The Use of Nasal Dilator Strips as a Placebo for Trials Evaluating Continuous Positive Airway Pressure

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The use of nasal dilator strips as a placebo for trials evaluating continuous positive airway pressure

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OBJECTIVES: The aim of the current study was to compare the objective and subjective effects of continuous positive airway pressure to the use of nasal dilator strips in patients with acromegaly and moderate to severe obstructive sleep apnea.

METHODS: We studied 12 patients with acromegaly and moderate to severe obstructive sleep apnea (male/females = 8/4, age = 52 ± 8 ys, body mass index = 33.5 ± 4.6 Kg/m², apnea–hypopnea index = 38 ± 14 events/h) who had been included in a randomized, crossover study to receive three months of treatment with continuous positive airway pressure and nasal dilator strips. All patients were evaluated at study entry and at the end of each treatment by polysomnography, and Epworth Sleepiness Scale, Pittsburgh Sleep Quality Index and treatment satisfaction questionnaires. ClinicalTrials.gov: NCT01265121

RESULTS: The apnea–hypopnea index values decreased significantly with continuous positive airway pressure treatment but did not change with the use of nasal dilator strips. All of the subjective symptoms improved with both treatments, but these improvements were significantly greater with continuous positive airway pressure than with the nasal dilator strips.

CONCLUSION: The use of nasal dilator strips had a much smaller effect on the severity of obstructive sleep apnea in patients with acromegaly and moderate to severe obstructive sleep apnea in comparison to the use of continuous positive airway pressure. Moreover, the improvement in several subjective parameters without any significant objective improvement in obstructive sleep apnea resulting from the use of nasal dilator strips is compatible with a placebo effect.

KEYWORDS: Obstructive Sleep Apnea; Continuous Positive Airway Pressure; Nasal Dilator Strips; Acromegaly; Placebo.

INTRODUCTION

Obstructive sleep apnea (OSA) is a disease characterized by repeated episodes of complete (apneas) or partial (hypopneas) cessations of breathing during sleep, which lead to intermittent hypoxia and disrupted sleep (1). OSA is common among the general population and is associated with multiple health problems. Continuous positive airway pressure (CPAP) is the treatment of the choice for patients with moderate to severe OSA (2). CPAP can improve sleep architecture, reduce daytime sleepiness, improve mood, and reduce automobile accidents (3). There is growing evidence that the treatment of OSA with CPAP can also improve several cardiovascular and metabolic outcomes, and this treatment has been associated with a decrease in deaths due to cardiovascular issues (4). Data from observational studies highlight the necessity of randomized controlled trials (RCTs) to evaluate the effects of CPAP in patients with OSA in regards to several outcome measurements.

Numerous RCTs have compared the effectiveness of CPAP to that offered by various control therapies, including conventional care (5), placebo tablets (6), nasal dilator strips (NDSs) (7), and sham CPAP (8). Several authors have argued that sham CPAP should be the placebo intervention of choice in RCTs. Sham CPAP consists of a CPAP machine that is modified to contain a large hidden leak in the exhaust port of the mask to disperse the therapeutic pressure, resulting in a...
pressure level at the mask interface of generally less than 2 cm
H2O (9). However, the placebo effects of sham CPAP may be
partially hampered by the discomfort and frustration caused
by the necessity of wearing a mask every night with delivery
of suboptimal pressure support (10). The Apnea Positive
Pressure Long-Term Efficacy Study (APPLES) (11) rando-
mized participants to receive six months of active or sham
CPAP, and the results found that not only was adherence to
sham CPAP significantly lower than the adherence to active
CPAP (3.4 vs. 4.2 hours) but that overall study retention was
lower in the sham group compared to the active CPAP group
(S Quan, personal communication). These results suggest that
sham CPAP may not only adversely influence sleep-related
outcomes but may also adversely influence the integrity of
a given study. Despite the need to understand the merits
and limitations of using alternative control interventions
in trials of CPAP, there has been a lack of research specifically
focused on the impact of alternative control interventions
on participant adherence, sleep quality, and other study
outcomes.

