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You Can Lead a Horse to Water

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Abstract

Letter from the Editor

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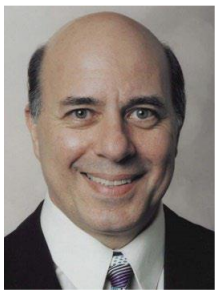
Letter from the Editor



Paul B. Freeman, OD
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You Can Lead a Horse to Water

When I started writing this editorial there was a new COVID variant which appeared to be more transmissible but apparently less virulent. But the good news is that although the virus "continues to constitute a public health emergency of international concern (PHEIC)," "the COVID-19 pandemic is probably at a transition point." And although "there is little doubt that this virus will remain a permanently established pathogen in humans and animals for the foreseeable future," it will hopefully be downgraded to an endemic.[1] Therefore, I find that I am reiterating the pledge I made in my April 2021 editorial: "Until we have conquered this pathogen, I will continue to recognize and thank, in each issue of our journal, the frontline professionals and those workers who keep our lives moving forward while putting themselves in harm's way. My hope is that each time I begin with this, it will be the last time." [2]

So, how has COVID changed the way we take medical histories? Prior to 2019, it was rare for eye doctors or healthcare practitioners to ask questions like, "In the last two weeks were you around anybody with an infectious disease? Have you been out of the country recently? Do you have symptoms of an infectious disease? Were you vaccinated against a specific (or any) viral disease? Did you have a recent viral infection? When you tested for a viral infection, which testing protocol did you use, and did it show up negative?" And this history was usually done before the patient was even seen. However, in the past few years, due to COVID, these questions were added to the history, specifically about the SARS-CoV-2 virus and, once this virus is no longer considered a pandemic, histories will likely go back to the questions we asked pre COVID.

Notably, in the early days of COVID, doctors and staff were typically on high alert when someone said they had had the virus, and gingerly tried to figure out the best timing for scheduling an examination. Now, a few years later, a fair percentage of patients report having had this virus (or a variant of the original strain), some more than once, and it is almost matter-of-fact when to schedule a patient after an exposure. Clinically, there is still now the added challenge of differential diagnoses when seeing an ocular pathology that might have been an outcome of either the virus or the vaccine. And, of course, the virus does not differentiate infecting healthcare professionals versus the general public, and in fact, many healthcare professionals suffered various degrees of illness because they put themselves in harm's way to help others. However, this also allowed for us, as health care professionals, to communicate with our patients at a different level, as more of us now shared this malady with our patients and could talk about how we collectively dealt with the impact of COVID, how it affected the quality of our lives, its potential long-term effects, and the importance of the vaccine and boosters. So having had COVID once and having the opportunity to commiserate with my patients, I thought about other healthcare maladies that, as I get older, I am now experiencing and thus could share firsthand with my patients. (Please do not interpret this as the need to have a condition to explain a condition, but it does present the possibility of a different dimension when talking with the patient.) Waving my rights to HIPAA privacy, I will use the example of obstructive sleep apnea (OSA), a condition which I have had for a number of years and am now substantively more aware of with respect to its impact on one's quality of life, on ocular complications, and on other systemic conditions (most specifically atrial fibrillation), and how it can be managed. First, a definition: obstructive sleep apnea is "repetitive partial or complete collapse of the upper airway during sleep, resulting in disruptions of normal sleep architecture."[3]

In our review of systems, we get a snapshot of our patient's current state of health and can consider how that can affect the patient's eye health and vision as well as quality of life. One health issue that is potentially glossed over is sleep. It is estimated that OSA is underdiagnosed. Frost & Sullivan estimate the prevalence of OSA to be approximately 12% or 29.4 million of the U.S. adult population with nearly 80% of that population being undiagnosed,[4] so that only a fraction of people with OSA actually receive a formal diagnosis and subsequent recommended treatment. This underdiagnosis means that millions of people with OSA remain untreated, putting them at increased risk of developing related health problems and affecting their quality of life.

Because my patient population is skewed toward older individuals, and sleep problems (specifically OSA), tend to initially present between the ages of 40 and

60,[5] one of my history questions pertains to how well my patient sleeps. This question is often met with a bit of surprise as the patient wants to know how does sleep, or lack thereof, affect vision (I will answer that shortly)? If the patient reports difficulty sleeping, especially snoring, I then ask questions from a questionnaire that was designed to screen for sleep apnea: STOP-Bang.[6] The questionnaire has eight questions, four questions (STOP) related to Snoring, Tiredness, Observed breathing cessation and high blood Pressure, and four questions (Bang) related to patient demographics: body mass index, age, neck size, and gender. Scoring is pretty simple:

OSA - Low Risk: Yes to 0 to 2 questions
OSA - Intermediate Risk: Yes to 3 to 4 questions
OSA - High Risk: Yes to 5 to 8 questions
or Yes to 2 or more of 4 STOP questions plus male gender
or Yes to 2 or more of 4 STOP questions plus BMI> 35/m^2
or Yes to 2 or more of 4 STOP questions plus neck circumference
16 inches/40 cm^2

Then, based on this scoring, I encourage that individual to think about having a thorough evaluation by a sleep specialist, or, at the very least, mention this to their primary care physician, much the same way as one might encourage a medical assessment based on in-office blood pressure screening. And just like explaining to a patient about the risk of high blood pressure and potential ophthalmic vascular problems, I review the potential risks associated with untreated OSA with respect to optic nerve disease and some retinal vascular issues, as well the association of OSA with hypertension, type II diabetes mellitus, stroke,[7] and atrial fibrillation (the most common arrythmia in the world).[8]

For those who have been diagnosed with obstructive sleep apnea (OSA), the approach is different. Although there are modifiable risk factors, such as weight and smoking,[9] patients with OSA are generally prescribed a continuous positive airway pressure (CPAP) machine. This machine delivers air pressure through a mask to keep the airway open and prevent obstructions in breathing. However, some patients find wearing the mask inconvenient or troublesome, or develop dry eye as a result of air escaping the mask and being directed towards the eyes. As a healthcare professional who also uses a CPAP machine, I can provide first-hand experience and explain the benefits of wearing it, reinforcing the benefit of reducing the risk of OSA complications like decreased breathing as well as the risks I mentioned above. Here is where my wearing the mask can help to underscore the need for, and benefit of using it. (And, for select patients I also explain to them that

I currently wear an N95 for the biggest part of my workday, go home, eat dinner, and put on my CPAP all night!)

So how does the analogy of leading a horse to water make sense with this editorial (my wife asked that question)? With COVID it was straightforward: if a patient was not feeling well, patients are told to get tested (lead the horse) and be treated if necessary (drink the water). With the many healthcare issues that we are able to identify which are not in our purview to treat, we (should) make a referral to the appropriate healthcare professional, the expectation being that the patient will follow our recommendation (leading the horse to water) and then hopefully follow through with the recommendation of their healthcare professional (drinking the water).

Over the years I've been in practice, I've come to realize that not all patients follow through (you can't force a horse to drink). A key point to consider, especially for conditions like OSA, which is often undiagnosed, is that if we don't lead the horse to water in the first place, the horse doesn't have the option to make the choice as to whether to drink or not.

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