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Sleep apnoea and your anaesthetic

> **The short version.** If you have sleep apnoea, bring your CPAP machine and mask to hospital and use it after the operation, including for naps. If you snore heavily, stop breathing in your sleep or feel sleepy during the day but have never been tested, tell me — it changes the plan, and it is worth investigating.

What sleep apnoea is

In obstructive sleep apnoea the upper airway repeatedly narrows or closes during sleep, so breathing pauses and oxygen dips, often dozens of times a night. The person usually does not know; a partner notices the snoring, the silences and the gasping. It is common — roughly one in four adult surgical patients has at least moderate sleep apnoea, and many do not know they have it.

Why it matters for an anaesthetic

- Anaesthetic drugs, sedatives and opioids all relax the airway and blunt the drive to breathe, which is exactly the problem sleep apnoea already causes. The effect can persist for hours and, with long-acting opioids, for days.
- People with sleep apnoea are more likely to have a difficult airway, and more likely to need support to keep the airway open.
- There is a higher rate of complications after surgery — low oxygen, heart rhythm problems, and unplanned intensive care — particularly with major surgery and with opioids.

If you already have the diagnosis

- **Bring your CPAP machine, mask, tubing and power supply** to hospital, labelled with your name. If you use it at home every night, you will usually use it every night in hospital.
- Use it for naps as well as overnight — daytime sedation is when the airway is most vulnerable.
- Tell me the severity, whether you use CPAP regularly and how many hours a night, your machine settings, and whether you have needed oxygen at home.
- Day surgery may still be suitable for minor procedures, but it depends on the severity, the operation, the pain relief needed and whether you have someone at home to watch you. We will make that decision together, before the day.

If you have never been tested but recognise yourself here

Loud snoring, witnessed pauses in breathing, waking gasping or choking, unrefreshing sleep, morning headaches, daytime sleepiness, and a collar size over about 43 cm all suggest it. So does needing to get up to pass urine several times a night. Tell me, and I will assess the risk — commonly with a short questionnaire (the STOP-BANG tool) — and adjust the anaesthetic and monitoring accordingly. If the risk looks significant, I will suggest a sleep study through your GP or a sleep physician, because

treating it reduces the risk of your next operation and of heart and stroke problems over the longer term.

What I will do differently

- Prefer regional or local techniques where they are suitable, to reduce sedatives and opioids.
- Use short-acting drugs, and avoid long-acting sedatives where possible.
- Watch you more closely after the operation — including oxygen monitoring — and position you with the head up.
- Encourage CPAP early, and avoid unnecessary overnight sedatives.

> **Tell me before the day if:** you use CPAP or a mandibular splint; you have had surgery on your nose, throat or jaw; you have ever been told you stop breathing; you feel dangerously sleepy while driving; or you take sleeping tablets, sedatives or opioids regularly.

Afterwards

- Use your CPAP every night for at least the first week or two, and for daytime naps.
- Do not drink alcohol or take sedatives while recovering — both make the airway worse.
- Do not drive while you are drowsy or taking opioids.
- Tell your GP that the risk was identified, so the diagnosis can be pursued properly.

On your phone: anaesthesia.herman.au/p/18
Prepared by Dr Herman Lim for patients of his anaesthetic practice · version 1.0, 27 November 2026.
There is no ANZCA position statement on obstructive sleep apnoea; the risk assessment described here follows the OSA screening tool published by ANZCA (STOP-BANG and the perioperative OSA risk score), the MJA review *Perioperative considerations in the management of obstructive sleep apnoea* (2019), and the SASM/SAMBA/SOCCA collaborative guidelines for postoperative management of OSA. This sheet is the one in the set where the evidence is international rather than Australian college guidance.
This pamphlet is general information and does not replace individual advice. If my rooms, your surgeon or your hospital have given you different instructions, **those instructions take priority** over anything written here.

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