NDSs have been designed to mechanically pull the lateral
walls of the nasal vestibule outwards, which dilates the
valve area of the nasal cavity and renders the vestibular wall
stable and resistant to collapse. The strip is placed superior
to the alar cartilage on either side of the nose, which enables
the built-in elastic splints to pull the wall of the vestibule
laterally and dilate the valve area (12). Similar to CPAP,
NDSs are mechanical devices that can be prescribed for
nightly use. However, the two types of devices look and feel
much different, and NDSs are typically less intrusive than
CPAP masks. Because NDSs are widely advocated for the
prevention of snoring and the promotion of nasal breathing
during exercise (13), they may serve as a potential control
intervention for controlled trials evaluating CPAP. However,
it is unclear the extent to which NDSs may influence study outcomes due to an active rather than a
placebo effect, which would therefore attenuate the esti-
mates of intervention effects associated with the use of
CPAP. In this study, we tested the effects of NDSs in a
particular group of patients with acromegaly and OSA, and
we herein report the effects of a randomized crossover trial
in which the objective and subjective effects of NDSs were
compared to the effects of CPAP in patients with acrome-
galy and moderate to severe OSA.

METHODS

Subjects

We studied patients with acromegaly and OSA who had
been recruited from out-patient clinics at the Division of
Endocrinology and Metabolism of Clinics Hospital, Faculty
of Medicine, University of São Paulo. The inclusion criteria
consisted of men and women with acromegaly who were
between 18–70 years of age, had experienced moderate or
severe OSA (≥15 events of apnea and hypopnea per hour of
sleep) as documented by polysomnography and who were
naive to treatment. The exclusion criteria included the
following: the presence of kidney or liver disease; malign-
nancy; hypercortisolism; endocrinological diseases, such as
hypothyroidism; uncontrolled diabetes mellitus (glycated
hemoglobin greater than 9%); and a history of alcohol abuse,
angina, acute myocardial infarction, or stroke. The study
was approved by the local institutional review board, and
all patients provided written informed consent.

Sleep Study

Overnight polysomnography was performed in the sleep
laboratory (EMBLA; Flagra hf. Medical Devices, Reykjavik,
Iceland) and included electroencephalography, electroocu-
lography, electromyography, oximetry, measurements of
airflow (oronasal thermistor and pressure cannula), and
measurements of the rib cage and abdominal movements
during breathing. Apnea was defined as the complete
cessation of airflow for at least 10 seconds and associated
with an oxygen desaturation of 3%. Hypopnea was defined
as a significant reduction (>50%) in respiratory signals for
at least 10 seconds and associated with an oxygen
desaturation of 3%. The apnea–hypopnea index (AHI) value
was calculated as the total number of respiratory events
(apneas plus hypopneas) per hours of sleep (14).

Study Design

Following the diagnostic polysomnography confirmation
of moderate to severe OSA, the patients were randomly
assigned, according to a computer-generated list of random
numbers to three months of treatment with NDSs
(ClearPassage® A.K.C, Inc., Korea) or CPAP (REMSstar Pro
with C-Flex with humidifier; Respironics, Inc., Murrysville,
PA). After three months, the treatment was discontinued
for one week and then patients were crossed over to the
alternative treatment. At the initiation of each treatment
period, participants underwent full polysomnography to
assess the effects of NDSs or CPAP. Therefore, all patients
underwent a total of three polysomnographic studies
including a diagnostic study, one using CPAP and other
using NDSs. During each three month intervention period,
participants were instructed to use NDSs or CPAP every
night. In each treatment period, participants returned for
evaluation once a week in the first month, and once a month
in the second and third month. CPAP compliance was
objectively measured by data collected on an adherence-
monitoring card (Smart Card; Respironics, Inc.). Similar to a
pill count approach, patients were given a limited number
of NDSs, and adherence was measured by counting the
NDSs that were returned at the next visit. After the
conclusion of the study, CPAP was offered to all of the
patients.

Evaluations

At the time of study entry and after the three-month
intervention, the subjects were weighed and evaluated
according to the questionnaires described below.

Epworth Sleepiness Scale

The Epworth Sleepiness Scale (ESS) was used to evaluate
subjective excessive daytime sleepiness. Briefly, the patient
rated the probability of dozing (from 0 to 3) in eight
different situations, where a score above 10 points repre-
sented the presence of excessive daytime sleepiness (15).

