SINGAPORE
SLEEP REVIEW

Singapore Sleep Society

SINGAPORE SLEEP SOCIETY NEWSLETTER

VOLUME 4 | ISSUE 2 | MAY | 2026

SSS NEWS

Welcome to the latest Issue of the Singapore Sleep. In this issue we cover several new research highlights from our members and other Singapore research labs. We're also excited to share two key dates for your calendar. First, the Asian Society of Sleep Medicine interim meeting takes place 10-13 September 2026, offering an excellent forum to exchange ideas, learn emerging best practices, and strengthen collab orations across Asia. Second, we want to update our earlier announcement with a date correction for the Singapore Sleep Conference which will be held on 2-3 April 2027. We are also happy to announce that the SSS Annual General Meeting (AGM) will be held on **Wednesday 5 August 2026, 6 pm**. Please save these dates, we are looking forward to seeing many of you at these events. Lastly, we are happy to introduce the Philips Learning corner, a recurring educational rubric presented by our new sponsor, Philips Respironics.

Courtesy of the Asian Society of Sleep Medicine

Singapore Sleep Society
Sleep Apnea Support Group

http://singaporesleepsociety.org
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SSS AGM: 5 AUG

Time: 6 PM
Venue: TBC

SLEEP AND AGING

New studies highlight the link between sleep and frailty, sleep and cardiovascular health, and sleep and cognitive again

POLYPHASIC SLEEP

Uberman polyphasic sleep worsens sleep quality and morning vigilance

SLEEP IN HOSPITAL

Multifaceted sleep-promotion bundle improved maternity ward practice

ADHD AND SLEEP

Treatment of OSA can improve sleep and attention in ADHD with comorbid OSA

PHILIPS LEARNING CORNER

Adaptive Servo-Ventilation treatment for Central Sleep Apnea

ACADEMY OF MEDICINE SINGAPORE
Chapter of Sleep Medicine Physicians
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Sleep and Frailty in Late-life

Reference: Chua, K.Y., Chua, R.Y., Li, H. et al. Association between sleep duration from midlife and the risk of physical frailty in late life. Sci Rep 16, 8426 (2026). https://doi.org/10.1038/s41598-026-39228-6

Frailty is a health state—most often seen in older adults—where the body has **reduced "reserve" and resilience**, marked by loss of strength, endurance, and physiological function. This large, long-running Singapore cohort study examined whether habitual sleep duration in midlife predicts physical frailty in later life, and whether changing sleep duration over time alters that risk. Using data from 10,792 community-dwelling Chinese adults in the Singapore Chinese Health Study, participants self-reported total daily sleep (including naps) at three time-points: baseline (1993–1998; mean age 52), second follow-up (2006–2010; mean age 64), and third follow-up (2014–2017; mean age 72). Physical frailty was assessed at the third follow-up using a modified frailty phenotype comprising four components: weakness (handgrip strength), slowness (Timed Up-and-Go), weight loss (≥10% since the prior follow-up), and exhaustion ("Do you feel full of energy?"). Participants meeting at least 2 of 4 criteria were classified as frail.

Key finding: both short and long sleep durations—already from midlife—were prospectively associated with greater odds of physical frailty in later life, with a consistent "U-shaped" pattern around 7 hours/day. Compared with 7 hours/day, at baseline (midlife) short sleep (≤5 h/day) was associated with increased odds of frailty at late life (OR 1.43), and long sleep (≥9 h/day) showed an even higher association (OR 1.62) after adjustment for demographics, lifestyle factors, BMI, and chronic conditions (hypertension, cardiovascular disease, diabetes). Similar associations were observed when sleep was measured at the second follow-up: ≤5 h/day (OR 1.29) and ≥9 h/day (OR 1.27) compared with 7 h/day. Cross-sectionally at the third follow-up, associations were stronger: ≤5 h/day (OR 1.67) and ≥9 h/day (OR 1.94).

