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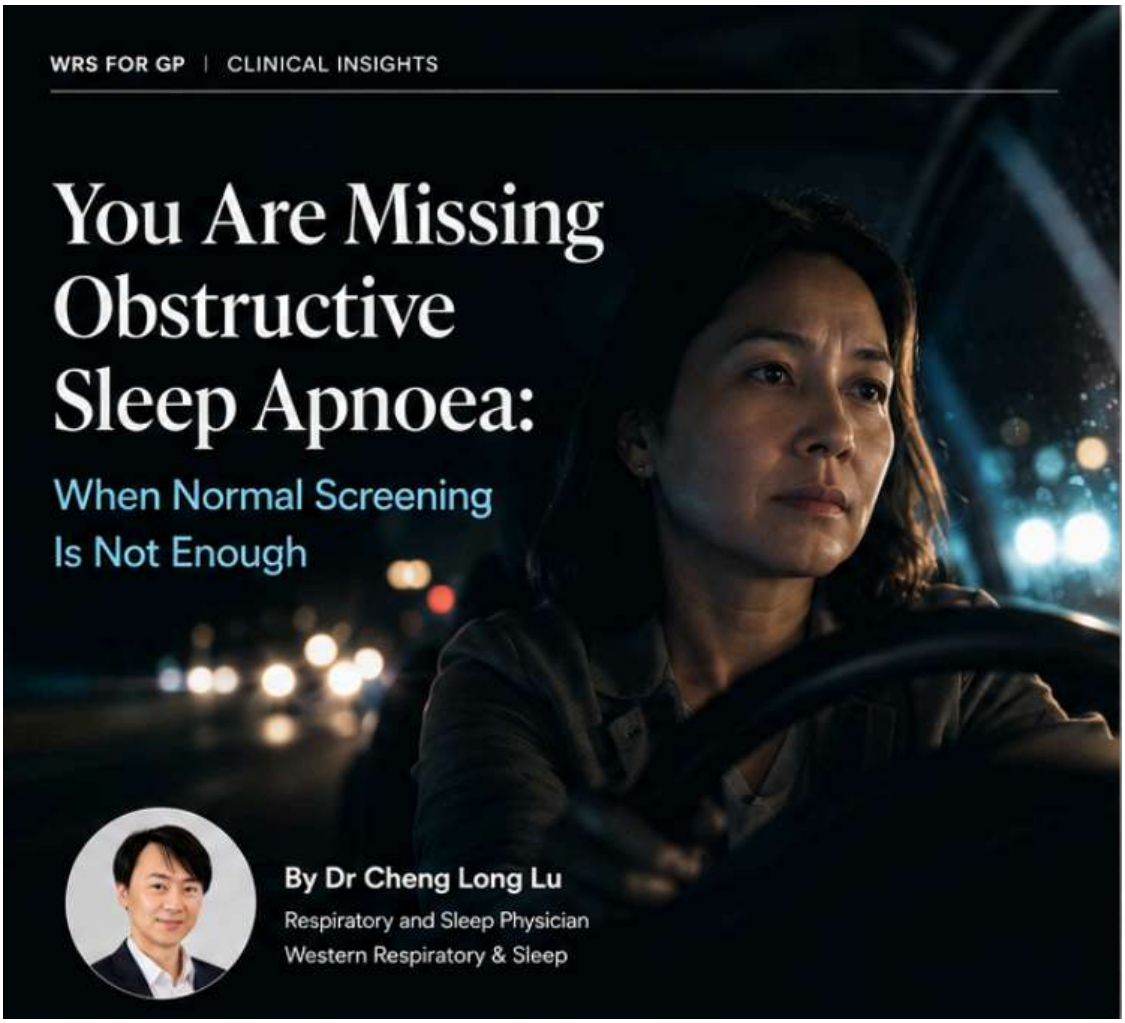

"Normal screening does not exclude clinically significant obstructive sleep apnoea".

