2025 Clinical Practice Guideline: Chronic Insomnia & Obstructive Obstructive Sleep Apnea

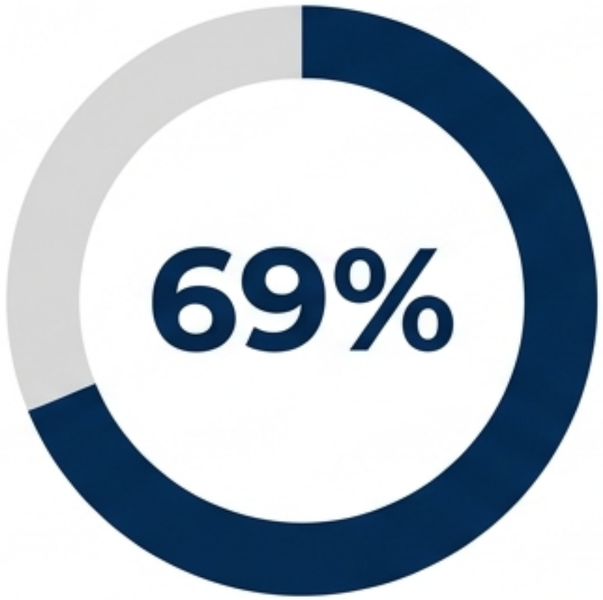
An Algorithmic Playbook for the VA/DOD Healthcare Provider

Operationalizing the 2025 Updates:
Evidence-Based Pathways for Screening, Diagnosis, and Treatment

DESIGNED FOR PRIMARY CARE, SLEEP SPECIALISTS,
MENTAL HEALTH PROFESSIONALS, AND DENTAL PROVIDERS

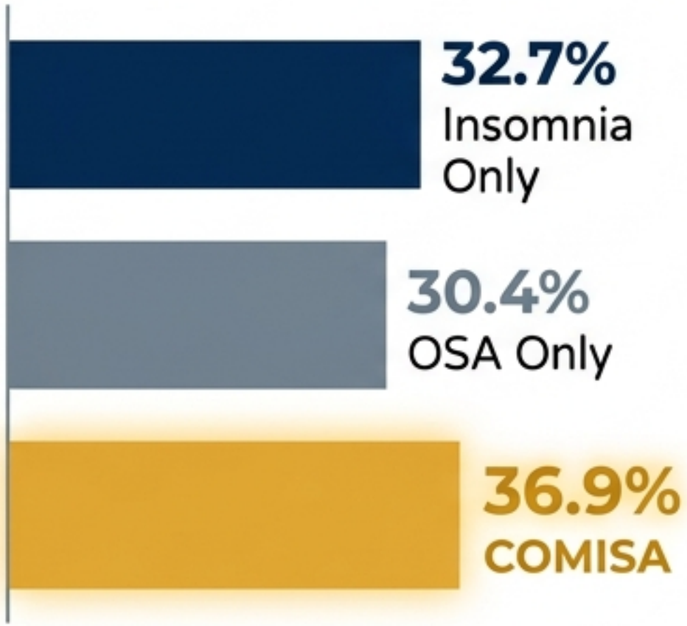
The Clinical & Operational Burden

The Military/VA Burden



of global military personnel and Veterans report poor sleep quality.