When frailty components were examined separately, the signal differed by time-point. At baseline, both short and long sleep were most clearly linked to later-life weakness (low grip strength). At the second follow-up, short sleep related most to exhaustion, while long sleep was associated with multiple frailty components (except slowness). These patterns are clinically intuitive: insufficient sleep may contribute to fatigue and impaired muscle recovery, whereas long sleep may act as a marker for underlying morbidity, sleep fragmentation, or reduced physiological reserve.

A particularly practical contribution is the analysis of sleep duration change over ~12 years (baseline to second follow-up). Using "recommended" sleep (6–8 h/day) maintained at both time-points as the reference, participants who shortened sleep by ≥2 hours/day had higher odds of later frailty (OR 1.30). Importantly, midlife short sleepers who increased sleep by ≥2 hours/day still had elevated odds of frailty (OR 1.51), and midlife long sleepers who reduced sleep by ≥2 hours/day also still had elevated odds (OR 1.57). In other words, moving toward a "normal" duration later did not clearly erase the risk associated with earlier short or long sleep in this cohort.

Sleep as a window into cardiovascular aging

Reference: Yilmaz, et al. (2026) Vascular age estimation using a consumer wearable sleep tracker. PLOS Digital Health: e0001329. https://doi.org/10.1371/journal.pdig.0001329

Vascular aging refers to gradual changes in the arteries over time—most notably increasing arterial stiffness and altered wave reflection—which raise cardiovascular risk. Clinically, vascular aging is commonly assessed using blood pressure together with measures of arterial stiffness, such as carotid–femoral pulse wave velocity or related pulse waveform analyses, but these approaches typically require specialist equipment and are not easy to repeat frequently outside the clinic.

A Singapore-based study evaluated whether a consumer sleep wearable (the Oura Ring Gen 3) can estimate “vascular age” from overnight photoplethysmography (PPG) signals, and how its performance compares with a clinical-grade fingertip pulse oximeter. PPG, the optical pulse signal captured by many wearables, offers a scalable alternative because the shape of the pulse waveform contains information related to arterial properties. As stiffness increases, the pulse wave tends to travel faster and waveform morphology shifts (for example, changes in the timing of the systolic peak and the prominence/timing of reflected components). The core evaluation was vascular age prediction using a compact 1D convolutional neural network (CNN) trained directly on standardized pulse waveforms. Prediction performance was similar between devices: mean absolute error was approximately 6–7 years, with strong correlations between predicted and chronological age for both the fingertip and ring signals. Differences between devices were not statistically significant and showed small average bias but a proportional bias pattern (overestimation in younger, underestimation in older participants)

Conclusion: High-fidelity nocturnal PPG from a consumer ring can approximate clinical-grade fingertip PPG for vascular age estimation, supporting the potential of wearables for scalable cardiovascular risk monitoring. Sleep presents a particularly stable monitoring window due to reduced movement artifacts and cleaner waveforms.

