

BSS International Sleep Medicine Course 2026

15th - 18th September | Newcastle



British Sleep Society



UK Multidisciplinary Sleep Professionals



Nederlandse vereniging voor
SLAAP- EN WAAKONDERZOEK
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Conflict of Interest Disclosures for Speakers

☒

1. I do not have any potential conflicts to disclose.

☐

2. I wish to disclose the following potential conflicts of interest:

Type of Potential Conflict	Details of Potential Conflict
Grant/Research Support	
Consultant	
Speakers' Bureaus	
Financial support	
Other	

☐

3. The material presented in this lecture has no relationship with any of these potential conflicts, **OR**

☐

4. This talk presents material that is related to one or more of these potential conflicts, and the following objective references are provided as support for this lecture:

- 1.
- 2.
- 3.

Taking a Sleep History

Intended Learning Outcomes

- Obtain a relevant and structured sleep-wake history.
- Understand the main symptoms of sleep disorders
- Perform a physical examination relevant for the various sleep disorders
- Become familiar with the systematic process of the diagnosis and differential diagnosis of sleep disorders.

1 | Medical History

- Social history [married, children, bed partner, profession, work schedule]
- Regular intake of substances affecting sleep and vigilance
- Comorbidities
 - Examples: OSA is a risk factor for hypertension / insomnia is a risk factor for incident depression/ chronic pain and insomnia
- Concomitant medication
 - Medication may induce sleep disturbances like insomnia/ aggravate sleep disorders / may indicate comorbidities

2 | Sleep History

- What is the habitual length and timing of lights off, during work days, weekends, and holidays? Shift work and travel across time zones apply?
- Do you have difficulties in falling asleep or maintain your sleep?
- Do you wake up with the impression of unrestorative/unrefreshed sleep? Do you feel sleepy during the day?
- Have you been told or do you experience unusual or complex behaviour during sleep?

2 | Sleep History

- Family history of sleep disorders (RLS, NREM)
- Evaluation of sleep related symptoms (known, unknown)
 - Timing is essential / for example the final awakening
 - Use of sleep diary/ actigraphy and digital technology
- Evaluation of morning and daytime symptoms
 - Daytime sleepiness
 - Concentration, fatigue, personality etc
 - Coping strategies
 - Sleep disorder specific daytime symptoms

3 | Interviewing Partner and Relatives

- Mandatory if unknown sleep related symptoms
- Experience their own sleep difficulties
- Children

4 | Semi-Structured Interview and Sleep Questionnaires

- Semi-Structured interviews
- Heterogeneity in reports of sleep problems (unspecific, culture, work)
- Questionnaires
- Structured interview for the DSM-5 *Taylor et al, 2018
- Questionnaires should be viewed as complimentary (for example ESS and MSLT)

5 | General Medical Examination

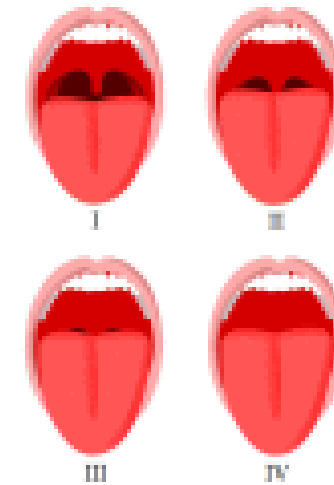
- Evaluate the general appearance of the patient
 - Obesity, tired, dyspnoea
 - Body language
 - Parkinsons/ slow start (gait disorder)
- General anthropometric measures (height and weight)
- Specific investigation when symptoms indicate
 - Cardiological, pneumonological, neurological, endocrinological cause or comorbidity of the sleep disorder
 - Sleep centres should collaborate with primary care and specialised healthcare

6 | Examination of the Upper Airway

- Mallampati Score
- Friedman staging of the upper airway

Stage	Tongue position [#]	Tonsil size [#]	BMI kg·m ⁻²
I	1 or 2	3, 4	<40
II	1 or 2	0, 1, 2	<40
	3 or 4	3, 4	<40
III	3	0, 1, 2	<40
	4	0, 1, 2	<40
IV	1, 2, 3, 4	0, 1, 2, 3, 4	>40
All patients with craniofacial or other anatomical deformities			

Data modified from [32]. BMI: body mass index. [#]: increasing values indicate higher tongue positions and larger tonsil sizes, respectively.



7 | Neurological Examination

- Assessment of consciousness and mental status
- Slow cognitive performance may found in RBD associated with neurodegenerative disease.
- Exploration of peripheral nervous system and spinal cord (RLS)
- Headache – in morning associated with sleep disordered breathing

8 | Psychological/Psychiatric Evaluation

- ICSD-2 contained “insomnia due to a mental disorder”
- ICSD-3 “hypersomnia associated to a psychiatric disorder” (AASM, 2014)
- Anxiety (11%-70%) and depression (7% - 60%) incidence in sleep disorders
- Self reported questionnaires (HADS, BDI-FS)
- Depression is a risk factor for EDS
- Depression high prevalence in females with sleep apnea

9 | Paediatric Sleep Disorders

- Sleep disorders are underdiagnosed in children
- Daytime symptoms are expressed different than in adults
- Behaviours and motor activity during sleep
- History should include sleep history for the entire family
- Sleep diary 2-3 weeks should include events and activities
- Screens and phones should be avoided

10 | Differential Diagnosis and Working H

- The sleep specialist should follow a strategy so
 - They pose appropriate questions
 - Validate the responses
 - Continue with new questions to get a valid diagnostic impression

10 | Differential Diagnosis and Working H