The COMISA Crisis

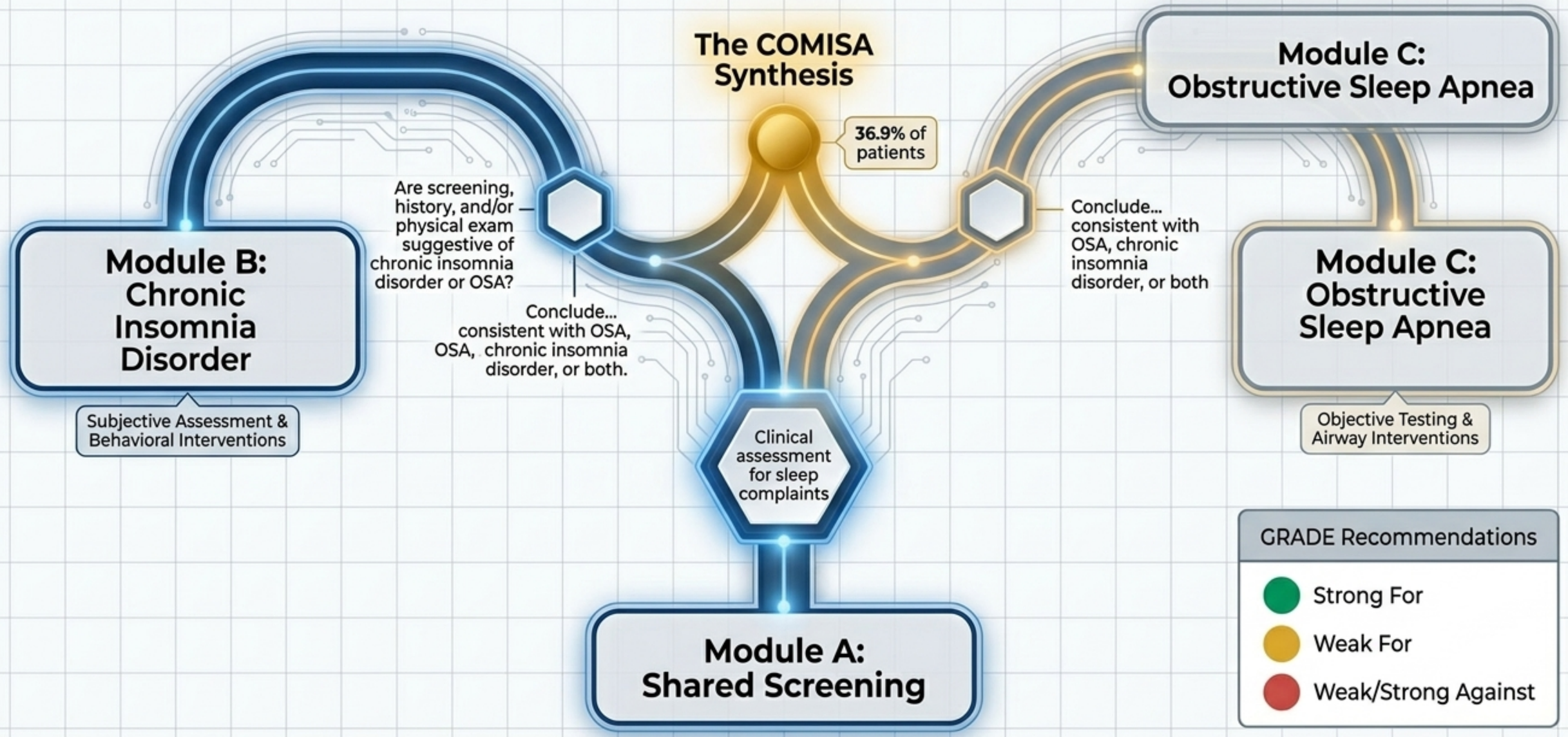


Comorbid Insomnia & Sleep Apnea is the majority presentation.

Clinical & Operational Stakes

- Independent risk factor for CVD, HTN, and strokes.
- Higher relative risk of suicide; disturbance precedes attempts.
- 3x increased risk of motor vehicle crashes; decreased readiness.

The Algorithmic Patient Journey



The Shared Gateway: Identifying the Risk

Does the patient, bed partner, or provider have concerns about the patient's sleep?

YES

Insomnia Screening

Weak For:
Use validated tools

Insomnia Severity Index (ISI)

7 items. Cutoff 11+
(Optimal clinical sensitivity)

Athens Insomnia Scale (AIS)

8 items. Cutoff 6+
(90% discrimination)