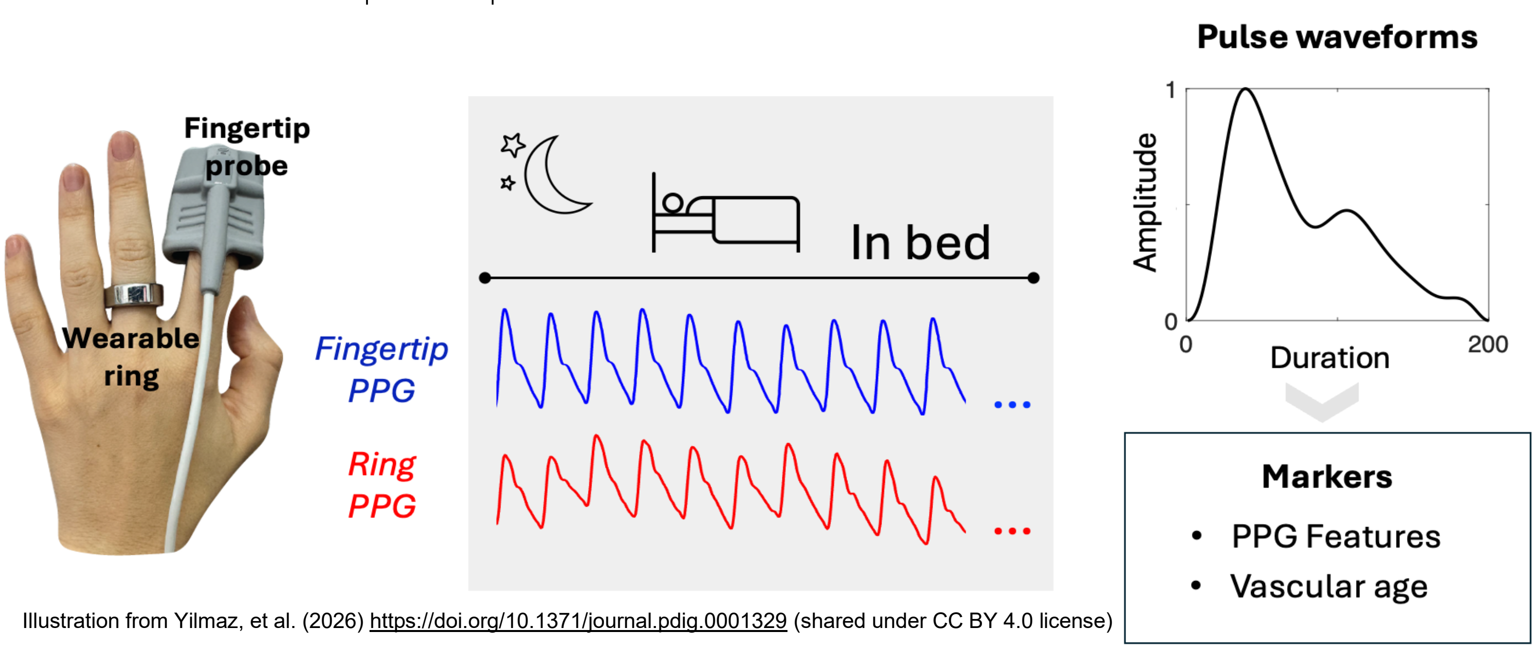

Illustration from Yilmaz, et al. (2026) https://doi.org/10.1371/journal.pdig.0001329 (shared under CC BY 4.0 license)

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Sleep Apnea Support Group

http://singaporesleepsociety.org
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Slow-wave power and cognitive aging

Reference: Qinet al. (2026), Association between slow-wave activity from multi-night at-home wireless EEG records and cognitive performance in older adults, Sleep, zsaf329, https://doi.org/10.1093/sleep/zsaf329

Sleep is increasingly recognized as a pillar of healthy cognitive aging. Disturbed sleep has been linked to worse cognitive performance and higher risk of later cognitive decline, but findings often rely on only one or two nights of in-lab polysomnography, and some commonly used sleep metrics may fluctuate substantially from night to night in older adults.

A new study assessed 49 community-dwelling older adults (median age about 75 years) who were functionally independent and screened to exclude cognitive impairment and self-reported sleep disorders. Participants contributed up to eight nights (total 308 nights) of at-home EEG using a wireless dry-electrode headband (Dreem). Cognitive testing covered multiple domains, and a global cognition composite was derived. The authors quantified night-to-night variability using the coefficient of variation (CV), treating CV below 20% as relatively stable.

Results showed that traditional sleep staging metrics did not behave equally across nights. Stage N3% (a standard proxy for "deep sleep") showed high variability across nights in these older adults (CV around the high-variability range), whereas N2% was relatively stable. In contrast, EEG power-spectrum measures were markedly more stable: relative power across frequency bands, especially slow-wave activity (SWA; ~0.8–4.5 Hz), showed low variability night-to-night. Most importantly, SWA was the standout metric linked to cognition.

After accounting for key covariates (including age, gender, education, BMI, and total sleep time), averaged multi-night SWA correlated strongly with global cognition. Exploratory analyses suggested associations with domains such as verbal memory and processing speed. Notably, SWA from any single night still showed significant associations with cognition, but the multi-night average produced the strongest relationship, aligning with the idea that aggregating across nights reduces measurement noise.

