Talking Sleep Season 4
Episode 12
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Dr. Andrea Matsumura, Guest

Episode Transcript

DR. KHOSLA: Thank you for joining us for Talking Sleep, a podcast of the American Academy of Sleep Medicine. I'm your host, Dr. Seema Khosla, medical director of the North Dakota Center for Sleep in Fargo.

We know that there are many differences between women and men, and this extends to their sleep as well. Here to talk with us today about women's challenges in getting consistent healthy sleep is Dr. Andrea Matsumura. Dr. Matsumura is a sleep specialist in Portland, Oregon, and is a member of the AASM Public Awareness Advisory Committee. Thanks for joining us today, Dr. Matsumura.

DR. MATSUMURA: Thanks for having me, Seema.

DR. KHOSLA: So, one of the things I really love about our field is that people seem to find it through so many different pathways. Tell me about yours.

DR. MATSUMURA: Well, I was an internal medicine doc for a really long time, practicing primary care deep in the trenches. And, you know, after about ten years or so, I started to realize that there was an association between people not getting enough sleep and me having a harder time helping them control their medical conditions. And so, I started to do more research about sleep.

What is sleep medicine… And after about 12 years, I decided to go back and do a fellowship in sleep medicine.

DR. KHOSLA: That's fantastic. So, were you interested in women's health when you did primary care?

DR. MATSUMURA: I was. I had a subset of patients that were, you know, female and I mostly saw female patients. Honestly, especially when you're in a group that the majority of them are men, I would say that I would say that the tendency is that women want to see other women. And that's just a general generalization.

DR. KHOSLA: Mm hmm. You know, I feel that I remember when I was a when I was a resident, I had a male attending. And, you know, in resident clinic, you kind of build your own panel and at least once a month, my clinic schedule would be full of middle-aged women that I literally never met before. And so, I got to the point where I would just walk in the room and I'd be like, oh, let me guess, are you do for your pap?

And that would be, like, amazed at my ESP for like, being able to figure it out.

DR. MATSUMURA: Yeah, I totally. Yeah. You know, I really think that sometimes, you know, women just women patients really just want to see other women clinicians, physicians, because there's something to be said for somebody who's kind of walking in the same shoes.

DR. KHOSLA: So, you presented at APSS, and your talk was called "No Sleep til Charlotte." Sleep Issues in women, a wake-up call to action. So, I love sort of the implication, like the music background to that. But through your presentation, you went through a number of sleep disorders and you kind of focused on how gender plays a role sort of in clinical symptoms, but also in the diagnosis of sleep disorders.

So, tell me, what was your overall message?

DR. MATSUMURA: Well, you know, the overall message of that presentation was that women present differently like we're a different gender. And a lot of the research, we you know, there's more research actually coming out around women, women's health, women in sleep. But we still have a lot of work to do. And I think that for me was the take home message that you can't always use the guidelines sometimes the literature that's out there for women.

Sometimes you have you have to do a lot of what I would consider to be called outside of the box, thinking when you're seeing women and thinking about sleep disorders and women because they just don't present the same way.

DR. KHOSLA: It's a lot like heart disease. Right. You know, where we were talking about sort of how myocardial infarction presents in men versus women. Right.

DR. MATSUMURA: Yes, very much so. And especially, you know, that holds true for sleep apnea, which is kind of what everybody thinks about when they think about sleep medicine. That the first thing that comes to mind is the sleep apnea. And even more commonly, the obstructed, you know, obstructive sleep apnea versus other types of sleep apnea.

DR. KHOSLA: So, let's talk about that a little bit. You know, so how is sleep inherently different in women?

DR. MATSUMURA: Yeah, I mean, you know, oftentimes when I start out this type of conversation or presentation, I often will point to the fact that, you know, physiologically we are different with each decade of life because our home hormones will change with each decade of life. And then the other piece is that there's this kind of psychosocial component also to a woman's ability to sleep and get sleep.

And so there's a lot of external factors, I would say, that can play a part in women achieving high quality and quantity of sleep. So that's kind of where I start off that, you know, there's a little bit of a I would say a normalization that women just don't typically or shouldn't get as much sleep as men do because they have all of these other external factors that are contributing to their inability to get good sleep.

And then I find that anecdotally that sometimes is leading to a delay. And in a woman's diagnosis of a sleep disorder.