OSA Screening

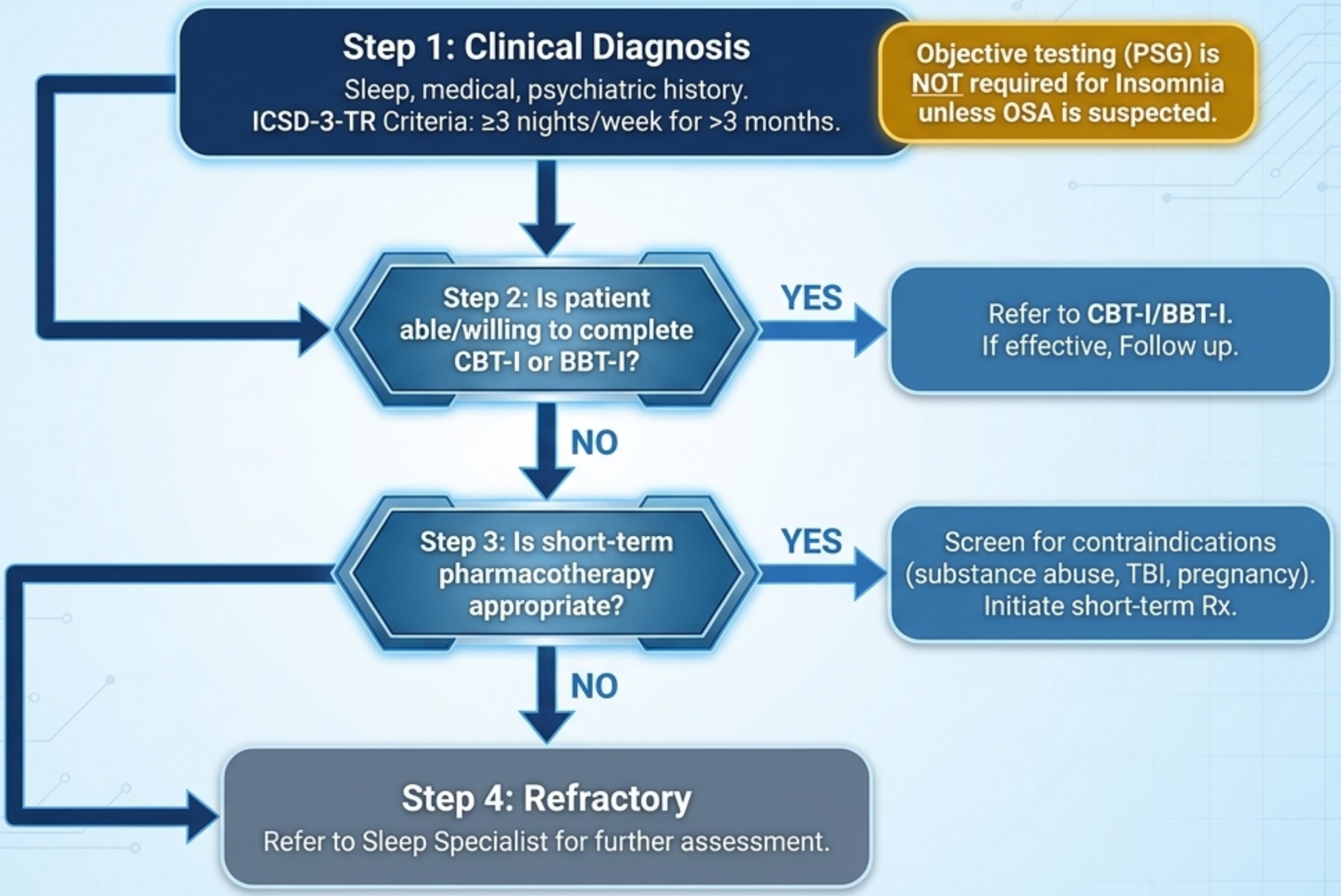
Weak For:
Use validated tools

STOP Questionnaire

4 yes/no items (Snoring, Tired, Observed, Pressure). Cutoff: Score ≥ 2 indicates High Risk

Note: Screening tools are not diagnostic. Positive screens must advance to specific diagnostic pathways.