Conclusion: This study shows that multi-night, at-home EEG is feasible in older adults and that slow-wave activity (SWA) is a more stable marker of "deep sleep" than stage N3 percentage. The main advantage of the current method is that it captures several nights of sleep in a natural home setting, reducing night-to-night noise and improving the reliability of sleep–cognition links. This makes SWA a promising objective metric for monitoring sleep-related cognitive aging.

Polyphasic Sleep

Polyphasic sleep, or the practice of sleeping in multiple bouts over the 24-hour day (rather than one consolidated nocturnal bout), has gained popular appeal as it promises to satisfy the need for sleep in fewer total sleep hours, and thereby allow more time awake for productive endeavors. However, scientific evidence for the benefits of polyphasic sleep is very sparse.

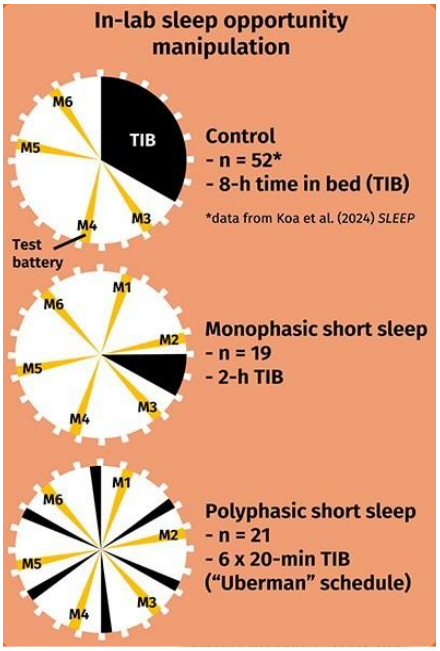

Illustration by Koa & Lo 2026 shared under CC BY 4.0 license

In this study, Koa and Lo investigated whether an extreme polyphasic schedule (“Uberman”) truly preserves key sleep stages and functioning, as often claimed online, and whether any effects differ from an equally short but monophasic sleep opportunity. Healthy young adults (18–35 years) completed a 29-hour laboratory protocol and were randomized to either monophasic short sleep (one 2-hour sleep opportunity ending at habitual wake time; n=19) or polyphasic short sleep (six 20-minute opportunities every 4 hours; n=21). Polysomnography was recorded for every sleep episode, and neurobehavioral testing (sleepiness, mood, vigilance, processing speed, working memory/executive tasks) was repeated across the circadian cycle.

A well-rested 8-hour control benchmark (n=52) from prior lab data was used for comparison at overlapping timepoints. Both short-sleep schedules produced clear impairment versus well-rested levels: participants were sleepier, showed poorer vigilance, and had lower positive mood, demonstrating that 2 hours/day is insufficient regardless of how it is distributed. Critically, the “Uberman” schedule did not reliably deliver the promised preservation of deep sleep and REM: total N3 and REM were markedly reduced versus 8-hour sleep, and overall sleep quality suffered.

When directly compared with the monophasic 2-hour condition (same total time-in-bed), the polyphasic group actually slept less in total and less efficiently.The main mechanism was “sleep initiation cost”: having to fall asleep six separate times led to a much longer cumulative sleep onset latency, plus slightly more wake after sleep onset, lowering sleep efficiency. Sleep architecture also shifted toward lighter sleep (greater N1/N2 proportions) and lower N3 proportion than the monophasic schedule.

Functionally, the polyphasic group showed greater vigilance impairment, particularly in the morning, despite similar total sleep opportunity. This suggests that splitting already severe sleep restriction into multiple short bouts can worsen real-world performance at certain times of day, even if subjective sleepiness does not always track objective deficits.

Overall, the study provides strong laboratory evidence that adopting an Uberman-style schedule is likely to degrade sleep architecture and daytime functioning rather than optimize them—at least during initial exposure.

Reference Koa, & Lo (2026), Neurobehavioral functions and sleep architecture during polyphasic and monophasic short sleep schedules, Sleep, zsag031, https://doi.org/10.1093/sleep/zsag031.