DR. KHOSLA: Well, and that kind of goes against what some of the data has shown us recently. Right. Like, do you remember when? So, one was Fitbit releasing like 6 billion nights worth of data, and they found that women achieve about a half hour more sleep. And then do you remember, I think within that same sort of timeframe, this study that came out sort of indicating that women need more sleep because of their brains.

Do you remember that and how controversial that was?

DR. MATSUMURA: Yeah. Yeah, I do. I do. I mean, you know, so I find it fascinating that they were recording that, you know, especially with Fitbit saying that women were getting more sleep when in fact, you know, women I guess the women that I see in my clinic often are reporting that they get less sleep or they sometimes feel more symptomatic.

Or, you know, honestly, when I have patients fill up sleep diaries or when we really kind of drill down specifics about their sleep schedule, they're not getting as much sleep as what, you know, was touted in that in that piece of information.

DR. KHOSLA: So, you mentioned earlier about the difference that you see between men and women with respect to sleep disordered breathing. And so, during your presentation at the question-and-answer session afterwards, this kind of struck a nerve and people brought up this idea of, you know, upper airways resistance and an elevated RDI versus an AHI of 5 or above right to qualify for CPAP.

And a lot of our colleagues were really, really frustrated that insurance wouldn't necessarily cover PAP for Upper Airways resistance. But you know, and I know you share this, too, you know, how many of our patients have benefited from treating this.

DR. MATSUMURA: Yeah, I agree. You know, I think I think the ownness is really on those insurance companies and actually on us as a medical community. To help educate the public that, you know, upper area resistant syndrome is really a phenotype of obstructive sleep apnea. And yes, there's not as much data and insurance companies tend to hang their hats on the data.

You know, where is all the evidence because machines are expensive, but they're also potentially lifesaving in the sense that, you know, if somebody is truly impaired, they need they need treatment. And, you know, disproportionately women have the diagnosis of upper area resistant syndrome. And so, in that question-and-answer section, our colleagues were really frustrated because insurance companies tend to not pay for those for that diagnosis.

So, it’s frustrating to me because, you know, just because the evidence isn’t out there and maybe, you know, maybe we need to push for more research around this particular type of phenotype of sleep apnea. You know, the other thing that I brought up in my presentation was that women weren't even included in studies pertaining to obstructive sleep apnea until 1993.

And you know that it boggles my mind that women weren't included in studies until practically the mid-90s because, you know, they were it was thought that there were too many complicating or confounding factors.

DR. KHOSLA: Isn't that crazy? So, so then do you have any sort of secret sauce or tips or tricks for how we can maybe document or better advocate for our patients specifically with insurance to have them cover CPAP therapy for Upper Airways Resistance?

DR. MATSUMURA: I mean, I wish I wish I had a, you know, a slam dunk for that, but, you know, it's really what I found during that question and answer was that it's region based because it's based really on what insurance is or in your particular region and how they're choosing to cover treatment options. One of the things, though, that, you know, just I would say that might be helpful is that I think women still when they present with symptoms similar to men and with sleep apnea, they're still a little bit more reluctant.

I find in women moving are in clinicians moving forward with referring for a sleep study. And I hear that almost weekly still in my office and I'm every week I'm still surprised like how like a woman say I knew I had sleep apnea I was telling my primary care clinician or I was telling my specialist that I've been seen for some other disorder that I, you know, that I, I knew I had sleep apnea and, and I kept getting told that that wasn't that.

And here it is. This is it. And, you know, women are really starting to advocate for themselves around their medical conditions. And it's not to throw my throat in the medical community under the bus. It's just that it's yet another thing that we have to kind of maybe think, again, I'm going to use that phrase outside of the box thinking to, to, to maybe start asking different questions around sleep for women.

So, you know, all those screening tools that we use which vary and their ability to help us truly and accurately screen for sleep apnea, I find that they're really male focused. You know, there's a little bit of gender bias going on. And I would love to work with anybody out there who wants to, you know, come up with a questionnaire that's more female focused frankly.

I mean, it's a tall order. But, you know, I really think that some of the things that I that I find that are happening for women who end up having sleep apnea is that they have more fragmentation of sleep. They don't always have the loud snoring. They don't always have the witness apnea. As excuse me, but that sometimes they'll have, you know, you know, just more fragmentation of sleep.