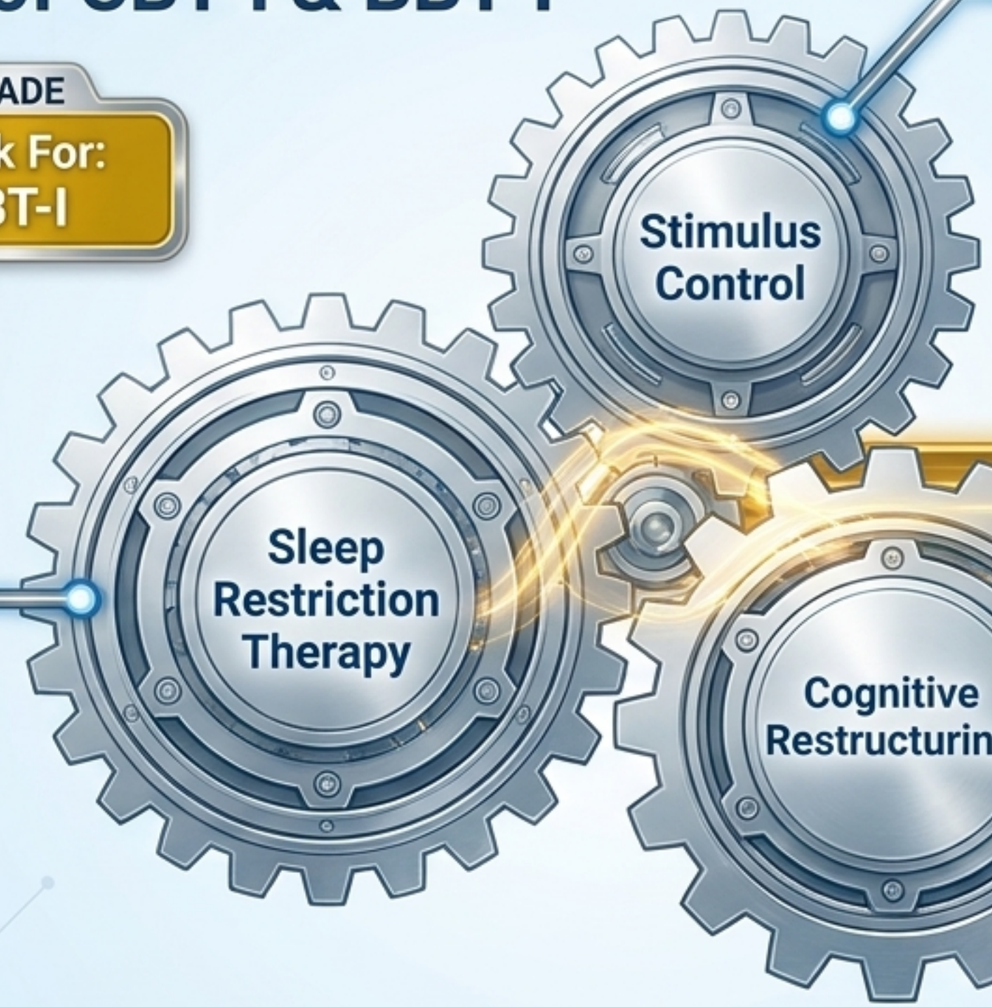
The Insomnia Clinical Workflow



First-Line Defense: The Mechanics of CBT-I & BBT-I

GRADE
Strong For: CBT-I

GRADE
Weak For: BBT-I



Re-associates the bed exclusively with sleep (breaking the bed=wakefulness neuro-pathway).

Limits time in bed to actual sleep duration. Builds homeostatic Sleep Drive.

Output: Increased Sleep Efficiency & Consolidated Sleep

Calms the racing mind; challenges unhelpful sleep anxiety (CBT-I only).

Provider Note Panel: Delivery matters. Use individual, group, or therapist-assisted digital formats. Standalone Sleep Hygiene education is Weakly Against (Orange)—it is insufficient as a monotherapy.

Targeted Pharmacotherapy: The Suggest List

Weak For Only to be used when CBT-I is unavailable/failed, for the shortest duration possible.

Drug Class	Agents	Dose	Onset / Half-life	Clinical Warnings
Dual Orexin Receptor Antagonists (DORAs)	Daridorexant, Lemborexant, Suvorexant	25-50mg / 5mg / 10mg	<30 min / 8-19 hr	Avoid in severe hepatic impairment.
Non-BZD BzRAs	Eszopiclone, Zaleplon, Zolpidem	1mg / 10mg / 5-10mg	15-30 min / 1-6 hr	⚠ April 2019 FDA Black Box for complex sleep behaviors (sleepwalking/driving). Avoid in elderly (Beers Criteria).
Histamine Receptor Antagonist	Low-Dose Doxepin	3-6mg	30 min / 15 hr	Not a controlled substance. Comparable to placebo for adverse events.

The Do Not Use Ledger: Insomnia Interventions

Strong Against

Kava
FDA advisory for severe liver damage.
No evidence of efficacy.

Weak Against

Cannabis / Derivatives (CBD/THC)
Mild side effects common; lacks rigorous long-term efficacy data; significant federal/military occupational implications.

Off-label Psychiatric Meds
Antipsychotics (Quetiapine), Trazodone (FDA black box for suicidal thoughts in young adults; grogginess).

Benzodiazepines
Adverse effect on sleep architecture; high risk of dependency, diversion, and daytime impairment.

Antihistamines (Diphenhydramine)
Beers Criteria warning; next-day psychomotor impairment.

Supplements
Melatonin, Chamomile, Passionflower, Saffron, Valerian (lack of objective efficacy).

The OSA Clinical Workflow

1 Risk Assessment & Objective Testing

High risk vs Low risk

Determine suitability for Home Sleep Apnea Testing (HSAT) vs. In-Lab Polysomnography (PSG).