Pittsburgh Sleep Quality Index

Subjective sleep quality was measured according to the
Pittsburgh Sleep Quality Index (PSQI) (16), which is a self-
report questionnaire that assesses sleep quality and dis-
turbances over a one–month interval. The 19– item index
generates the following seven component scores: subjective
sleep quality, sleep latency, sleep duration, habitual efficient
sleep, sleep disturbances, the use of sleeping medications,
and daytime dysfunction. Each component score is equally weighed on a 0–3 scale. The sum of these seven component scores yields a global score ranging from 0 to 21. This questionnaire has been previously translated and validated in Brazilian Portuguese (17). Higher global scores indicate worse sleep quality. A cutoff score of 5 yielded a diagnostic sensitivity of 89.6% and a specificity of 86.5% for distinguishing between good and poor sleepers.

Treatment Satisfaction

A questionnaire was designed to evaluate the level of satisfaction with the given treatment and included questions regarding the impact of the treatment on sleep quality, feelings upon waking, difficulty falling asleep, and satisfaction with the treatment effect concerning daytime sleepiness. The patients were also asked to rate the treatment with a score from 0–10 (0 = poor, 10 = excellent).

At the end of the study, when the patients had been exposed to both treatments, they were again asked to rate each treatment. In addition, participants were asked to list the advantages and disadvantages of each treatment and were asked to select which treatment for OSA they preferred.

Statistical Analysis

The data were analyzed with the statistical software SigmaStat for Windows, version 2.0. A descriptive analysis was used to define the study population. The results are expressed as the means ± standard deviation, medians (interquartile range) or percentages, as appropriate. The Student’s t test for independent samples and an ANOVA were used to compare the quantitative variables when appropriate. The χ² test was used for the qualitative variables. The potential explanatory variables used as independent variables consisted of demographic and clinical parameters. A p-value<0.05 was considered to be significant.

RESULTS

During a one-year period, we invited 19 patients with acromegaly to participate in this study. Seven patients were excluded after diagnostic polysomnography due to an AHI<15 events/h. Therefore, the total study sample comprised 12 patients with moderate to severe OSA. All of the patients had confirmed acromegaly (growth hormone (GH): 1.32±0.9 ng/l; insulin–like growth factor 1 (IGF1): 337±180 ng/l) and were receiving octreotide. The demographic and clinical characteristics of the population studied, including medications, are described in Table 1. The body mass index (BMI) values of the patients did not change during the intervention period (33.4±4.8 Kg/m² and 33.05±4.9 Kg/m² at the end of CPAP and NDS treatment, respectively (p=0.94)).

The sleep parameters at baseline, during CPAP titration and with the use of NDSs are presented in Table 2. As expected, the administration of CPAP virtually abolished OSA. In contrast, the NDSs did not significantly alter OSA severity. The mean CPAP pressure was 10.1±1.1 cm H₂O and median use of the CPAP was 6.6±1.6 h per night. The patients used the NDSs 98% of the nights studied. The subjective parameters at the time of study entry and following the use of CPAP and NDSs are presented in Table 3. The reported satisfaction with the use of CPAP and NDSs is shown in Table 4. The benefits of CPAP, as perceived by the patient and measured by the ESS, included improved sleep, less snoring, and a decrease in sleepiness. The disadvantages of CPAP were mainly related to the use of the mask and included the need to adjust the mask to prevent air leakage and the discomfort of using the mask, particularly related to the headgear. The advantages of the NDSs included their perceived practicability and comfort. At the end of the study, 10 patients considered CPAP and two patients considered NDSs to be the more effective treatment.

Table 1 - The demographic and clinical characteristics of the patients.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value (n=12)</th>
<th>Mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, ys</td>
<td>52±8</td>
<td></td>
</tr>
<tr>
<td>Male/Female</td>
<td>8/4</td>
<td></td>
</tr>
<tr>
<td>Body mass index, Kg/m²</td>
<td>33.5±4.6</td>
<td></td>
</tr>
<tr>
<td>Caucasians/Mulatto/Black, n</td>
<td>5/4/3</td>
<td></td>
</tr>
<tr>
<td>Abdominal circumference, cm</td>
<td>102±8</td>
<td></td>
</tr>
<tr>
<td>Neck circumference, cm</td>
<td>42±3</td>
<td></td>
</tr>
<tr>
<td>Hypertension, n (%)</td>
<td>9 (75)</td>
<td></td>
</tr>
<tr>
<td>Diabetes, n (%)</td>
<td>4 (33)</td>
<td></td>
</tr>
<tr>
<td>Diuretics, n (%)</td>
<td>5 (42)</td>
<td></td>
</tr>
<tr>
<td>β-Blockers, n (%)</td>
<td>3 (25)</td>
<td></td>
</tr>
<tr>
<td>ACE inhibitors, n (%)</td>
<td>5 (42)</td>
<td></td>
</tr>
<tr>
<td>Calcium blockers, n (%)</td>
<td>3 (25)</td>
<td></td>
</tr>
<tr>
<td>ARBs, n (%)</td>
<td>4 (33)</td>
<td></td>
</tr>
<tr>
<td>Antiplatelet, n (%)</td>
<td>3 (25)</td>
<td></td>
</tr>
<tr>
<td>Oral hypoglycemic, n (%)</td>
<td>6 (50)</td>
<td></td>
</tr>
<tr>
<td>Antidepressants, n (%)</td>
<td>3 (25)</td>
<td></td>
</tr>
</tbody>
</table>