Improving Sleep in Maternity Patients

Reference: Woo, et al. (2026). Improving sleep quality in maternity patients in a Singapore academic hospital: a best practice implementation project. JBI Evidence Implementation. https://doi.org/10.1097/XEB.0000000000000488.

Sleep disruption is common during pregnancy and the postpartum period, and hospitalization can further worsen sleep through noise, lighting, alarms, and overnight care activities. Poor sleep in this population is clinically relevant because it can compound fatigue, impair coping, and is associated with adverse maternal outcomes and mental health risks. This Singapore implementation project reports a pragmatic, ward-level effort to improve night-time sleep quality for antenatal and postnatal inpatients by increasing nursing adherence to evidence-based, non-pharmacologic sleep-promotion practices.

The project was conducted in an obstetrics and gynaecology ward in a tertiary hospital in Singapore (a mixed-class ward with >40 beds). The team first identified key sources of sleep disruption through local surveys of nurses (n=9) and mothers (n=35): overnight procedures (e.g., vital signs, monitoring, blood-taking) and equipment alarms emerged as prominent contributors. The intervention then targeted a multifaceted sleep-promotion bundle, translated into eight audit criteria: provision of ear plugs on admission; reducing alarm volume; dimming corridor/cubicle lights; bundling nursing activities and non-urgent tasks; conducting necessary vital signs checks efficiently; and optimizing PRN medication practices (including asking about night PRN needs and serving routine PRNs before 1:00 AM). Evaluation used a baseline audit (April 2020) and two follow-up audits (July 2020; January 2021), each sampling 30 eligible obstetric patients (total n=90). Mothers were interviewed on discharge using structured questions to assess whether the bundle had been delivered.

At baseline, bundle-level implementation was effectively absent, and practice was inconsistent across individual components. After implementation activities—primarily focused on raising staff awareness and capability—the proportion of patients receiving the multifaceted bundle increased to 63.3% in follow-up audit 1, and this improvement was sustained at 63.3% in follow-up audit 2 (both statistically significant vs baseline). Strategies that appeared to drive change included face-to-face staff education, onboarding new staff, and visible prompts such as posters and placement of materials in communication/orientation files. Component-level compliance improved most for actions largely within nursing workflow control, such as dimming lights and bundling care. Some elements did not reach the 80% compliance target, including routine provision of ear plugs, alarm volume adjustments (complicated by equipment constraints and system-wide pump changes), and some medication-timing practices.

Patient-reported sleep scores showed a modest upward trend (mean ~26.3 at baseline to ~29.2 by follow-up 2), but differences across audits were not statistically significant. Importantly, mothers continued to experience multiple nighttime awakenings—likely reflecting unavoidable physiological and caregiving factors in pregnancy and postpartum—yet most reported being able to fall back asleep and were generally "fairly satisfied" with sleep.

Conclusion: This project demonstrates that a structured evidence-implementation approach can improve adherence to sleep-friendly ward practices in maternity care, particularly for environmental and workflow interventions (light/noise reduction, clustering care). Improving subjective sleep outcomes may require additional strategies e.g., broader environmental redesign, interdisciplinary alignment on overnight routines, and tailored approaches distinguishing antenatal vs postnatal needs).

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Attention-Deficit Hyperactivity Disorder and OSA in children

Reference: Leow, et al. (2026). Association between Attention Deficit Hyperactivity Disorder and Obstructive Sleep Apnea in Children: A Systematic Review and Meta-Analysis. Journal of Attention Disorders: 10870547261426094. https://doi-org.libproxy1.nus.edu.sg/10.1177/108705472614260

Leow and colleagues synthesize longitudinal evidence on the bidirectional relationship between pediatric obstructive sleep apnea (OSA) and attention-deficit/hyperactivity disorder (ADHD), focusing on studies that used formal diagnostic approaches (polysomnography for OSA; DSM-based clinical criteria/validated diagnostic methods for ADHD). The authors searched PubMed, Embase, Scopus and Cochrane Library up to 1 December 2024, and included 11 studies (total 903 children).