2 Diagnosis & Severity

Classify by Event Index (AHI):

- Mild: AHI 5-<15 with symptoms
- Moderate: AHI 15-<30
- Severe: AHI ≥30

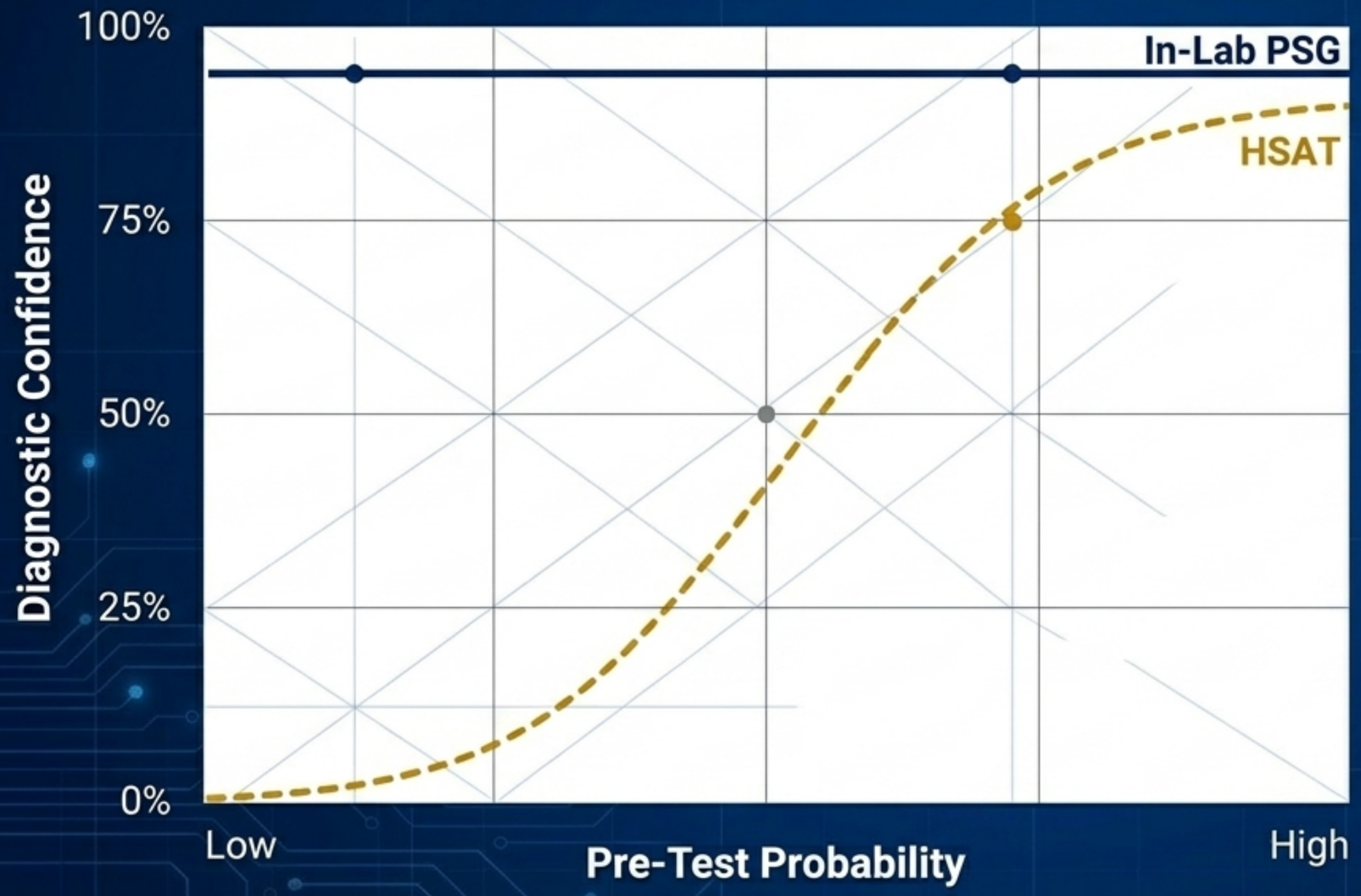
3 Individualized Treatment

Select PAP, MAD, Surgical Evaluation, or Behavioral Weight Management based on patient profile and shared decision-making.

Follow-up for adoption/adherence.

The Diagnostic Confidence Curve: HSAT vs. PSG

Strong For: PSG or HSAT for suspected OSA



When to strictly use In-Lab PSG

- Significant comorbidities (Advanced heart failure, stroke, neuromuscular dysfunction).
- Significant sleep disruption (Comorbid Chronic Insomnia).
- Chain of custody concerns / Occupational mandates.

