LETTER TO THE EDITOR

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Response to "Treating OSA Patients Right: Commentary on *Identifying the Appropriate Therapeutic Position of an Oral Appliance* by Sheats et al. (2020)"

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We appreciate Hambrook's *et al*. response to our paper "Identifying the appropriate therapeutic position of an oral appliance." The authors state correctly that our paper defines the appropriate therapeutic position as one that "improves signs, symptoms or objective indices of sleep related breathing disorders." Taken out of context, however, the authors conclude that we were equating the value of patients' subjective responses to that of objective data obtained during sleep. To be sure, our paper did not intend to establish a hierarchy of the value of responses, subjective or otherwise, to discern the therapeutic position. In fact, we subsequently state that the "determination of improvement is agreed upon by the patient, dentist and medical provider."

More patients than ever seek a medical system that respects their perceived needs and values, if only to ensure that their input is considered in clinical decisions. The patient's response to a selected therapy may not be binary; there can be graded levels of improvement. To wit, many patients will struggle with positive airway pressure (PAP), even though it can more uniformly provide an adequate objective response to controlling obstructive sleep apnea (OSA). Understanding this limitation in providing the most efficacious therapy has helped us advance the concept of mean disease alleviation.[1]

The initial success from most oral appliance therapy focuses on patient acceptance and the resolution of snoring early in the process, even though the AHI may not be normalized. As we strive to establish the therapeutic position, the intention is to achieve objective resolution of disease. Some patients will achieve it and others will not. To that end, there is little variance between oral appliances and PAP.

Defining success in our patients cannot be limited to objective metrics such as the AHI alone.[2, 3] Success includes other parameters such as quality of life and health outcomes.[4] Our paper never suggests or intimates that titration by signs and symptoms should take precedence over an objective assessment. Each protocol described in our paper stipulates that an objective assessment must verify the therapeutic position. However, achieving an AHI of 3 in a non-compliant patient would hardly constitute success by any standard.

The task force was mindful that not all dental sleep medicine providers have the resources for costly technology or the consent of their state dental boards to deploy technology that obtains objective data during sleep. Thus, the task force was leery of being too prescriptive about its recommendations or the suggested pathways for combining methods. The challenge was to offer the best evidence available for each method and to enable clinicians to develop the method or combination of methods most appropriate for their patients, practices, and community standards.

The AADSM and our members work diligently, with our partners, to advance the field of sleep medicine. This paper was designed to continue this progress and is an endorsement of the importance of the physician/dentist relationship in helping to manage the unmet need of the estimated 54 million U.S. adults with OSA.[5]

CITATION

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SUBMISSION AND CORRESPONDENCE INFORMATION

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DISCLOSURE STATEMENT

The authors have no conflicts of interest to disclose.