

From fragmented nights to unified care: Consensus directions in obstructive sleep apnoea

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Obstructive sleep apnoea (OSA) has long been recognised as a highly prevalent and underdiagnosed disorder across the Asia-Pacific region, including Singapore.^{1,2} In this issue of the *Annals*, Leow et al.³ chart a major milestone by synthesising available evidence, contextualising it to the local healthcare system in Singapore, and providing clinicians with a practical framework for daily practice. This editorial seeks to situate the significance of these consensus statements within the broader global literature, highlight their implications for clinical care and public health, and outline directions for future work.

OSA is increasingly appreciated not only as a sleep disorder but also as a multisystem disease with profound cardiometabolic and neurocognitive consequences.^{4,5} The consensus process in Singapore is notable for its inclusiveness, bringing together respiratory physicians, otolaryngologists, paediatricians, dental specialists and allied health professionals.³ Such multidisciplinary collaboration is essential because OSA management spans preventive screening in primary care, complex diagnostic pathways requiring polysomnography or home-based testing, behavioural and lifestyle interventions, device-based therapies, and in select cases, surgery. By establishing 72 carefully deliberated statements—49 for adults and 23 for children—the authors provide a broad yet nuanced roadmap that extends beyond technical diagnostic thresholds to encompass feasibility, acceptability and equity considerations. This pragmatic approach ensures that recommendations are not merely aspirational but also implementable in real-world practice. Of note, strengthening engagement with primary care physicians in future updates will be essential to enhance early recognition, screening and referral of at-risk individuals in community settings.

One of the most commendable aspects of the consensus statements is the deliberate attention paid to the context of the Singapore population.³ For instance, evidence supporting a lower Epworth sleepiness cut-off score in Singapore underscores the importance

of culturally and ethnically sensitive adaptations when applying international guidelines. Similarly, the panel emphasised cost-effectiveness data, which strengthens the case for structured screening and early treatment adoption in high-risk groups. These insights resonate with prior global efforts, including the International Consensus Statement on OSA⁶ and the Asian Pacific Society of Cardiology recommendations,⁷ yet they go further in tailoring guidance for a healthcare system with constrained specialist resources and rising burden of sleep-related morbidity. In addition, recent expert consensus from China⁸ has underscored the importance of integrating OSA assessment into cardiovascular disease management, highlighting its role in risk stratification and comprehensive care pathways.

From a clinical practice perspective, the recommendations reinforce several key principles.³ First, polysomnography remains the diagnostic gold standard, but the role of home sleep apnoea testing is acknowledged for carefully selected patients. This balanced view reflects current evidence, in that outcomes are comparable in high-pretest probability populations, while safeguarding against inappropriate use in complex or comorbid patients. Second, continuous positive airway pressure remains the cornerstone therapy, with strong evidence for symptomatic relief, quality-of-life improvement, and in some subgroups, cardiovascular benefit. Yet, adherence remains the Achilles' heel. The consensus statements rightly underscore multifaceted strategies—educational, supportive, behavioural and even surgical interventions—to enhance adherence and provide alternatives for non-responders. Third, weight management, oral appliances, hypoglossal nerve stimulation and upper airway surgery are appropriately positioned as complementary or second-line therapies. The inclusion of pragmatic considerations such as nasal obstruction, humidification and dental requirements reflects a refreshing level of clinical detail that will resonate with practicing clinicians. While the consensus underscores

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the importance of multidisciplinary collaboration, it does not prescribe a single preferred referral pathway, making coordinated case-based decision-making the most practical for real-world implementation. The consensus also acknowledges the limited availability of sleep-trained clinicians, underscoring the need for expanded training and capacity-building to ensure equitable access and sustainable adoption of these recommendations.

Equally important is the paediatric section, which synthesises limited but growing evidence for the screening, diagnosis and management of childhood OSA. The emphasis on adenotonsillectomy, careful diagnostic confirmation with polysomnography, and long-term follow-up highlights both the opportunities and challenges in paediatric care. The recognition of craniofacial development, orthodontic interventions and myofunctional therapy points to the importance of early, multidisciplinary engagement to mitigate lifelong consequences of untreated paediatric OSA.

While the breadth and depth of the consensus are commendable, several challenges remain. The first is implementation. The translation of statements into routine care requires primary care engagement, training of non-specialist providers and expansion of diagnostic capacity. Second, patient-centered perspectives—although considered—were not directly incorporated into the consensus process. Future efforts would benefit from the structured involvement of patient representatives to ensure that values and preferences are fully integrated. Third, the consensus statements highlight but do not expound on the rapidly evolving role of telemedicine, artificial intelligence and digital health platforms in screening and longitudinal monitoring. Singapore, with its advanced digital infrastructure, is well-placed to pilot such innovations.

Beyond Singapore, the significance of these statements lies in their potential as a model for other countries with similar healthcare landscapes. Middle-income and multicultural societies in Asia face parallel challenges: high prevalence of OSA, limited specialist manpower and variability in access to diagnostic facilities. The Singapore framework offers a template for balancing evidence-based rigour with local adaptability. In this way, the consensus statements contribute not only to national practice but also to regional and even global discourse on sleep medicine.

In summary, the Singapore consensus statements provide clinicians with a robust and contextually relevant framework for OSA management. They integrate the best available evidence with pragmatic

considerations, bridging the gap between global guidelines and local realities. Their publication should stimulate both immediate improvements in patient care and longer-term research into implementation, adherence strategies and novel technologies. As the field of sleep medicine advances, these consensus statements will serve as a living reference point, guiding clinicians while inviting continuous refinement.

Ethics statement

Not applicable as no study participants are involved.

Declaration

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