And then, you know, sometimes they're provided with a sleep aid, and it still doesn't work. And they've been really struggling for, you know, a decade or more sometimes. And here we are, low and behold, they have sleep apnea.

DR. KHOSLA: So, do you think part of that then is our responsibility in terms of educating our colleagues and our because it's multi it's on multiple, multiple levels, right. That patients need to understand that? Yes. Just because, you know, if you're thin and female, right. You're non-obese and female, but your sleep is fragmented, you're not off the hook. Right. It's not a get out of jail free card being thin and female from having sleep apnea.

And it's also so educating patients, but then also educating clinicians. Right. Because isn't it on average like an hour of sleep education through from medical school, through residency?

DR. MATSUMURA: Oh, yeah, absolutely. I mean, you know, coincidentally, I was just on the call for the Sleep is Good Medicine campaign, and we were just talking about that, that, you know, how do we help our fellow community of clinicians out there start just talking about sleep, just engaging patients in general, but even more so, engaging our female patients around sleep, health and wellness because it's such a cornerstone for how everything else in our bodies work and function.

DR. KHOSLA: So, you know, I think the big one that we see and when we think about women and sleep, the big one obviously is insomnia. Right? Yeah. And so, with a little caveat, right? Because sometimes some of that insomnia, is it sleep disordered breathing with sleep fragmentation like you alluded to earlier, yeah, right.

DR. MATSUMURA: Yeah, definitely. You know, insomnia, chronic insomnia, you know, that oftentimes women will be presenting that way, whether that fragmentation of sleep has been labeled as insomnia. And indeed, sometimes it is chronic insomnia. But sometimes, you know, for me as a sleep medicine specialist, I typically see somebody who has more than one sleep disorder going on. And so, I will see a lot of them, and having both sleep apnea and some form of insomnia together at the same time. And then we treat both of them. And that person is in such a different place.

DR. KHOSLA: Mm. Well, that's one of the things we've learned, right, that you do have you do have to treat both right.

DR. MATSUMURA: Yeah, absolutely.

DR. KHOSLA: So then does your approach to treating female patients with insomnia differ from your approach in treating male patients with insomnia?

DR. MATSUMURA: Well, you know, I tend to have a lower threshold for testing my female patients for sleep apnea. You know, and the reason being is because as we know, that pattern around sleep apnea for women sometimes bubbles up a little bit more frequently in the sense that women are going to present maybe with that more fragmentation of sleep because they may have more REM related events around their sleep apnea.

And so, they'll have mild sleep apnea overall. But then during REM sleep, they have moderate or severe sleep apnea. And so sometimes it's masquerading as insomnia. And then, you know, the brain says, oh, I'm learning a new pathway. And then they actually do apply for insomnia along with this untreated sleep apnea.

DR. KHOSLA: And I think that kind of goes back to this diagnosis, right when women have upper airways resistance because a lot of the time, they will have an elevated AHI in REM or during supine sleep or something like that. Right. But then overall, they don't meet that criteria I know.

DR. MATSUMURA: And it's so frustrating, I think, for me from a clinician standpoint, because you know that this person is suffering. But, you know, that then you're going to meet with meet up with some roadblocks around getting the patient the treatment that they really need.

DR. KHOSLA: Well, I think that's kind of what it comes down to. And, you know, it's our job to advocate for our patients and to partner with our patients. And sometimes we do need to be creative or sometimes we do need to say, OK, well, this is what I see, right? Like on your back, you've got an AHI of ten.

And then is the right answer to repeat a study in the supine position or is the answer to say, OK, well, let's try positional therapy first and see if you get better yeah.

DR. MATSUMURA: I mean, those are really both, you know, options that I've used in my practice, you know, I just I you made me think of a patient that had had three sleep studies and was still very symptomatic feeling very sleepy you know, high Epworth scores and kept coming up with an AHI of like four or three. But you can see elevated events. But they also had delayed sleep phase so they weren't being given enough time to actually get enough REM sleep and so I had this long conversation with the patient and I finally said, you know, I think we actually need to do another study and I made sure that I instructed our sleep technicians to provide the patient with, you know, enough time to capture, you know, 20% REM sleep.

Once we did that patient then, you know, became positive for sleep apnea with their AHI and their whole world changed once I started them on CPAP.

DR. KHOSLA: Isn't that amazing?