The values represent the numbers of patients (percentage) or the mean ± SD.

Abbreviations: ACE: angiotensin–converting enzyme; ARBs: angiotensin receptor blockers.

Table 2 - Sleep parameters of the participants at baseline, on nasal dilator strips and on CPAP.

<table>
<thead>
<tr>
<th>Sleep Parameter</th>
<th>Baseline</th>
<th>CPAP</th>
<th>NDSs</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TST (min)</td>
<td>409±51</td>
<td>378±78</td>
<td>394±55</td>
<td>0.49</td>
</tr>
<tr>
<td>Sleep efficiency (%)</td>
<td>86±8</td>
<td>80±16</td>
<td>88±7</td>
<td>0.49</td>
</tr>
<tr>
<td>Sleep latency (min)</td>
<td>11±13</td>
<td>16±16</td>
<td>13±15</td>
<td>0.71</td>
</tr>
<tr>
<td>REM latency (min)</td>
<td>91±52</td>
<td>141±90</td>
<td>110±45</td>
<td>0.18</td>
</tr>
<tr>
<td>Stage 1 (%)</td>
<td>6±3</td>
<td>7±5</td>
<td>6±5</td>
<td>0.58</td>
</tr>
<tr>
<td>Stage 2 (%)</td>
<td>64±9</td>
<td>68±11</td>
<td>61±11</td>
<td>0.26</td>
</tr>
<tr>
<td>Stage 3 (%)</td>
<td>11±5</td>
<td>12±6</td>
<td>9±6</td>
<td>0.35</td>
</tr>
<tr>
<td>REM (%)</td>
<td>20±7</td>
<td>17±10</td>
<td>18±6</td>
<td>0.63</td>
</tr>
<tr>
<td>AHI (events/h)</td>
<td>27±9</td>
<td>17±10*</td>
<td>27±9</td>
<td>0.02</td>
</tr>
<tr>
<td>Apnea index (events/h)</td>
<td>17±14</td>
<td>3±3*</td>
<td>23±18</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypopnea index(events/h)</td>
<td>22±12</td>
<td>5±4*</td>
<td>16±7*</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Obstructive apnea, n</td>
<td>79±79</td>
<td>6±10*</td>
<td>110±99</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Central apnea, n</td>
<td>22±42</td>
<td>14±13</td>
<td>28±59</td>
<td>0.82</td>
</tr>
<tr>
<td>SatO₂ min, %</td>
<td>79±7</td>
<td>86±6*</td>
<td>79±6</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Abbreviations: CPAP: continuous positive airway pressure; NDSs: Nasal dilator strips; TST: total sleep time; REM: rapid eye movements; AHI: apnea-hypopnea index; SatO₂ min: minimal oxygen saturation. * Different from CPAP with baseline and NDSs. † Different from NDSs with baseline. Variables expressed as mean ± SD. Variables with skewed distribution are present as median (interquartile range).
DISCUSSION

This crossover study tested the efficacy of NDSs to be used as a placebo by comparing the objective and subjective effects of CPAP versus NDSs in patients with acromegaly and moderate to severe OSA. In contrast to CPAP, the NDSs showed no effect on several polysomnographic parameters, including sleep structure, arousals, AHI, and minimal oxygen saturation. Despite the absence of objective effects, patients treated with NDSs reported significant improvements in several subjective measurements, including sleep quality, snoring intensity, and somnolence during the day. The subjective improvement associated with the use of NDSs was intermediate and significantly lower than the beneficial effects resulting from CPAP. The subjective comparison at the conclusion of the study showed that the vast majority of the patients (10 out of 12) considered CPAP therapy to be more effective than NDSs. The high level of adherence for the NDSs and the subjective improvements in sleep associated with their use support the concept that NDSs are an attractive control intervention for use in controlled clinical trials aimed at evaluating the effects of CPAP in patients with moderate to severe OSA in regards to objectively measured (physiological or biochemical) outcomes.

