



Expand Your Practice, Change Your Life!

Obstructive sleep apnea (OSA) is a very common ailment, usually represented by snoring and upper airway obstructions. Patients suffering from OSA have an increased risk of high blood pressure, heart attack, and stroke and often display excessive daytime sleepiness, which can result in serious accidents.

A May 2002 study in the *American Journal of Respiratory and Critical Care Medicine* found that one in six people over the age of 50 in the United States had at

least mild OSA and that one-third of those patients had severe OSA. According to *Sleep Review* (July/August 2006), an examination of epidemiologic studies in the United States indicates that 75 percent of OSA sufferers go undiagnosed.

When patients have problems that are seen as an annoyance, rather than a serious problem requiring immediate attention, they tend not to seek medical help. As a result, snoring and sleep apnea concerns often are not discussed between patients and their physicians. Dental check-ups, on the other hand, provide a great opportunity for patients to be screened for sleep-disordered breathing (SDB).

Dentists who are knowledgeable about SDB and trained in the clinical use of oral appliance therapy (OAT) can treat these patients easily once a sleep physician has properly assessed them. Because sleep is such a complex state, it often gives rise to many problems that are only partially corrected by a single solution. For this reason, it is very important to perform follow-up examinations.

The American Academy of Dental Sleep Medicine (AADSM) is an organization of dentists that promotes research and the clinical use of oral appliances and upper airway surgery for the treatment of SDB and pro-

vides training and resources for those who work directly with patients. Membership in the AADSM has more than doubled over the last three years, from 500 to more than 1,300 members.

The AADSM's Web site (www.aadsm.org) offers a "Find a Dentist" feature, courses in dental sleep medicine, and information about the organization's Annual Meeting, which provides lectures and discussions on sleep medicine, dental sleep medicine, and practice management. You also can find dental sleep medicine research, as well as resource materials for dentists who are interested in incorporating dental sleep medicine into their practice. The AADSM also provides public relations information on OAT to both the public and dental and medical professions.

The AADSM steadfastly declares that patients must be diagnosed by a qualified physician as a baseline before treatment is started. Even with the advent of home monitoring, dentists shouldn't diagnose this disorder due to its complexity.

The Standards of Practice Committee of the American Academy of Sleep Medicine (AASM) published practice parameters for OAT for snoring and OSA in the February 2006 issue of *SLEEP*. The committee concluded that oral appliances are a first line of treatment for patients with mild or moderate sleep apnea. For patients with severe sleep apnea, oral appliances may be recommended when continuous positive airway pressure (CPAP) alone is not effective.

It is possible to combine the two therapies in order to allow patients to use lower CPAP pressures and thus be more compliant with treatment. In my own study, published in *CHEST* in 1999, the average patient had severe sleep apnea, with an average apnea hypopnea index (AHI) of more than 44. (The AASM considers an AHI over 30 to be severe.) This study showed how OAT could be used to treat any severity of sleep apnea where specifics indicate using proper protocol.

The AADSM Web site lists both the parameters of practice and the treatment protocol for OAT, as well as a copy of an

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informed consent form. OAT for SDB can have adverse effects, such as bite change, jaw discomfort, tooth position change, tooth mobility, excessive salivation, and so forth. These problems usually are minor and often disappear or subside. However, major adverse effects can cause patients to discontinue treatment, leading to the need for alternate therapies that the medical-dental team would need to consider.

Habitual snoring and sleep apnea are often closely associated with diabetes. Habitual snoring is associated with glucose intolerance and/or diabetes, as shown in the *American Journal of Epidemiology* (March 2002). Therefore, diet counseling also could be a referral information opportunity that dentists should recommend. It has been shown that higher body mass index (BMI) tends to reduce the efficacy of OAT. We need more dentists treating SDB so that the problem can be adequately—and globally—addressed.

OAT requires regular check-ups to ensure efficacy of oral appliance setting and fit—mandibular advancement, retention, and comfort. But there are many different types of oral appliances for sleep disordered breathing. Some are poor, such as the “boil and bite” appliances. It is necessary to be aware of the mechanisms of action of the various appliances for dentists to be able to select the one that’s best for the patient. This is imperative in creating better patient compliance.

Even after completing treatment for snoring and sleep apnea, patients still may display symptoms of tiredness and/or sleepiness, despite evidence at follow-up visits that the problems have been corrected. Other types of treatment may be necessary to improve the patient’s sleep condition, which is why it’s important to have follow-up therapy and close communication among the entire medical-dental team.

There is a critical need for more dentists to be trained in dental sleep medicine so that we can treat the increasing number of patients who are being diagnosed with SDB and OSA. The rewards are immediate—I don’t know of any other therapy I provide in my dental practice where patients are so amazed at the improvement in their quality of life.



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