EDITORIAL

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My Wish for the Coming Year - Clinical Practice Guideline for the Treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance Therapy: An Update for 2022

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As I look back at the changes that have occurred in the last few years and I read the clinical practice guidelines published by the AADSM and the AASM in 2005 and updated in 2015[1], I realize that despite the excellent work that had been done at the time, it is the time to update guidelines and policies in order to better represent the new reality we are living. There are a number of reasons to update these guidelines:

It Has Been Seven Years Since the Guidelines Were Updated

The number of new papers on dental sleep medicine and sleep apnea has increased tremendously. We know a lot more now than what we used to. Among other things, we now know that the sleep apnea index is not as important as it used to be for medical clinicians.

As I explained in my last editorial[2], many clinicians no longer view the apnea-hypopnea index (AHI) as the only important measure for assessing the severity of a patient's condition. Why should primary oral appliance therapy be mainly based on that criterion for selection? Of course, therapy is not only about treating symptoms of sleep apnea, but sleep apnea itself. Nevertheless, the existing model needs to be re-evaluated.

Combination Therapy Could be the Way to Go

The concept of personalized medicine is becoming increasingly popular and advances in phenotyping now give us a preliminary idea of what works and what does not work. Thus, combination therapy, whether it is an oral appliance (OA) with continuous positive airway pressure (CPAP), OA with position trainers, OA with O_2, medication or surgical procedures (ENT and OMFS), should be considered as a tool in the toolbelt of sleep apnea treatments. It is not just solo CPAP, or OA, or surgery anymore. Provided we find enough evidence, this approach should be considered in new guidelines.

Epidemiologically Speaking, We are Losing the Battle

With an increasing prevalence of sleep apnea cases[3] and the number of sleep doctors declining,[4-5] the quality of the services provided to the general population is also declining. Something has got to give: do we, as a society, want to serve just a small fraction of the population, or are we interested in providing treatment to the maximum number of people. The number of dentists interested in treating sleep apnea has increased tremendously in the last years. Could a new pathway of collaboration be created between qualified dentists and sleep physicians to alleviate the burden to the population? I think it is only a matter of time before changes occur.

Times Change

Considering the recent Philips recall and COVID-19 that keeps on coming back, we now realize that some of the things we used to take for granted are not a guarantee. Artificial intelligence is becoming increasingly common in all aspects of the health sector. Telemedicine brings patients into our offices who are constrained by geographical distance or even illness. Sleep testing applications have been introduced, inexpensive oximeters can now be purchased on the web as easily blood pressure monitoring devices, making basic sleep testing easier than ever. Patients can now provide us with some basic information regarding their health. Because these technologies are relatively new , I would not say that they should be universally used with all of our patients. Nevertheless, I believe that they should be kept in mind, as they are certainly changing our perspective on the field of sleep.

As I am writing this, I know that guidelines are based on prior solid research papers, and some of the elements discussed here are fairly recent and thus, not well researched yet. I am not expecting my wish (as my title mentions) to be fully granted, but I sincerely hope these elements are at least considered in the next published guidelines, when it is published. In the meantime, I wish you all a happy new year!

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SUBMISSION AND CORRESPONDENCE INFORMATION

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