OSA is common among children with ADHD. Pooling four studies that reported OSA prevalence in ADHD, the meta-analysis estimated a 44% prevalence of OSA among children with ADHD. Evidence for the reverse direction was also notable: in two included studies, ADHD prevalence among children with OSA ranged from roughly 28% to 43%, highlighting clinically meaningful overlap. Mechanistically, sleep fragmentation and intermittent hypoxia may worsen attention and behavioural regulation, while ADHD-like hyperactivity can mask sleep-disordered breathing symptoms, raising the risk of missed diagnosis.

OSA treatment, particularly adenotonsillectomy for pediatric OSA, was consistently associated with improvements in both OSA severity (e.g., reductions in apnea–hypopnea index) and ADHD symptom measures (including improvements across commonly used behavioural rating scales and attention testing)In contrast, evidence regarding treatment of ADHD with methylphenidate suggested it can improve ADHD symptoms, but does not reliably improve sleep-disordered breathing, and some studies noted no meaningful benefit on key respiratory sleep parameters, highlighting the importance of evaluating airway obstruction in addition to treating neurodevelopmental aspects of the condition.

Conclusion: For children presenting with ADHD symptoms, this review supports incorporating OSA screening and, when indicated, objective sleep evaluation into routine assessment. Where OSA is confirmed, addressing airway obstruction (often via adenotonsillectomy) may provide behavioural as well as sleep benefits.

Presented by Philips Respironics
Journal Review

Adaptive Servo-Ventilation Therapy for Central Sleep Apnea

TEOFILO L. LEE-CHIONG JR., MD
CHIEF MEDICAL LIAISON
PHILIPS RESPIRONICS

Since the 2015 publication of the SERVE-HF trial that demonstrated increased all-cause and cardiovascular mortality in patients with heart failure and reduced ejection fraction (HFrEF) who were treated with minute ventilation-triggered adaptive servo-ventilation (ASV) for their central sleep apnea (CSA), there has been increased interest in understanding the physiological effects of minute ventilation- vs. peak flow-triggered ASV. [1,2]

The American Academy of Sleep Medicine Clinical Practice Guideline for the treatment of central sleep apnea in adults (version January 2025) suggests the use of ASV over no ASV in adults with primary or treatment emergent CSA or with CSA due to heart failure, medication or substance use, or a medical condition or disorder. The report emphasized that "Devices that deliver adaptive servo-ventilation have different proprietary algorithms for sensing and responding to respiratory events. Safety data are not available for all devices on the market. Increased mortality was associated with only one device in patients with heart failure with reduced ejection fraction…" [3]

The following seven articles represent the most current research findings in the use of ASV therapy for sleep-disordered breathing and highlight the importance of choosing the appropriate patient and selecting the proper ASV therapy.

1. In a multicenter, randomized controlled trial, 731 adult patients with heart failure and reduced ejection fraction (left ventricular ejection fraction [LVEF] ≤45%) and sleep-disordered breathing (non-sleepy predominantly obstructive sleep apnea (OSA) or predominantly CSA; apnea hypopnea index [AHI] ≥15 events per hour of sleep), were randomly assigned to receive either standard optimal medical treatment alone or optimal care plus peak-flow triggered ASV. Enrolment was terminated prematurely due to COVID-19-related restrictions. Over a mean follow-up period of 3.6 years, ASV had no effect on the primary composite outcome (cumulative incidence of the composite of all-cause mortality, first admission to hospital for a cardiovascular reason, new onset atrial fibrillation or flutter, and delivery of an appropriate cardioverter-defibrillator shock) or all-cause mortality. ASV eliminated sleep-disordered breathing and improved sleep quality, and no safety issues related to its use were noted.

   Bradley TD, Logan AG, Lorenzi Filho G, et al. Adaptive servo-ventilation for sleep-disordered breathing in patients with heart failure with reduced ejection fraction (ADVENT-HF): a multicentre, multinational, parallel-group, open-label, phase

   3 randomised controlled trial. Lancet Respir Med. 2024 Feb;12(2):153-166.

