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TOP STORY**Davey & Goliath: Doc slings doubt at sleep academy**

By Jim Sullivan, editor

BALTIMORE - A sleep physician who claims that 95-99% of people with obstructive sleep apnea can be diagnosed in the home has prompted CMS to reassess its decision to require beneficiaries receiving CPAP to be diagnosed in a lab using polysomnography (PSG).

In his Jan. 29 letter to CMS, Dr. Terence Davidson, who runs the sleep lab at the University of San Diego's School of Medicine, argues that the current policy is inhibiting the diagnosis of obstructive sleep apnea because the nation's 692 sleep labs are simply too full.



T. Davidson

To support his request, Davidson cited 14 studies involving 747 patients using eight different, multi-channel home sleep tests that demonstrate correlation between tests conducted in the lab and tests conducted in the home. The articles were published in such peer review journals as Chest and Sleep.

"It's not hard to diagnose sleep apnea," said Davidson. "We now have the ability to do CPAP titrations in the home. The fact of the matter is that this disease is so prevalent we need to start diagnosing it."

Approximately 12 million Americans suffer from some form of sleep apnea, according to the American Sleep Apnea Association; the vast majority, perhaps 90%, of those suffering from sleep apnea are not yet diagnosed.

Davidson's request will meet stiff opposition from the American Academy of Sleep Medicine. Last year, the AASM together with the American College of Chest Physicians and the American Thoracic Society published a study in Chest that reviewed 51 articles pertaining to home diagnosis of sleep apnea.

"The Academy is not in favor of unattended home studies," said Jerry Barrett, executive director of the AASM. "The Academy, and the ATS and the ACCP worked jointly on a clinical practice guideline that basically came out and said there isn't enough evidence to do this. We're staying with that decision."

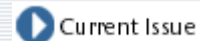
Davidson refuted the findings of this study in his letter to CMS, stating that the review reads more like a "filibuster" than a scientific document.

"The finest attorney in the world couldn't have provided a better defense, [and that is] more misleading," said Davidson. "If you read through their article, they nitpick every miniscule thing they can and miss the forest for the trees."

Davidson's point of view finds widespread traction in the home medical equipment industry but providers and manufacturers are reluctant to go on the record because of possible repercussions from sleep labs with whom they do business.

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The issue, say many, is not one of science but dollars.

"Right now, this disorder is one of the few forms of diagnosis and treatment that are generating a lot of money for certain groups," said one prominent respiratory therapist, who does a robust business in sleep. "For physician diagnoses, this is one of the few cash cows for the neurologists, ear nose and throat (ENTs) and pulmonologists."

The money, according to the source, breaks down this way: \$1,000 for the diagnosis; \$1,500 - \$2000 for the titration and professional fees of \$300 to \$700 every time a sleep doc interprets the results.

Home respiratory providers charge about \$250 for the diagnosis, and \$200 for the titration. Annually, Davidson's lab treats about 250 patients. Nearly every one is diagnosed and treated in the home.

Davidson sits on ResMed's medical advisory board as a paid consultant.

"Resmed, and their auto titration CPAP stands to gain substantially [if CMS opens the door to home testing]," said Barrett.

Davidson said he is paid a "pittance" by ResMed and that he didn't tell ResMed he planned to submit his request to CMS.

Barrett questions why Davidson didn't alert CMS to his affiliation with CMS. But in its paper published in Chest last year, the Academy didn't reveal that its members stood to financially benefit from the status quo. While their analysts were careful to draw up "careful conflict of interest guidelines" to prevent people from links to manufacturers from working on the project, the study failed to state the corollary - that people with a link to facility-based diagnosis were kept from working on the report.

Both Davidson and the respiratory therapist cited earlier said the clinical literature does not contain an irrefutable, double-blind, controlled randomized study that supports their position, and they doubt you could even conduct such a study in the home. That, said the therapist, is why the Academy can reject home diagnosis so handily.

"Evidence-based medicine is interesting because when there is overwhelming evidence it's very valuable," he said. "But when there is a lack of complete evidence, that's when the academics get to use it for or against their position."

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