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Sleep Disorders

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PATIENT AND PHYSICIAN AGREEMENT ON SYMPTOMS OF OSA AT DIAGNOSIS: A REAL-WORLD STUDY IN THE UNITED STATES

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PURPOSE: Obstructive sleep apnea (OSA) is a very common disease with a heterogeneous clinical presentation - some patients report significant daytime sleepiness and fatigue, while others have few or no symptoms. Symptom recognition often drives the diagnosis and reducing symptom burden is one of the key goals of OSA management. Agreement between patient- and physician-perceived disease severity and symptom burden is essential for timely diagnosis and shared decision-making, yet this concordance remains poorly defined. We addressed this evidence gap using real-world data.

METHODS: Data were analyzed from the Adelphi Real World OSA Disease Specific Programme™, a cross-sectional survey of physicians and patients in the United States conducted between April and November 2025. Physicians completed chart reviews for 8 consecutively consulting adult patients diagnosed with OSA, capturing demographic, physician-assessed disease severity, and symptomatology data. These patients completed questionnaires assessing their perceived OSA severity and symptoms. Kappa analysis (κ) was used to assess patient-physician agreement on presence or absence of symptoms (unweighted) and perceived OSA severity (linear weights). Agreement was interpreted according to the criteria by Landis and Koch (1977).

RESULTS: Overall, 142 physicians reported data on 1096 patients with OSA, of whom 365 (33%) completed patient surveys. Mean (SD) patient age was 54.6 (13.4) years old, 64% were male, 74% were White, and 65% had concomitant obesity. Substantial agreement was noted between patient- and physician-reported OSA severity at diagnosis (κ=0.755, n=358). Patients reported milder severity than their physicians in 9% of cases, while reporting greater severity than their physicians in 9%. Fatigue (patient-reported: 73%; physician-reported: 64%), loud snoring (patient: 69%, physician: 55%) and daytime sleepiness (patient: 56%, physician: 54%) were the top three symptoms at the time of OSA diagnosis (n=351). Fair agreement was noted for fatigue (κ=0.269), loud snoring (κ=0.301) and daytime sleepiness (κ=0.328). Patients reported symptom presence in the absence of physician report in 21%, 24%, and 18% of cases, respectively, and physicians reported symptom presence in the absence of patient report in 11%, 10% and 15% of cases, respectively. Fair agreement was observed for difficulty concentrating (κ=0.367; patient presence in absence of physician report: 24% vs physician-reported presence in absence of patient report: 7%), nocturnal gasping/choking (κ=0.344; 17% vs 11%), morning headaches (κ=0.364; 21% vs 5%), mood changes/disturbances (κ=0.272; 22% vs 5%) and sore throat in the morning (κ=0.324; 12% vs 3%). Moderate agreement was noted for dry mouth in the morning (κ=0.433; 19% vs 3%), insomnia (κ=0.453; 14% vs 5%) and no symptoms (κ=0.494, 2% vs 3%).

CONCLUSIONS: Substantial agreement was reported between patient and physician assessments of OSA severity but only fair to moderate agreement for perceived symptom burden at diagnosis. Strengthening clinician-patient communication and enhancing awareness of OSA symptomatology may help facilitate earlier diagnosis, promote shared-decision making, and support effective treatment—key elements to optimizing patient outcomes.

CLINICAL IMPLICATIONS: OSA is a heterogeneous chronic disease characterized by variation in symptoms and severity. Enhancing recognition and awareness of OSA and its symptom presentation will enable the earlier diagnosis and treatment of OSA.

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