Managing the Non-Diagnostic HSAT

Strong For:
Further testing

State: Patient takes HSAT.
Result = Non-diagnostic (AHI < 5).

CRUCIAL AXIOM:
A non-diagnostic HSAT does NOT rule out OSA in a high-risk patient.

Action: Must escalate to In-Lab PSG or repeat HSAT.

Clinical Context

Why it matters: Untreated OSA carries a 3x risk of motor vehicle crashes, stroke risk (AHI > 20), and dysrhythmia/mortality risk (AHI > 30). You cannot leave a high-pre-test-probability patient undiagnosed due to a false-negative HSAT.

Mild OSA Sidebar

AHI 5 to <15 on HSAT: Treat if symptomatic. If occupational limitations exist, confirm with In-Lab PSG.

First-Line Therapies: PAP vs. MAD

Weak For: Either MAD or PAP as first-line for Mild/Moderate OSA (AHI <30)

Strong For: PAP for Severe OSA (AHI ≥30)

Positive Airway Pressure (PAP)	Mandibular Advancement Devices (MAD)
Mechanism	
Pneumatic splint.	Physical advancement of the mandible.
Efficacy (AHI Reduction)	
Superior in raw AHI reduction.	Highly effective for mild/moderate.
Adherence / Adoption	
Often lower due to mask discomfort or claustrophobia.	Frequently shows superior patient adherence and preference (crucial for austere environments/deployment).
Mean Disease Alleviation	
Equivalent (Efficacy × Adherence = Net Clinical Benefit).	
Contraindications	
Claustrophobia, mask leak.	Unstable dentition, severe TMJ, central sleep apnea.

The PAP Adoption & Optimization Toolkit

Hardware Optimization

Weak For (Yellow)

Suggest initiating Auto-titrating PAP (APAP) over fixed CPAP to facilitate comfort and usage.

Add heated humidification.

Behavioral & Educational Support

Weak For (Yellow)

Use in-person or telehealth support.

Incorporate Behavioral Sleep Medicine providers.

Supervised mask-fitting sessions increase adherence ≥4 hours/day.

Pharmacological Bridge

Weak For (Yellow)

Suggest up to a 2 2-week course of Eszopiclone to bridge initial PAP adoption in appropriate patients.

(Use lowest effective dose; warn of complex sleep behaviors).

The OSA Treatment Escalation Ladder

Surgical Anatomical Modification

- **Nasal Surgery (Weak For):** Septoplasty/turbinate reduction strictly to remove barriers to PAP tolerance.
- **Hypoglossal Nerve Stimulation (HGNS):** Escalation for PAP-refractory patients.

First-Line Airway Interventions

- PAP Therapy.
- Custom-fabricated MAD (from a qualified dental sleep medicine professional).

