Obstructive Sleep Apnea and Sodium Intake

What Is the Mechanism?

To the Editor:

We read with keen interest the study by Pimenta et al in a recent issue of CHEST (April 2013). These researchers enrolled 97 patients with resistant hypertension (RHTN) and screened them with overnight polysomnography for the presence of obstructive sleep apnea (OSA). In addition, 24-h urinary sodium and aldosterone levels were measured. It was found that 77.3% of the patients with RHTN had OSA, which is much greater than the prevalence of OSA in the general population. On the other hand, 28.9% of the patients with RHTN were found to have hyperaldosteronism. It was found that the urinary sodium level was an independent marker for OSA severity in the patients with hyperaldosteronism. We congratulate the authors, who contributed extensively to the topic of OSA and aldosterone metabolism. We would like to mention some of the possible mechanisms that may explain this association.

It is well known that patients with RHTN (including hyperaldosteronism), congestive heart failure, and advanced renal disease have a greater prevalence of OSA. Fluid overload associated with these conditions and rostral fluid shift may lead to narrowing of the upper airways, with resultant OSA. This hypothesis is bolstered by the fact that therapies aiming to remove excessive body fluid are associated with an improvement in OSA severity. Nevertheless, additional pathobiologic pathways may be implicated in the development or worsening of OSA severity. Research data point out that aldosterone may mediate multiple detrimental effects, such as tissue fibrosis, systemic inflammation, and oxidative stress. These mechanisms are believed to be responsible for an aldosterone-mediated increase in cardiovascular disease.

**References**


**References**


**Response**

To the Editor:

We thank Dr Kastelik et al for their commentary and interest in our article. As they note, we found evidence that bronchoscopy simulation was effective compared with no intervention but found limited data comparing alternate simulation models. These authors’ experience with two different instructional designs during a bronchoscopy simulation course reflects a contribution in addressing that gap.

We repeat our proposition that the field would benefit from further work to study the effect of training features such as model type, feedback, mastery learning, and duration of training. Furthermore, evidence in the field remains limited with regard to higher-risk procedures, such as rigid bronchoscopy, transbronchial needle aspiration, and transbronchial biopsies. We encourage educational researchers to pursue these questions in future studies.

One other area we were not able to explore in our review is simulation-based assessment, which has been used to measure bronchoscopic skill. Further research in simulation-based assessment in bronchoscopy would complement the research agenda for training activities.
It is possible that aldosterone may mediate upper airways inflammation and fibrosis. This, in turn, may contribute to the detrimental effects of fluid overload in patients with OSA and hyperaldosteronism. However, to our knowledge, there are no studies investigating this potential mechanism. It will be important to study this hypothesis in future research, which should provide more basic knowledge on the pathophysiology of both OSA and aldosterone excess.

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Response

We thank Drs Mirrakhimov and Mirrakhimov for their interest in our article1 and their comments. They point out that additional mechanisms other than fluid overload and rostral fluid shift may be associated with severity of obstructive sleep apnea (OSA) in patients with hyperaldosteronism and high dietary salt intake. Drs Mirrakhimov and Mirrakhimov are correct in hypothesizing that fibrosis and inflammation of the upper airway tissues may also contribute to the severity of OSA, although, as highlighted by them, there are no studies exploring this potential mechanism.

Experiments in animal models indicate that aldosterone excess, in addition to increasing BP, contributes directly to target-organ (heart, brain, and kidney) deterioration by inducing inflammation and perivascular fibrosis.2,3 These same studies have been consistent in demonstrating that the pressor, proinflammatory, and profibrotic effects of aldosterone are dependent on concomitant high dietary salt intake.

Clinical studies do suggest that aldosterone blockade reduces the severity of OSA. In a prospective, open-label study, 12 patients with resistant hypertension and moderate to severe OSA (apnea-hypopnea index ≥ 15) received spironolactone in addition to their previous antihypertensive medications for 8 weeks, after which overnight polysomnography was repeated.4 The apnea-hypopnea index was reduced by a mean of about 50% in all patients. This benefit occurred in the setting of increased diuresis, suggesting that aldosterone and sodium-mediated chronic fluid retention is an important mediator of OSA severity. This study is not able to distinguish diuretic vs antiinflammatory/fibrotic effect of mineralocorticoid blockade but does confirm aldosterone as an important mediator of OSA severity at least in patients with resistant hypertension.

In conclusion, we agree that additional mechanisms, other than fluid overload, may be involved in the development of OSA in these patients. Additional experimental and clinical studies are necessary to explore additional mechanisms involved in the development and maintenance of OSA in patients with resistant hypertension, hyperaldosteronism, or both to prospectively test management strategies of OSA.

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