A middle-aged woman presented following a motor vehicle accident. She denied excessive sleepiness and described her sleep as “normal.” No prior suspicion of a sleep disorder had been raised.
A subsequent sleep study demonstrated severe obstructive sleep apnoea. After commencing therapy, she reported a clear improvement in

daytime function—only then recognising that her prior state was not normal.

This pattern is not uncommon. In many patients, the first clinical signal of obstructive sleep apnoea is *not a symptom—but a consequence.*



The Diagnostic blindspot

Obstructive sleep apnoea is often framed as a condition of snoring, obesity, and daytime sleepiness. In practice, this is an incomplete model. Patients recalibrate their sense of “normal” to chronic sleep disruption. Symptoms are under-reported, sleepiness may not be perceived, and clinical suspicion is lowered.
Instead of presenting with classical features, these patients appear across multiple domains—cardiovascular, neurological, and functional—without a unifying diagnosis.
This reflects the underlying physiology. Repeated airway collapse leads to intermittent hypoxia, sleep fragmentation, and sympathetic activation across the night. The result is not a single-organ disease, but a systemic disturbance affecting cardiovascular regulation, brain function, and alertness.

If the condition is not actively considered, it will be missed.



Why Screening tools fail

Common screening tools have important limitations. The Epworth Sleepiness Scale measures perceived sleepiness, not fatigue or cognitive impairment, and relies heavily on patient insight. Many patients with significant disease score within the normal range.
STOP-BANG is weighted toward a classical phenotype—typically overweight males who snore—and may fail to identify women, non-obese patients, East Asians, and those with atypical presentations.

Normal screening does not exclude clinically significant obstructive sleep apnoea.



When to Refer

The decision to refer should not be outsourced to screening tools. It requires clinical judgement. Three patterns should prompt consideration of obstructive sleep apnoea—even when screening is normal.

Functional mismatch - If a patient reports adequate sleep but remains persistently fatigued, their sleep is not normal—no matter how "normal" they believe it is. Patients who describe "sleeping fine" yet wake unrefreshed are often describing disrupted sleep physiology they have normalised.

Multisystem signal- Atrial fibrillation and resistant hypertension are not just cardiac diagnoses—until proven otherwise, they should be treated as potential manifestations of sleep apnoea. Similarly, fatigue, low mood, and cognitive impairment without a clear cause are often not separate problems—they may represent the neurological effects of disordered sleep.

Safety signal- An unexplained motor vehicle or workplace incident should not be considered benign. Impaired alertness must be assumed until sleep apnoea has been excluded.
This matters. Missing obstructive sleep apnoea is not a neutral error. It delays treatment of a condition that is both common and modifiable. Patients continue to experience impaired function, reduced quality of life, and increased cardiovascular risk. In some cases, the first recognised consequence is a preventable adverse event.

The cost of delayed diagnosis is often only recognised in retrospect—after treatment has normalised what the patient had long accepted as "baseline."



A Practical approach

In practice, referral should be considered when there is a mismatch between reported sleep and daytime function, or when multisystem disease lacks a clear unifying diagnosis. This does not require classical symptoms such as loud snoring or excessive daytime sleepiness. A normal Epworth Sleepiness Scale or STOP-BANG score should not be used to exclude disease when clinical suspicion is present.
In these situations, a sleep study is not an extension of screening, but a diagnostic test to confirm or exclude a unifying cause for the patient's presentation.
Obstructive sleep apnoea is not being missed because it is rare—it is being missed because it is framed incorrectly. As long as clinicians rely on classical symptoms and screening tools to trigger suspicion, a significant proportion of patients will remain undiagnosed.

The question is not whether these patients exist in your practice. The question is how many you have already seen—and not recognised.

Key messages

1. Normal Epworth or STOP-BANG scores do not exclude clinically significant obstructive sleep apnoea
2. Unexplained fatigue, cardiometabolic disease, and safety-related events should trigger referral consideration

3. Clinical pattern recognition should override screening tools when the story does not fit

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