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Reply to the letter to the editor: The spectrum of sleep-related breathing disorders in idiopathic pulmonary fibrosis

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Thank you for your valuable contributions and insightful review. We have carefully considered your comments regarding our study.[1] Regarding your comment on the STOP-Bang questionnaire scoring, we acknowledge that categorizing average scores into specific ranges could result in both groups being classified as intermediate risk, treating them as ordinal data. However, in our study, individual patient scores were entered as scale data, and the average scores were analyzed as nominal values. This approach enables us to identify a statistically significant difference. Moreover, our statistical analysis revealed a specific cut-off value for patients with sleep-related breathing disorders (SRBD). We believe that, if confirmed by future studies, this finding could be clinically significant, particularly for patients diagnosed with idiopathic pulmonary fibrosis (IPF).

In line with the existing literature, our hospital's sleep clinic considers a total sleep time (TST) of at least six hours essential for an accurate polysomnography (PSG) evaluation. Patients with a TST below this threshold were excluded from the study. Despite this, our average sleep efficiency (SE) was statistically analyzed and found to be 66.88%. It is important to note that a diagnosis of insomnia is made clinically based on anamnesis, and PSG is not routinely indicated for its diagnosis. Sleep questionnaires, however, can be beneficial in this context.[2,3] In our study, patients completed the recommended Epworth Sleepiness Scale questionnaire with an average score of 5.9±4.6, which falls within the normal range. COMISA (Comorbid Insomnia and Sleep Apnea) is an emerging research area in the literature, with many aspects still to be ex-

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plored.[4–6] We believe that considering this condition, and taking a detailed sleep history beyond standardized questionnaires, can be highly beneficial.

In our study, 43 out of 55 IPF patients were diagnosed with SRBD, and these findings were presented accordingly. We found no statistically significant difference when comparing the proportion of patients with apnea and daytime sleepiness symptoms within each group relative to the total number of patients. However, the reported symptom ratios between the groups, based on symptom descriptions, were regarded as a weak clinical finding in this study. Therefore, drawing strong statistical conclusions or general inferences solely from the "OSA Symptoms" section of Table 4 is limited. Conversely, the numbers of obstructive apnea (OA) and central apnea (CA), as shown in Table 4, were statistically significantly higher in the SRBD group. Notably, no mixed apnea (MA) was detected in IPF patients without SRBD, making statistical analysis for this category unfeasible. Even based solely on this analysis, it is clear that IPF patients without SRBD are less likely to experience apnea compared to those with SRBD. Daytime sleepiness should be evaluated using standardized outcome measures rather than solely relying on symptom declarations, particularly when considering Epworth Sleepiness Scale scores. While the Epworth scores suggest a greater impact of daytime sleepiness in IPF patients with SRBD, this difference was not statistically significant. However, this outcome is considered reasonable within the scope of our study.

Regarding your fourth comment, we agree that nocturnal cough can negatively affect sleep quality. However, the polysomnographic data analyzed in our study provided an objective and homogeneous evaluation of sleep-related parameters. While symptoms like cough can influence sleep quality and daytime sleepiness, our statistical analysis was based on internationally accepted and validated outcome measures.

Although an analysis comparing patients receiving oxygen therapy could be useful in principle, it would not have meaningfully contributed to the primary aim of our study. Our main objective was to examine the differences between IPF patients with and without SRBD. Moreover, only four IPF patients without SRBD were receiving oxygen therapy. If we were to compare patients on oxygen therapy between groups, the low number of patients would significantly weaken any statistical analysis and would not provide the desired contribution.

Once again, we thank you for your detailed review and thoughtful criticisms of our study. We hope our responses have adequately addressed your concerns.

Conflicts of Interest Statement

The authors have no conflicts of interest to declare.

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Author Contributions

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