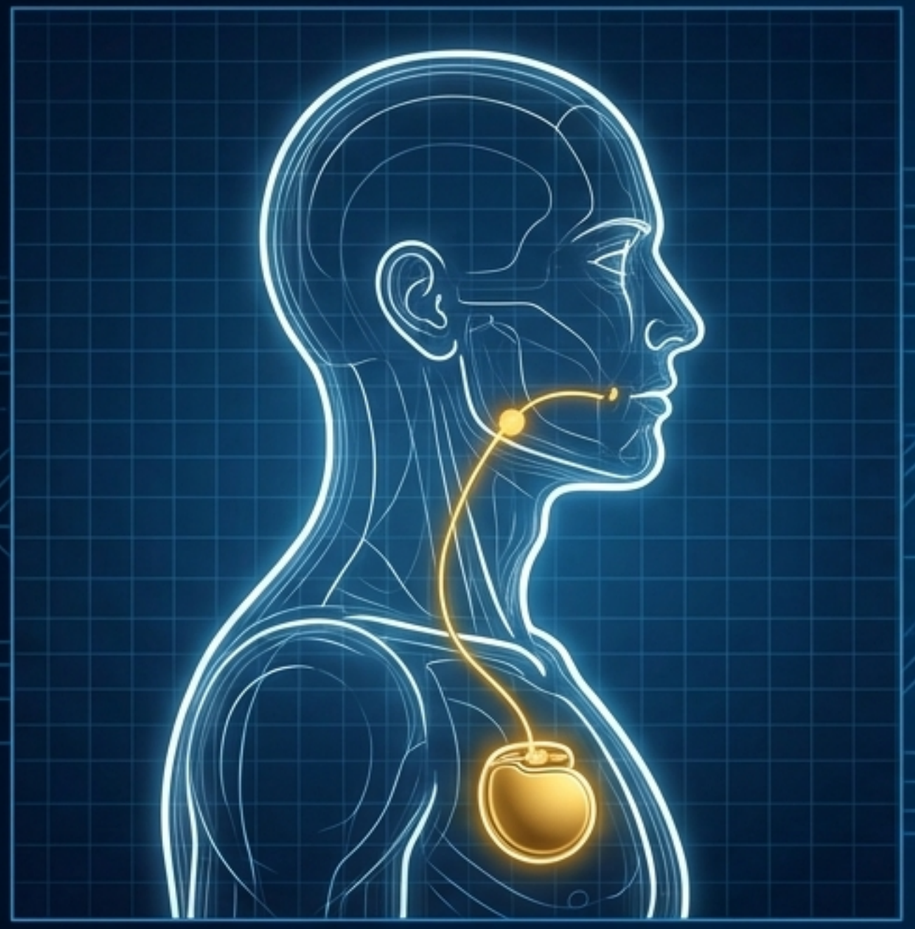
Foundational / Adjuncts

Weak For (Yellow)

- **Evidence-Based Weight Management:** E.g., Tirzepatide (recent FDA approval for OSA with obesity), bariatric referral.
- **Positional Therapy:** Effective for severe supine-specific OSA. Low cost, non-invasive.

Escalation: Hypoglossal Nerve Stimulation (HGNS)

Weak For: Referral for HGNS evaluation



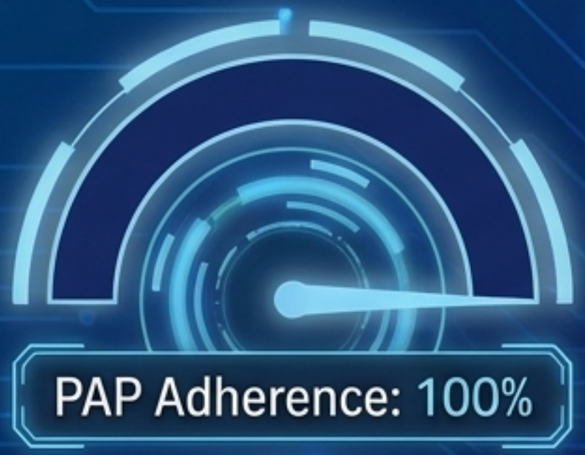
The Mechanism: An implanted neurostimulator dilates the upper airway by selectively stimulating branches of the hypoglossal nerve (genioglossus muscle) during sleep.

Strict FDA Referral Criteria Checklist

- [ ] Adult ≥ 18 years old.
- [ ] BMI ≤ 40 kg/m^2.
- [ ] Moderate to Severe OSA (AHI 15–100 events/hour).
- [ ] Documented failure or intolerance of PAP therapy.
- [ ] Absence of complete concentric collapse at the velopharynx (verified via drug-induced sleep endoscopy).
- [ ] Central/mixed apneas account for <25% of total AHI.

Addressing Residual Excessive Daytime Sleepiness (EDS)

Weak For:
Wake-promoting agents



The Clinical Prerequisite

Before prescribing, the provider **MUST** confirm:

1. Patient is optimally treated (residual AHI < 5).
2. Patient has sufficient therapy use (e.g., FAA/Military standard: >5-6 hours/night for >75-90% of nights).
3. Other causes ruled out (insufficient sleep time, COMISA, psychiatric).

The Suggest List (Wake-Promoting Agents)

- Armodafinil
- Modafinil
- Solriamfetol

Operational Warning: Use in active-duty members may lead to occupational restrictions, deployment limitations, or Medical Evaluation Board referral. Caution in CVD.

The Do Not Use Ledger: OSA Interventions

Weak Against

- **Oxygen as a Standalone Therapy**
  Does not resolve the physical airway collapse; may actually prolong apnea-hypopnea events. (Allowed as adjunct to PAP for residual hypoxia).

- **Atomoxetine / Oxybutynin combination**
  Inconclusive efficacy; high risk of anticholinergic side effects (falls/cognitive impairment in elderly) and CVD exacerbation.

Insufficient Evidence

Neither for nor against:

- Expiratory positive airway pressure (EPAP)
- Inspiratory muscle therapy
- Intra-oral negative airway pressure (iNAP)
- Myofunctional exercises
- Neuromuscular electrical stimulation (eXciteOSA)

Reason: Patient burden is high; risks delaying effective therapies.