2. The prospective, multicenter European READ-ASV (Registry on the Treatment of Central and Complex Sleep-Disordered Breathing with Adaptive Servo-Ventilation) registry assessed the impact of first-time ASV therapyondisease-specificqualityoflife(QOL)in801adultindividualswith CSA ± coexisting OSA (AHI of 48 ± 22 events per hour). Median Functional Outcomes of Sleep Questionnaire [FOSQ]) score increased significantly from baseline after 12 ± 3 months on ASV therapy, particularly among symptomatic individuals (FOSQ score<17.9 and/or Epworth Sleepiness Scale [ESS] score>10). There was also a significant improvement in daytime sleepiness (medial ESS score) from baseline during ASV therapy.

   Arzt M, Munt O, Pépin JL, et al. Effects of adaptive servo-ventilation on quality of life: The READ-ASV registry. Ann Am Thorac Soc. 2024 Apr;21(4):651-657.

3. A network meta-analysis of randomized controlled trials compared the relative effectiveness of the different therapeutic interventions, including ASV, automatic positive airway pressure, bi-level positive pressure ventilation, continuous positive airway pressure (CPAP), and oxygen therapy, against placebo or standard care, for sleep-disordered breathing in patients with heart failure. Among patients with OSA, CPAP was the most effective treatment for improving average oxygen saturation (SaO2) and LVEF, and for reducing AHI. In contrast, ASV was the most effective intervention for decreasing AHI, increasing lowest SaO2, and improving LVEF in patients with CSA.

   Lin Y, Chen Y, Tu W, et al. Comparative effectiveness of therapies for sleep-disordered breathing in heart failure patients: A comprehensive systematic review and network meta-analysis. Respir Med. 2025 Jan;236:107907.

4. A multicenter, prospective observational study reported that the median time to a composite of all-cause death and urgent rehospitalization for heart failure over a one-year follow-up period was significantly shorter in patients hospitalized for heart failure who were treated with ASV therapy than in the non-ASV group. However, chronic ASV use did not affect all-cause mortality event-free rate in patients with recurrent admissions for heart failure.

   Fukumoto Y, Tada T, Suzuki H, et al. Chronic effects of adaptive servo-ventilation therapy on mortality and the urgent rehospitalization rate in patients experiencing recurrent admissions for heart failure - A multicenter prospective observational study (SAVIOR-L). Circ J. 2024 Apr 25;88(5):692-702.

5. Treatment of sleep apnoea Early After Myocardial infarction with Adaptive Servo-Ventilation (TEAM-ASV I) study is a multicenter trial of patients with acute myocardial infarction (AMI) and sleep-disordered breathing (AHI ≥15events per hour) who were randomized to standard medical care alone or with ASV therapy early in the post-AMI period. At 12 weeks after AMI, the myocardial salvage index was significantly higher and the reduction in infarct size was greater in the ASV versus control group. No serious ASV-related adverse events were reported.

   Arzt M, Fox H, Stadler S, et al. Treatment of sleep apnoea early after myocardial infarction with adaptive servo-ventilation: a proof-of-concept randomised controlled trial. Eur Respir J. 2024 Sep 5;64(3):2302338.

6. After analyzing their registry of 90 patients with HFrEF and CSA, investigators found no evidence of increased mortality with the use of ASV therapy. A majority of the patients received a peak-flow triggered ASV device with automatically adjusting end-expiratory pressure (EPAP). A survival advantage was evident at 64 months among patients who used their ASV device for more than 3 hours per night compared to those who used it for a shorter time nightly. There was a trend toward a positive correlation between minute ventilation-triggered ASV with fixed EPAP and worse survival.

   Sun P, Porter K, Randerath W, et al. Adaptive servo-ventilation and mortality in patients with systolic heart failure and central sleep apnea: a single-center experience. Sleep Breath. 2023 Oct;27(5):1909-1915.