CPAP is the gold standard treatment for OSA and, although effective at relieving symptoms, its role in reducing long-term morbidities, such as cardiovascular disease, requires further evaluation in trials that also include proper control interventions. Because of its physical nature, an "ideal placebo" for CPAP likely does not exist. In this context, several alternatives, including pills, oral appliances, and conservative treatment, have been used in RCTs evaluating the effects of CPAP on different outcomes (5,6,18,19). However, there has been little research that has specifically evaluated the effectiveness of placebo candidates. Several studies have argued that sham CPAP is an appropriate control for CPAP, although sham CPAP may serve as a poor placebo due to its negative effects on sleep quality combined with the patients’ ability to identify the sham treatment and secondary disappointment about being placed in an untreated control group. In contrast, NDSs are generally accepted by patients, many of whom perceive benefits and thus may be motivated to continue with long-term studies.

We reasoned that an ideal placebo should, similarly to CPAP, be used every night but not adversely influence sleep quality. Sleep apnea efficacy trials are typically designed to

Table 3 - PSQI component scores and global score of the participants baseline, nasal dilator strips and CPAP.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>CPAP</th>
<th>NDSs</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EES, score (0-24)</td>
<td>12 ± 6</td>
<td>5 ± 5*</td>
<td>9 ± 7</td>
<td>0.016</td>
</tr>
<tr>
<td>Global PSQI score</td>
<td>12 ± 3</td>
<td>4 ± 2*</td>
<td>6 ± 5†</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PSQI ≥4, n (%)</td>
<td>12 (100)</td>
<td>5 (41)*</td>
<td>6 (50)</td>
<td>0.006</td>
</tr>
<tr>
<td>Subjective sleep</td>
<td>2 (1.5–2.5)</td>
<td>1 (0–1)*</td>
<td>1 (1–1.5)†</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep latency</td>
<td>2 (1.5–3)</td>
<td>0 (0–1)*</td>
<td>0.5 (0–1.5)†</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sleep duration</td>
<td>3 (2–3)</td>
<td>1 (0–1.5)*</td>
<td>1 (0–1.5)†</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sleep efficiency</td>
<td>3 (1.5–3)</td>
<td>0 (0–1)*</td>
<td>0.5 (0–1.5)</td>
<td>0.003</td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td>2 (1.5–2)</td>
<td>1 (1–1)*</td>
<td>1 (1–2)</td>
<td>0.009</td>
</tr>
<tr>
<td>Use of sleep</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>0 (0–0)</td>
<td>0.99</td>
</tr>
<tr>
<td>medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daytime dysfunction</td>
<td>2 (2–2)</td>
<td>0 (0–1)*</td>
<td>1 (0–1)†</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Abbreviations: CPAP: continuous positive airway pressure; NDSs: Nasal dilator strips; EES: Epworth Sleepiness Scale; PSQI: Pittsburgh Sleep Quality Index.

Variables expressed as mean ± SD. Variables with a skewed distribution are presented as medians (interquartile range). *For the comparisons between CPAP with baseline; †For the comparisons between NDSs with baseline.

Table 4 - Satisfaction treatment questionnaire of the participants with nasal dilator strips and CPAP.