DR. MATSUMURA: It was amazing, sad and rewarding at the same time.

DR. KHOSLA: Think that's where, you know, you kind of the test is one part of it, right? Yeah. But it's that clinical picture and I know, you know, our colleague Dennis W talks about this a lot, that obstructive sleep apnea should be, you know, perhaps modeled after asthma where you have this clinical picture of sleep apnea and would you do empiric pap and see if they get better versus testing and sort of we go back and forth.

So, I agree with Dennis on almost every single thing he says and he's very, very smart. So, when he comes up with something, I think you have to listen to it, you know? But I know for me personally, the value in a sleep study isn't always just on the diagnosis because they usually come in knowing their sleep apnea.

Right and so to me, the value is look at this nadir saturation and look at, you know, how much time you spend hypoxic or hey, look at how your sleep architecture is super fragmented. And then look at how much better it gets on treatment. So, I think the value of the testing is sort of, you know, beyond just the AHI.

I but it's interesting, right? And I think he reminds us that it is about the clinical picture. So, like what you're saying that you're like, OK, clinically, she has sleep apnea and the test is not capturing it because we are missing REM because of her delayed sleep phase. So how can we tailor the test to the patient in a more meaningful way?

DR. MATSUMURA: Yes, right. You know, and that's where we come in, right? That's where we come in as clinicians saying, hey, we need to think differently. Not, you know, that the

diagnostic test is a tool for us to be able to then help patients identify what diagnosis they may have that will then lead to treatment to truly then help them.

And yeah, to his point, I wish we could do more of that type of testing. I mean, that's such a valid point. I think sometimes I get I personally get a little siloed and in thinking at times because I'm trying to make sure that all those balls are there in the air and that big ball, which is that insurance piece that I'm actually helping the patient because then it can become another burden for the patient.

Right. Think about treatment and it's not covered by insurance.

DR. KHOSLA: Right? Well, that's exactly right. I've learned it's you know, you can fight insurance as much as you want, but inevitably they delay care, right? When you're fighting with them and you're you know, you're incensed and you're trying to fight the good fight. And sometimes you just, you know, have to take a step back and be like, OK, well, am I doing this truly in the patient's best interests?

And maybe is there another way, you know, a passive lesser resistance happens?

DR. MATSUMURA: Definitely.

DR. KHOSLA: Let's take a short break. And when we come back, we'll talk more about how women's sleep changes through the years. You're listening to Talking Sleep from the American Academy of Sleep Medicine.

AD BREAK: A new AASM accreditation program is designed to improve sleep care access to patients at high risk for obstructive sleep apnea. The Specialty Practice Accreditation program is available to cardiology practices that evaluate and test patients for OSA and collaborate with an AASM-accredited sleep facility for treatment and management. Learn more about this initiative to reduce the number of people living with undiagnosed sleep apnea. Visit aasm.org/accreditation today.

DR. KHOSLA: Welcome back to Talking Sleep We're talking with Dr. Andrea Matsumura about the unique sleep challenges of women. So, part of your presentation was talking about how sleep changes over a woman's lifetime. And that's a very broad question. So, if I focus and I think about, you know, when do we see women in Sleep Clinic? So, I think a lot of us see women in sleep clinic around the time of menopause.

And they complain about hot flashes, for example. So as a sleep person, not a primary care person, what treatment options should we be offering? So, I know and I can just say this from my personal experience, like my background is pulmonary critical care. I am not super comfortable providing estrogen replacement. So, what do you have for me? What are my other options?

DR. MATSUMURA: Yeah, I know. You know, and I can say from an internal medicine you know, the primary care kind of end of the funnel person, I too would echo your sentiments that, you know, when it comes to treating and I think that the latest the way that we describe any type of hormone therapy is simply that hormone therapy.

So, I've been doing a lot of research and reading about perimenopausal menopausal symptoms. And the aim is not to replace the hormone because we'll never be able to replace it the way that it was one that it once was. What we're going to be doing is providing hormone therapy to help alleviate symptoms that may be impairing to our female patients.

And so, I too am uncomfortable with hormone therapy, but at least I start that conversation and a lot of what I do is empowering the, the patient to say, hey, you know, you deserve to have a conversation with the gynecologist about what is affecting your sleep potentially. And, you know, clearly as a sleep medicine doc, I'm going through all the other things that could be affecting their sleep, like, you know, their breathing, their timing, you know, their environment, other medications, blah, blah, blah.

