EDITORIALS

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On the Role of Dentists in the Diagnosis and Treatment of Obstructive Sleep Apnea: Controversy and Controversy

Jean-François Masse, DMD, MSc, Diplomate, ABDSM, Editor-in-Chief *Journal of Dental Sleep Medicine*

Universite Laval, Quebec City, Quebec, Canada

It is with the greatest interest that I have read the editorial titled The Role of Dentists in the Diagnosis and Treatment of Obstructive Sleep Apnea: Consensus and Controversy in the *Journal of Clinical Sleep Medicine*.[1] This article was authored by highly respected members of the medical sleep community, and one author has been instrumental in getting the field of dental sleep medicine recognized as a key player in the treatment of obstructive sleep apnea (OSA). However, I take exception to some of the assertions made in the editorial.

I agree that the diagnosis of OSA has to be made by a sleep medicine physician in a face-to-face evaluation. Studies like the HypnoLaus study[2] have shown the high prevalence of OSA and its association with comorbidities like hypertension. The assessment of these common comorbidities is not in the scope of dental practice.

Regarding the need for treatment and the evaluation of treatment success, recent studies like the ones by McEvoy et al.[3] and Yu et al.[4] that show no cardiovascular risk reduction through treatment of OSA by continuous positive airway pressure, are shaking the foundations of dogma that seemed unquestionable just two years ago. Sleep physicians at the forefront of their field seem to disagree on these topics.[5] I can only imagine the vigor of the discussions on this subject in academic medical settings. As long as this potential controversy lingers, it is in everyone's best interest to follow the guidelines established in 2015 by both the American Academy of Dental Sleep Medicine and the American Academy of Sleep Medicine[6] until new guidelines are made.

I believe that the editorial was short-sighted in discouraging the use of home sleep apnea tests for interim testing. The authors of the editorial are from large academic institutions where there are ample board-certified sleep medicine physicians. For the majority of patients across the country, there is a dearth of sleep medicine physicians; wait times to get into a sleep facility to confirm oral appliance treatment efficacy are at minimum six weeks, but can be several months. Patients do not have the time, finances or will to make multiple trips between the dentist and the sleep facility. From a dentist's perspective, the objective is that the treatment the patient receives includes the least possible amount of mandibular advancement while getting the best reduction of the apnea-hypopnea index. Some evidence now seems to suggest that the response to oral appliance therapy is not dose dependent. This means we do not need to always advance the mandible to the position of maximum protrusion as we used to do.[7] Minimizing the level of protrusion helps to reduce potential side effects and improve compliance. To successfully carry out this treatment, we must perform free of charge interim testing as illustrated by new progressive dental protocols like the one proposed by Anitua et al.[8]

It is essential that sleep physicians and qualified dentists maintain a close relationship. This relationship is meant to evolve as new research is published. Treatment decisions should be based on scientific evidence and the patient's best interest. As the new Editor-in-Chief of the *Journal of Dental Sleep Medicine*, I am looking forward to seeing what changes are in store for the field of dental sleep medicine. I invite every member of the sleep community to share their ideas by submitting their research, case reports and opinions to the journal. Only by listening to all comments and fostering constructive discussion will we improve the quality of the services that we deliver to patients with sleep-related breathing disorders.

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Address correspondence to: Jean-François Masse, Professor, Universite Laval, 2780 Masson #200, Quebec City, QC, G1P 1J6, Canada; Tel: 418-871-1447; Fax: 418-871-4983; Email: jean-francois.masse@fmd.ulaval.ca