7. Researchers described the effects of ASV on morbidity and mortality in consecutive heart failure patients with predominant CSA ± OSA. The 2-year primary endpoint (time to composite first event [all-cause death, lifesaving cardiovascular intervention, or unplanned hospitalization for worsening of chronic heart failure]) event-free survival was significantly greater among ASV-treated patients compared to the control group in univariable analysis. Positive effects on event-free of cardiovascular death or heart failure-related hospitalization, and all-cause death or all-cause hospitalization were also observed with the use of ASV.

   Tamisier R, Damy T, Bailly S, et al. FACE study: 2-year follow-up of adaptive servo-ventilation for sleep-disordered breathing in a chronic heart failure cohort. Sleep Med. 2024 Jan;113:412-421.

References

1. *Cowie MR, Woehrle H, Wegscheider K, et al. Adaptive servo-ventilation for central sleep apnea in systolic heart failure. N Engl J Med. 2015 Sep 17;373(12):1095-105.*
2. *Bradley TD, Logan AG, Floras JS. Treating sleep disordered breathing for cardiovascular outcomes: observational and randomised trial evidence. Eur Respir J. 2024 Dec 12;64(6):2401033.*
3. https://aasm.org/wp-content/uploads/2025/02/Treatment-of-CSA-in-Adults-CPG

About

Teofilo L. Lee-Chiong Jr., MD is a Professor of Medicine at the University of Colorado Denver School of Medicine, and Tenured Professor of Medicine at National Jewish Health in Denver, Colorado. He joined Philips Respironics as its Chief Medical Liaison in 2011. He is the recipient of the 2012 American Academy of Sleep Medicine Excellence in Education Award. This award is presented to those individuals who have made outstanding contributions in the teaching of sleep medicine. The award serves to recognize and honor dedicated individuals who have skillfully taught and enhanced the knowledge of professional and lay people in the areas of sleep and sleep medicine.

ASSM Asian Society of Sleep Medicine · 香港中文大學 The Chinese University of Hong Kong · CU Medicine 香港中文大學醫學院 Faculty of Medicine The Chinese University of Hong Kong · 香港睡眠醫學會 THE HONG KONG SOCIETY OF SLEEP MEDICINE · Meeting endorsed by World Sleep Society

Asian Society of Sleep Medicine
INTERIM MEETING

Hong Kong 2026 SEP 10-13

Henry Cheng International Conference Centre
Cheng Yu Tung Building, The Chinese University of Hong Hong, Shatin

IMPORTANT DATES

Early Bird Registration	15 Aug
Symposium Deadline	15 Jun
Symposium Notification	30 Jun
Abstract Deadline	31 Jul

CO-CHAIRS OF THE LOCAL ORGANISING COMMITTEE

Prof. Yun-Kwok Wing
Professor and Chairman,
Department of Psychiatry, CUHK

Dr. Joey Chan
President,
Hong Kong Society of Sleep Medicine

FOR MORE DETAILS/ENQUIRES:

Website:
http://assm2026-hk.com/

Email:
assm-interimmeeting2026@cuhk.edu.hk

CALENDAR

14-17 JUN

Sleep 2026
The 40th annual meeting of the Associated Professional Sleep Societies, LLC (APSS)
Baltimore, MD, USA, https://www.sleepmeeting.org

5 AUG

SSS AGM
The Annual General Meeting of the Singapore Sleep Society (Time: 6pm, Venue: TBC)

10-13 SEP

ASSM 2026
The interim meeting of the Asian Society of Sleep Medicine (ASSM)
Hong Kong SAR, https://www.assm2026-hk.com/

20-23 OCT

Sleep Europe 2026
The 28th Congress of the European Sleep Research Society
Maastricht, the Netherlands, https://esrs.eu/event/sleep-europe-2026/

11-14 NOV

Sleep Down Under 2026
The Annual meeting of the Australasian Sleep Society
Brisbane, Australia, https://www.sleep.org.au/Public/Public/Events/SDU2026.aspx

2-3 APR2027

Singapore Sleep Conference 2027
Save the Date

Singapore Sleep Society

Membership Application and Fees

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$30/year – sleep professionals with a medical degree, PhD or equivalent.

Associate members:
$10/year – any person involved in the field of sleep disorders without the above qualification.

Supporting members:
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