[2]

Second, the results stated that the mean sleep efficiency percentage of the patients was 66.8±15.2%. A sleep efficiency below 85% is considered poor and may indicate coexisting insomnia. This finding raises the possibility of coexisting insomnia and sleep apnea (COMISA) in these patients, which should be considered.[3]

Third, the difference in OSA symptoms, specifically apnea and daytime sleepiness, is a key issue. Table 4 presents more than one remarkable finding: patients with SRBD had apnea and daytime sleepiness rates of 4.7% and 23.3%, respectively, compared to 7.7% and 30.8% in patients without SRBD. This suggests that IPF patients without SRBD may experience apnea and daytime sleepiness more frequently than those with SRBD. Additionally, a comparison of the Epworth Sleepiness Scale between the two groups showed similar

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results: 5.8±4.6 for patients with SRBD versus 5.6±5 for those without SRBD. Furthermore, the Apnea-Hypopnea Index (AHI) was found to be 19.2±19.3 in IPF patients with SRBD and 6.7±10.5 in those without SRBD. It was previously mentioned in the results section on page 104 that "*The mean AHI was 15.1±17.3.*[4] *An AHI value above 5 was observed in 43 patients*." Based on these combined findings, we considered the possibility that a significant proportion of the 55 IPF patients enrolled in the study could be diagnosed with SRBD.[5]

Fourth, it is important to consider the overlapping nature of symptoms such as dyspnea and cough symptoms in the categorical analysis of IPF symptoms. Although statistical significance was observed regarding IPF symptoms between the two groups, we noticed that cough—either alone or in combination with other symptoms—appeared to be a major factor interfering with the sleep quality of IPF patients. This effect was especially pronounced in the group with SRBDs, intensifying their complaints.[6]

Finally, it is important to consider the evaluation of oxygenation parameters. It would provide valuable information if the authors could provide results for minimum O_2 saturation (%), average O_2 saturation (%), O_2 saturation over 90% (%), oxygen desaturation index (ODI), and average O_2 saturation during wakefulness (%) between IPF patients receiving oxygen therapy and those who are not. This data could offer further observational insight into whether the need for oxygen therapy influences OSA symptoms and sleep quality.[7]

Further clinical studies are needed to clarify the spectrum of SRBDs in IPF and their implications for early diagnosis.

Conflicts of Interest Statement

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