The Role of Iowa Dentists in Managing Sleep-Related Breathing Disorders

In October 2017, the American Dental Association (ADA) House of Delegates approved a policy statement on the "Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders (SRBDs)." Subsequently, the Iowa Dental Board convened a work group to examine the ADA policy and develop clarifications to provide information to Iowa dentists in the management of patients diagnosed with SRBDs and in identifying undiagnosed patients at risk of having these disorders. The work group developed a set of recommendations for the "Role of Iowa Dentists in the Management of Sleep-Related Breathing Disorders."

It is understood that the field of dental sleep medicine is constantly evolving, and that due to changes in knowledge and technology, future modifications to these recommendations may be necessary. These non-binding recommendations are provided for informational purposes only and do not constitute requirements of the Iowa Dental Board.

Note: In these recommendations, "physician" refers to a licensed medical provider with an MD, DO, PA (physician assistant) or NP (nurse practitioner) degree. "Sleep physician" refers to licensed medical provider (MD or DO) who is board-certified in sleep medicine, and also refers to a PA or NP who works with the board-certified provider.

The dentist's role in the treatment of SRBDs includes the following:

1. Dentists are encouraged to screen patients for SRBDs as part of a comprehensive medical and dental history and to recognize symptoms such as daytime sleepiness, choking during sleep, snoring or witnessed apneas and other risk factors such as obesity, macroglossia, Mallampati class 3 or 4, or hypertension. If risk for SRBD is determined, patients should be referred to a sleep physician[1] or their managing physician for follow-up evaluation and diagnosis.

   Working with a licensed physician (preferably a sleep physician), dentists may elect to administer pulse oximetry as part of initial screening for SRBD the scoring and interpretation of such testing as well as the patient's diagnosis should be the sole responsibility of the physician.

   Dentists' use of unattended Home Sleep Apnea Testing devices for screening should be considered within the scope of practice of a qualified dentist, defined as a dentist treating SRBDs who continually updates his or her knowledge and training with related continuing education. Data from the HSAT ***must*** be interpreted by a licensed medical provider, preferably a sleep physician, which may be accomplished by a face to face or telehealth visit.

2. In children, screening through history and clinical examination may identify signs and symptoms of dysmorphic growth and development, and other risk factors that may lead to airway issues. If risk for SRBDs is determined, intervention through medical/dental referral or evidenced based treatment may be appropriate to help treat the SRBD and/or develop an optimal physiologic airway and breathing pattern.

3. Oral appliance therapy (OAT) is an appropriate treatment for the spectrum of SRBDs in adults including diagnosed primary snoring, upper airway resistance, and obstructive sleep apnea. For all patients, a diagnosis rendered by a medical provider is required. When the diagnosis is obstructive sleep apnea, the patient must have a written or electronic prescription (work order) by the patient's medical provider for OAT.

4. When OAT is prescribed by a physician through written or electronic order for an adult patient with obstructive sleep apnea, a dentist knowledgeable in the practice of dental sleep medicine should evaluate the patient for the appropriateness of providing a suitable oral appliance.[2] If an oral appliance is deemed appropriate, the dentist should fabricate the oral appliance.

5. Dentists should obtain appropriate patient consent for treatment after obtaining baseline pre-treatment records. The written consent should review the proposed treatment plan, all available options, potential side effects of using OAT, and importance of follow-up care with both the dentist and the patient's physician.

6. Dentists treating SRBDs with OAT should be capable of recognizing and managing the potential side effects through treatment or proper referral.

7. Dentists who provide OAT to patients should adjust the Oral Appliance (OA) for treatment efficacy. Patient symptoms and objective data may be utilized to monitor or improve treatment efficacy.

   As titration of OAs has been shown to improve the final treatment outcome and overall OA success, dentists may use pulse oximetry or an unattended home sleep apnea testing device to help define the optimal target position of the mandible. A dentist trained in the use of these devices may assess the objective interim results for the purposes of OA titration.

   In no instance should the dentist rely on the outcomes of these devices to make the independent determination that the SRBD has been optimally treated. The patient's physician has ultimate responsibility for judging treatment efficacy.

8. Dentists should maintain regular communications with the patient's physician and other healthcare providers such as the patient's general dentist to inform them of the patient's treatment progress and recommended follow-up treatment.

9. Follow-up sleep evaluation and communication with the patient's physician is indicated to assess obstructive sleep apnea (OSA) improvement or to confirm oral appliance treatment efficacy. Dentists should monitor and re-assess treatment efficacy at least annually.

   In addition, dentists are strongly encouraged to closely communicate with the training physician/sleep physician or medical provider to see what information, or what frequency of information they would prefer.

   Provider should follow patient who is on OAT at least one time per year, as a safeguard to ensure everything is as optimal as could be medically.

   Treated patients who develop recurring OSA-relevant symptoms or comorbidities should be referred to their physician for follow-up sleep evaluation and alternative treatment if necessary.

10. Surgical procedures may be considered as a secondary treatment for OSA when CPAP or OAT is inadequate or not tolerated. In selected cases, surgical intervention may be considered as a

primary treatment. This decision should be made by the surgeon in collaboration with the patient's physician.

11. Training in dental sleep medicine is necessary for the dentist to provide safe, quality care to patients using oral appliances for SRBDs. Dentists treating SRBDs should take a minimum of 6 hours of related continuing education per licensing period in order continually update their knowledge and training.

[1] Patient's medical insurance may necessitate referral being made to the primary care or other managing physician.

[2] This may include the dentist's use of unattended home sleep apnea testing devices with a trial oral appliance to determine if the patient's sleep breathing sufficiently improves with jaw advancement. In no instance should the dentist rely on the outcomes of this testing to make the independent determination that the SRBD will be optimally treated. The patient's physician has ultimate responsibility for judging treatment efficacy of the final custom-fabricated oral appliance.