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TITLE  
OF  
THESIS

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# Abstract

Abstract text

# Chapter 1

## Introduction

A recent study estimated that over 900 million adults globally are affected by the common group of respiratory sleep disorders called Sleep-disordered breathing (SDB) [bla-F5], or in particular, Sleep Apnea, which clinical manifestations include sleepiness, fatigue, cardiovascular disease, and hypertension. SDB is even linked to higher cases of diabetes, stroke occurrences and increased morbidity [bla-2,3,4]. Diagnosis of the disorder relies on detecting repeated respiratory events in which airflow is either reduced (hypopnea) or entirely paused (apnea) during sleep [bla-1,2]. These events can further be categorized into obstructive or central origin, depending on if the apnea happens due to a physical blockage of the upper airway or if caused by the brain failing to signal breathing resulting in missing breathing effort. In case the event shows features of both, it is classified as a mixed. Dividing the number of events by the total sleep time (TST) gives the Apnea-Hypopnea-Index (AHI), which indicates the severeness of the disorder.

Gold standard for detecting SDB in Polysomnography (PSG) which captures physical and biological signals like heart (electrocardiogram, ECG) and brain (electroencephalogram, EEG) activity, airflow, peripheral oxygen saturation (SpO2), chest and abdominal movements, sleeping position, and blood volume changes (photoplethysmographie, PPG). This approach comes with a few downsides: Firstly, due to the vast amount of sensors and specialized equipment, setup and analysis of the full PSG is costly, requires human experts and might impact sleep quality. Secondly, looking only at a single night might have low diagnostic meaningfulness [bla-5] and the analysis of multiple nights is needed. All this contributes to the fact that an estimated 93% of women and 82% of men with at least moderate SDB are undiagnosed [bla-A5=D4].

In 2000, PhysioNet started interest in the topic of less complex apnea detection by holding a competition on their Apnea-ECG Dataset that only consists

of labeled ECG recordings split into one-minute epochs. Although presented models reached high performances, later studies showed poor generalizability for these models and indicated that the dataset doesn't fully cover the broad spectrum of apneic events [bla-6]. Therefore, in the last decades, a wide range of sleep disorder datasets and apnea detection architectures were published that focused on generalizability. For instance, Olsen et al. [2] used bidirectional GRUs on ECG data to achieve a sensitivity (Se) of 68.7%, a precision (Pr) of 69.1%, and an F1-score of 66.6% on their self-defined event-level metric and an AHI-correlation of  $R^2 = 0.829$ . Xie et al. [4] later validated Olsens model on the SOMNIA dataset and achieved an F1-score of 0.708 using the PSG-computed hypnogram and an F1-score of 0.631 with their Multi-Task model that computed sleep stages based on ECG and respiratory effort (RE) only [3]. Also using ECG and RE, Fonseca et al. [1] achieved intraclass correlation coefficient of 0.91 across different datasets. **TODO: OTHER, OTHER**

One of the simplest signals to record while sleep is PPG, which can be obtained through the use of a pulse oximeter that illuminates the skin to measure changes in light absorption. These devices come in a range of forms such as wrist-worn, like most modern smart-watch already have, or finger-worn, which can also calculate SpO2. **TODO: OTHER used these sensors, OTHER also**

In this work, we present an event-level apnea detection model that relies solely on signals obtained by easy to use recording hardware, namely PPG and SpO2, and show the importance of correct sleep stage identification.

# Chapter 2

## Methods

### 2.1 Dataset

- Explain MESA (what Patients, how did they record the nights, ...)
- Statistical analysis (Count, Age, ...)
- Scorings from SOMNOLYZER (OSA, HYP, ...)
- Kappa between NSRR and SOMNOLYZER
- Use predicted Hypnogram (maybe?) and their Kappa

### 2.2 Preprocessing

- PPG [256Hz], SpO2 [1Hz], Hypnogram [1Hz]
- For PPG: Statistical Analysis, Denoising, VAE?, Conv-Block

### 2.3 Model Architecture

- U-Net (with PPG Conv-Block), Batch-Norm, Attention, ...
- Output: Detection at 1Hz - Event vs No Event
- TODO Next model then classifies into SDB classes

### 2.4 Training and Evaluation

- Training Parameters (Optimizer, LR, BS, ...) and Setup (Machines, ...)

- Seed and Cross-Validation
- Train on 30min (?) segments. For Testing: Concat 30min Windows with Overlap for full night result.
- Correct results (like Olsen, 10sec minimum event and distance between events)
- Event-based metrics (Se, Pr, F1) and when to count TP, TN, FP, FN
- AHI-based metric (Linear Correlation, Severity Classes, Near-Boundary Double-Classification)

## Chapter 3

# Results

- Baseline Model vs PPG Preprocessing vs Attention Model Results
- Significance of SpO2 and the Hypnogram (No SpO2/Hypnogram, Only PPG Baseline Model)
- AHI correlations and Severity class results



## Chapter 4

# Discussion

- Discussion and Implications (Is this way applicable in the real world)
- Limitations
- Further work

## Chapter 5

# Conclusion

- Summerization of paper
- Significance of work
- Outlook

# Bibliography

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