But when the when we're left with, you know, hormonal shifts and changes and especially in that perimenopausal menopausal state, I mean, hot flashes and disruption in sleep due to hormonal shifts can really, really impair people. And I think that they should seek out the help of a specialist who can really inform them around the positives and potential risks.

The risk benefit of going down the hormone therapy pathway or other options such as, you know, SSRI for the treatment of hot flashes in particular.

DR. KHOSLA: What about. So, I agree. I think that is kind of what I'm very curious about. So, SSRI is like venlafaxine maybe. What about something like Clonidine?

DR. MATSUMURA: Well, I mean, you know, it, it's on that list and some, some patients I have had some patients over the years as a primary care doctor and even sleep medicine when I see patients sometimes that that potentially does work, I think I think it's really just kind of exploring all the potential options that are out there and starting like we do like we should do with everything in medicine, which is the least invasive to that to the most invasive.

Right. So, starting out with environmental, you know, changes how can a person do all the things that they that that might potentially help reduce that hot flash from causing impairment in the middle of the night? And then if we have to then move to pharmacological options and, you know, it might be an SSRI and SNRI, clonidine, you know, gabapentin has been used now.

And I think that maybe normalizing a little bit and saying, you know, it's all about balancing, you know, the suffering versus, you know, that that cost benefit around using a medication if you have to for a period of time if you are really, truly suffering. And I see that in a lot of my female patients who come to me who are middle aged or who have gone through a surgical menopause, that they're really impaired.

And sometimes they need to be on something for a period of time to get them through the phase in life that they're at.

DR. KHOSLA: So, I didn't know you could use Gabapentin for hot flashes.

DR. MATSUMURA: I know I didn't either until I started doing my research for this talk. And then I realized, well, you know, Gabapentin is like I think it's like the number one medication that's prescribed in the country.

DR. KHOSLA: For hot flashes.

DR. MATSUMURA: No, for like and so when I when I found it in the literature, I was like, oh, yeah, no surprise. Gabapentin. It came in because it's kind of a cure all medication. But, hey, you know what? It's worthwhile to actually pursue all of those options because some people may not want the side effects that an SSRI or an SNRI brings and, you know, so.

DR. KHOSLA: Yeah, well, no, it was some guessing this low dose gabapentin.

DR. MATSUMURA: Yeah, super low dose. Yeah. Like 100 milligrams. Yeah.

DR. KHOSLA: I mean, I have to try it. I have somebody in mind I have somebody in mind who is trying to get off of her venlafaxine and her, you know, she is for hot flashes so I'm going to have to bring this up. Thank you.

DR. MATSUMURA: You're welcome. Yeah. You never know what we're, what, you know, might be on the horizon, right?

DR. KHOSLA: Honestly, so let's talk about sleep during pregnancy. So how? This is a big one, right? And this is a huge topic, and we don't want to do it a disservice but just sort of in broad, sweeping strokes, we know that sleep changes, you know, first trimester, second trimester, third trimester. So how does it change broadly? And I think more importantly, how can we help our pregnant patients sleep better during pregnancy?

DR. MATSUMURA: Right. And, you know, the biggest thing is that if patients who are in their first trimester already have risk factors related to sleep apnea and they don't come up positive for sleep apnea with that literature that's out there, it's not published but it's that new. What is it? The new mom to mom to data. Yeah. Yeah.

So when I was looking at the database, what I came across was that there is some evidence based on the data that that's available that maybe we should be retesting those patients and their third trimester and I feel like that's a real call to action because, you know, everything in sleep is sleepy, right? It takes forever to get a test to get treat treatment.

Right. And, you know, every week counts in your third trimester, right? So, you know, now I'm following those first trimester patients that I have in my own practice. So, if they come in, they are symptomatic. I'm calling them in their second trimester and just asking them, you know, the general I tend to use in Epworth have to use something so that I can kind of, you know, check for any pattern changes and then just generally ask some of their sleep time.

And then I call them again at the beginning of their third trimester. And if they're having an increase in symptoms, I bring them into in for a sleep study.

DR. KHOSLA: So, can you remind me again about the new mom to be study? I was following it for a while, but I haven't I haven't seen so outline exactly what the study was and just broad sweeping strokes.

