BACKGROUND

Despite Aboriginal and Torres Strait Islander people having increased risk factors for OSA (diabetes, obesity) and high levels of comorbid associated conditions (chronic non-communicable diseases) there are currently no published data relating to the nature of sleep-related breathing disorders affecting Indigenous adults. Although there is considerable information from metropolitan services regarding diagnostic and management pathways for OSA, there is less information regarding care for Australians living in regional and remote Australia and particularly for Indigenous Australians.

AIMS/OBJECTIVES

The aim of this study was to compare the use of sleep diagnostic tests, the risks, and cofactors, and outcomes of the care of Indigenous and non-Indigenous Australian adults in regional and remote Australia in whom sleep related breathing disorders have been diagnosed.

METHODS

A retrospective cohort study of 200 sequential subjects: 100 Aboriginal and/or Torres Strait Islander people and 100 non-Indigenous Australians in northern Queensland and Central Australia. Subjects were eighteen years or older with a diagnosed sleep disorder (AHI > 15). Retrospective data collected from patients’ medical records included: demographics; comorbidities; BMI; fatigue score; referral source and management details for 12 months following diagnosis. Follow up included the number of reviews booked and number of reviews attended.

DISCUSSION

Accessing sleep services is a significant issue for Indigenous and non-Indigenous Australians living in regional and remote communities. Aboriginal and Torres Strait Islander people suffering from sleep disorders are more likely to be; younger, female, obese and have a history of chronic disease.

Access to sleep services in these regional and remote communities is poorer than that seen in Australia overall (see Table below), particularly for Aboriginal and Torres Strait Islander people. Reasons for this may include:

1. Population at much lower risk
   Unlikely, especially in Indigenous Australians with greater obesity and co-morbidity.

2. Accessing other diagnostic services
   Likely for non-Indigenous Australians but unlikely for Indigenous Australians who rarely access private healthcare.

3. Differing referral patterns
   Only people perceived likely to be able to attend, afford and/or comply with treatment are referred for diagnostic sleep studies.

Diagnosis and Follow Up

<table>
<thead>
<tr>
<th>Diagnosis (%)</th>
<th>95% CI</th>
<th>Aboriginal &amp; or Torres Strait Islander</th>
<th>Non-Indigenous Australian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snoring</td>
<td></td>
<td>40 (38-42)</td>
<td>39.7 (35-45)</td>
</tr>
<tr>
<td>Witnessed apnoea</td>
<td></td>
<td>100</td>
<td>95 (90-99)</td>
</tr>
<tr>
<td>History of trauma/accident</td>
<td></td>
<td>100</td>
<td>96 (92-99)</td>
</tr>
<tr>
<td>History of fatigue/sleepiness</td>
<td></td>
<td>100</td>
<td>97.5 (94-99)</td>
</tr>
</tbody>
</table>

There is a poorer uptake of treatment following sleep studies in Indigenous Australians. This may occur because:

1. more remote and more limited access to follow-up services
2. cost implications (replacement of machines, masks etc).

CONCLUSION

Appropriate and more accessible diagnostic and treatment sleep services are required in regional and remote Australia. Further research is required to validate appropriate screening tools and pathways of care especially for Aboriginal and Torres Strait Islander peoples.