The Convergence: Managing COMISA

Patients report vastly worsened fatigue, impairment, and psychiatric distress compared to OSA alone.

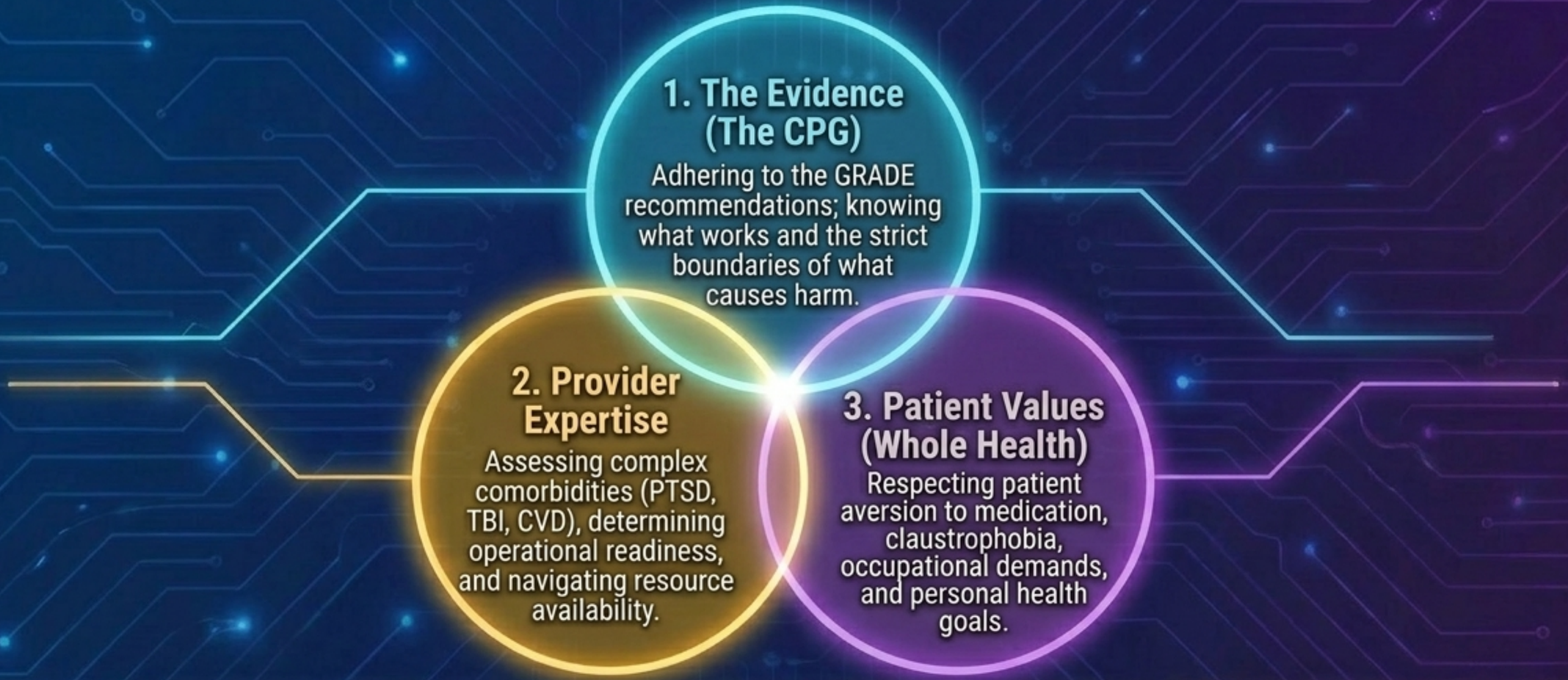
The Clinical Trap

The Error: Prescribing CPAP without behavioral support. → **The Result:** Physical discomfort of CPAP mask exacerbates hyper-arousal. → **Failure:** Patient abandons CPAP; both conditions remain untreated.

The Integrated Solution

- Screen for both simultaneously (ISI + STOP).
- Treat concurrently: Deploy CBT-I to lower sleep anxiety and build sleep drive while introducing PAP or MAD.
- Consider MAD over PAP if claustrophobia/insomnia prevents CPAP tolerance.

The Core of the 2025 CPG: Shared Decision Making



This guideline is a blueprint, not a mandate. True clinical excellence lies in adapting these algorithmic pathways to the unique physiology and lived experience of the individual Veteran or Service Member.