DR. MATSUMURA: Yeah. Yeah. So well, the part that I focused on was that I'm around sleep apnea. So came out to be there was there's all kinds of data points that that are part of that study.

It's a large-scale study over gosh, years. Years, I want to say was like what, at least a decade's worth of information. I think so.

But there is like this subcategory of sleep apnea in in pregnant women. And so that data specifically you know, what they found was that a lot of women who have symptoms and their first trimester actually don't end up having sleep apnea. And so, when I first started looking at the data, I kept, I was like rubbing my eyes, looking at the chart, trying to make sure I was reading it right because I was thinking to myself, huh?

So, women who have symptoms of sleep apnea in their first trimester are coming up, not having sleep apnea. But then they had this data where they followed these women and there was an increase in that subset of women having sleep apnea and their third trimester. And I was like, OK, wait a minute, they're on to something here. I hope that somebody can publish this data.

But there are some trends here, right?

DR. KHOSLA: So, is that an AHI RDI thing, do you think?

DR. MATSUMURA: Yeah, it was an AHI. I think they didn't even calculate RDI. And even show, RDI in the data, it was an AHI thing. And it's interesting. I found that fascinating because, you know, that's really when we need to hurry. You know, I you know, in that third trimester, if somebody ends up having sleep apnea, we absolutely need to, you know, get them treated yesterday.

DR. KHOSLA: Right. Yeah, because the outcomes for, you know, adverse events for women with untreated sleep apnea who are pregnant, you know, is pretty significant.

DR. MATSUMURA: Yes. And you know, I was just thinking I wish, you know, we could get together with like ACOG you know another ASM ACOG really collaborating on this work because it's so important, you know women, pregnant women, mortality, infant mortality rate, all that stuff is so high for us. And in the United States. And here's some data that's just hanging out on a data base website that's actually pretty darn compelling.

DR. KHOSLA: No, you're exactly right. I think, you know, and I think that always becomes our drumbeat, right, that we need more research even when we talk about ozone phenotyping, when we talk about biomarkers, you know, all of us, even the AHIQ reports about CPAP efficacy all right. We need more data to demonstrate that it is effective and hopefully we'll have better outcomes data than we do currently.

DR. MATSUMURA: Yes, I agree. I think, you know, I there's still this this weird philosophy to me and the right and this and with sleep apnea that, you know, we machines are so cost prohibitive, treatment is cost prohibitive. And it's literally on some level a form of lifesaving treatment.

DR. KHOSLA: When I think about pregnancy, I have to think about RLS. And this is completely biased because I had RLS with both of my pregnancies and it was completely miserable so. Oh, my gosh, yes. I remember fleeing my legs out of bed and looking at my husband. I was like, this is why people complain about this. This is miserable.

So, what are the treatment options for RLS during pregnancy? And are they any better than they were when I was pregnant, you know, 12 years ago?

DR. MATSUMURA: Well, you know that there was this whole new guideline that came out. I think it was Mayo Clinic proceedings that came out with this kind of review article around Restless Leg Syndrome. And they specifically had a section for pregnant women. And, you know, I was really the focus was really treating the iron deficiency and being more aggressive around treating iron deficiency, if indeed that's what the issue is, you know, I, I, in my time as a sleep medicine doc, I haven't really offered iron infusions all that much, but they actually spoke to that specifically in this article that if the patient if a patient has a low ferritin level, don't wait, just do the iron infusion because it actually does really improve the symptoms rather dramatically.

DR. KHOSLA: Yeah. I will never forget a lady I had so many years ago who had some, you know, a gut thing and malabsorption or whatever, and she had horrible RLS. And, you know, we had tried all of these medications and we, you know, she, she got an iron infusion and literally during the infusion, her legs got better. She told me.

DR. MATSUMURA: Oh, my gosh. That's crazy.

DR. KHOSLA: I mean, it didn't last very long. So, she needed another one. But still, I was like, wow, that is that's impressive.

DR. MATSUMURA: That that is. Yeah. The other thing is that, you know, there's not a whole lot of medications really that we would we really want to use. Right. For you know, for women while they're pregnant. But I think the focus really is just making sure, you know, keeping close tabs on that ferritin level. Like there's a lot of data out there that says some say 75, others say over a hundred.