<table>
<thead>
<tr>
<th>Using the treatment over the last 3 months</th>
<th>CPAP</th>
<th>NDSs</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How was your sleep?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much worse</td>
<td>0</td>
<td>0</td>
<td>NS</td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Equal</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Better</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Much better</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Much worse</td>
<td>0</td>
<td>0</td>
<td>NS</td>
</tr>
<tr>
<td>Worse</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Equal</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Better</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Much better</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Little difficult</td>
<td>1</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>No difficult</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Much difficult</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>How pleased was with the treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very discontented</td>
<td>0</td>
<td>1</td>
<td>NS</td>
</tr>
<tr>
<td>discontented</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Equal</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Satisfied</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Did the treatment helped in your daily activities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>2</td>
<td>NS</td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Rate the treatment (0–10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 = no effect</td>
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<td>10 = maximal effect</td>
<td>9 ± 1</td>
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<td>Rate both treatments at the end of study (0 – 10)</td>
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<td>0 = no effect</td>
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<td>10 = maximal effect</td>
<td>9 ± 1</td>
<td>5 ± 3</td>
<td>0.007</td>
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Abbreviations: CPAP: continuous positive airway pressure; NDSs: Nasal dilator strips. Variable with normal distribution is express as mean ± SD.
compare an active intervention, such as CPAP, with an inactive treatment. Thus, the use of NDSs as a “placebo” assumes that NDSs do not positively (or negatively) influence study outcomes. The effects of NDS are based on the assumption that nasal resistance may play a pivotal role in the genesis of OSA. Several studies have evaluated the effects of different strategies to decrease nasal resistance on OSA severity, and there have been controversial results (20). The beneficial effects of NDSs on perceived snoring and obstructed breathing are likely due to an active effect resulting from the increased cross-sectional area of the nasal cavity and the consequently reduced nasal airway resistance (21). The efficacy of NDSs, however, remains controversial. Although several studies have demonstrated beneficial effects of NDSs on snoring (22-24), sleep maintenance insomnia associated with sleep-disordered breathing (25), and AHI (21,26,27), others have not supported these findings (28,29). In our study, NDSs had no significant effect on the AHI and caused a small but significant decrease in the hypopnea index (Table 2). It is possible that NDSs may have a somewhat greater effect in patient groups besides this OSA–acromegaly patient sample. For example, the study by Redline et al. (7) reported that NDSs had a small beneficial effect on AHI in a subgroup of mildly affected OSA patients with sinus disease. It is likely that, among patients with moderate to severe OSA, neither the site of obstruction during apnea nor the site of generation during snoring is in the nose, and rather this location may be in the oropharynx or hypopharynx at the level of the soft palate or the velopharyngeal level (22). NDSs are therefore an attractive placebo because they offer high patient acceptability and a potential for minimal improvement in the AHI, although the level of improvement in OSA is much less than what can be achieved with CPAP.

The previously reported effects of sham CPAP (30), conservative treatment (5), and oral placebos (6) on subjective parameters have been extremely variable. For instance, Jenkinson et al. (30) found a 29% improvement in ESS associated with sham CPAP, whereas Engleman et al. (6) found no effect of oral placebos on ESS. In contrast to the overall lack of changes in objective measurements observed in our study, patients given NDSs reported significant improvements in several subjective measurements, including quality of sleep, perceived snoring, and symptoms of excessive daytime somnolence, as evaluated by the ESS. Compared to the baseline values, the ESS score decreased by 25% during NDS treatment, which is in line with previously reported studies that also reported positive effects of NDSs on ESS as high as 66% (21-24,31). We also evaluated sleep quality by PSQI, and whereas CPAP improved six out of seven PSQI items, NDSs improved four of these items.

Our study had several limitations. First, we studied patients with underlying acromegaly and OSA. Although unlikely, it is possible that NDSs are more effective for patients with OSA but without acromegaly. Second, the number of patients studied in this report was relatively small. However, the crossover nature of our study increased its statistical power and allowed us to evaluate differences between the CPAP and NDS arms not only for the objective parameters but also for the subjective parameters. Moreover, the study design enabled the comparison of the strengths and limitations of each treatment according to the patients’ perspectives. Finally, the long-term acceptability and use of this type of placebo requires further study.

In conclusion, this study demonstrated that NDSs did not appreciably affect objective measurements of sleep/OSA but were associated with modest improvements in subjective responses. Thus, NDSs may be an effective control intervention for trials aimed at evaluating the objective effects of CPAP in patients with OSA. The present study, however, evaluated patients with acromegaly, and it is possible that small beneficial effects may occur in other groups, such as patients with mild OSA and nasal obstruction. In those cases, the estimated differential effect of CPAP may be modestly underestimated.

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AUTHOR CONTRIBUTIONS

Amaro ACS and Lorenzi-Filho G participated in the study design, interpretation of results, analysis and collection of data, and preparation of the manuscript. Duarte FHG, Jallad RS, and Bronstein MD participated in the collection of data. Redline S contributed to the preparation of the manuscript.

REFERENCES