Right. And so, I'm kind of landing on the ferritin level being 100 and so that's I find that in my own, you know, with my own personal patient population that if I treat for that to get that ferritin level higher, I find that I get greater resolution of symptoms. And this is just my an of one practice right that I, I have, you know, patients that are happier and they're not and they're happy that they're not taking a prescription medication.

DR. KHOSLA: Oh, that's a good point. And I like that it's addressing the actual what we think is, you know, the pathophysiology behind it, right?

DR. MATSUMURA: Actually, yes. You got it. You know, because I always felt a little that internists, I think, in me would always say, gosh, you know, I haven't given this person a medicine for something else that you know, maybe it's the iron. You know, granted, there are patients who have high ferritin levels who also do need medication. But for a lot of patients just really teaching them.

Right. It's about education, about how the physiology works and why the iron replacement is potentially going to help them.

DR. KHOSLA: So, you mentioned something about, you know, medications for use in pregnancy. And one of our colleagues on our committee, Dr. Anne-Marie Morse, pointed out that there are medications to use during pregnancy for every major disorder except narcolepsy.

DR. MATSUMURA: You're right. There is. And I was just looking up. Oh, there's a really great I think it's called Project Sleep. And I think Dr. Morse testified. Yeah, she was part of that. And they have a really great educational kit for women who are thinking about becoming pregnant, who may have narcolepsy. And there is you know, I was reading that.

I was I've also then reached out to the rep for medications like Xyrem. And there just aren't there's just not a lot of data for patients who have narcolepsy who are thinking about becoming pregnant or who are pregnant. But there's more I guess what they're doing is, you know, any patient who does become pregnant and they're and is on these medications, they're enrolling them in a registry.

Yeah, a registry. Right. And so far, the data looks pretty promising, I would say, for Xyrem that, you know, you potentially might be able to stay on that medication while you are pregnant. But it's unfortunate that there's a positive rate of data to help us because these patients are real. They have lives, they've got jobs. And they want to have families.

DR. KHOSLA: So how are you doing this work to increase the awareness of sleep disorders in women where you are?

DR. MATSUMURA: Well, I'm on a lot of just spreading the word locally. I do a lot of presentations I've been going to a lot of different offices just talking about women in sleep. And I find it really refreshing that when I when I mentioned that I'm going to specifically be talking about women in sleep, a lot of times people get excited about it because they realize that there really isn't a lot of information that's been provided to them.

And they also then say, yeah, we have a lot of female patients. So yeah, any kind of information you have, we'd love to hear it. So, I do a lot of it. Speaking to other offices, I do a lot of public speaking, so you know, spots anything I can. I've got a Facebook group, I've got, you know, Instagram.

I use social media a lot just to try and spread the word. I don't use Twitter as much as you do, but maybe that's maybe that's one avenue for me.

DR. KHOSLA: Well, you cover Instagram and I'll cover Twitter. How about that?

DR. MATSUMURA: Yeah, let's do that. Let's do that. It's just really kind of, you know, I'm a I'm a one person show, I guess in my general area, I'm trying to spread information and education around, you know, women in sleep.

DR. KHOSLA: I love that. So, any final thoughts?

DR. MATSUMURA: No. Just keep we should do this again, right? Because, you know, in another few years, we're going to get to hear this information again. But I would say my flag would be that, you know, we need to do more research on women and finding ways that that we

can help, you know, acquire that data. You know, wouldn't it be really great to be able to personalize data that, you know, for patients based on their gender and their and their age of life?

And we could we I can kind of see how that could happen with sleep. Mm hmm. So, yeah, that's it and thank you for having me on the show.

DR. KHOSLA: Thanks so much for joining us today and providing helpful insights into treating women with sleep problems. I hope our colleagues agree that treatment isn't one size fits all, and we'll continue to advocate for appropriate sleep care for all of our patients.

DR. MATSUMURA: Thanks, Seema.

DR. KHOSLA: Thanks for listening to Talking Sleep, brought to you by the American Academy of Sleep Medicine. For more podcast episodes, please visit our website at aasm.org. You can also subscribe through your favorite podcast service. And if you enjoyed this episode, please take a moment to leave a rating or review. For more feedback or suggestions email us at podcast@aasm.org. I hope you'll join us again for more Talking Sleep. Until next time this is Seema Khosla, encouraging you to sleep well so you can live well.