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Do you recommend combined use of CPAP/oral appliance in patients with severe OSA who fail to respond to either intervention?

As this was not part of our systematic review, the task force did not directly address this question in the guideline paper. In clinical practice, CPAP (or BPAP) is effective to treat severe OSA as long as the patient is able to tolerate CPAP with no pressure related side effects. In circumstances where a patient fails to respond to CPAP for severe OSA, the sleep physician has to evaluate causes for failure to respond to CPAP such as concomitant nasal obstruction. If the patient is experiencing high pressure related side effects from CPAP to treat severe OSA, some clinicians may combine CPAP with an oral appliance to reduce the pressure requirement on CPAP. In such circumstances, a follow up study and follow-up with both the sleep physician and a qualified dentist have to occur to confirm efficacy of the combined treatment.

I understand that for mild or moderate OSA the standards are oral appliance as first line of treatment?

CPAP is still the first-line treatment for OSA. Exploration of candidacy for oral appliance therapy should occur in close collaboration between a sleep physician and a qualified dentist for patients unable to use CPAP or who strongly prefer oral appliance over CPAP (rather than no treatment).

Is CPAP still considered gold standard for OSA treatment regardless of the intensity of OSA (mild/moderate/severe)?

Yes, CPAP is still the first-line treatment for OSA irrespective of OSA severity.

Are you suggesting that the 2006 guideline of having OAT as a first-line of therapy for mild and moderate OSA is no longer considered even after patients are given an informed consent of their options?

CPAP is still the first-line treatment for OSA and should be offered as an option to all patients. However, exploration of candidacy for oral appliance therapy should occur in close collaboration between a sleep physician and a qualified dentist for patients unable to use CPAP or who strongly prefer oral appliance therapy over CPAP (rather than no treatment). The 2006 practice parameter (3.3.3) does not state that OAT is a first-line therapy for mild/moderate OSA. Rather, the practice parameter states that, "Although not as efficacious as CPAP, OAs are indicated for use in patients with mild to moderate OSA who prefer OAs to CPAP or who do not respond to CPAP, are not appropriate candidates for CPAP, or who fail treatment attempts with CPAP".

Would you please explain the term "dental-related" side effects of MADs and how the project participant came to this term as it would seem to suggest a dental cause? As this is a medical device and these side effects are related to it, would the term "device-related side effects" be more accurate?

The oral appliance is a dental therapy used to treat a medical problem. Most side effects are dental related.



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## Can you talk about teeth shifting and techniques to avoid problems, and concerns about TMJ?

Concerns about occlusal changes are known to occur and are listed as frequent side-effects of oral appliance therapy. Techniques to mitigate these problems were not addressed in any of the studies included in the systematic review and, therefore, were not addressed in the recommendations. This is an area we hope to address in future guidelines.

## Should a sleep physician have a face to face consultation with a patient prior to oral appliance therapy (OAT)?

In ideal circumstances, all patients evaluated and treated in an accredited sleep center should be seen by a board-certified sleep physician or center staff provider prior to testing and the initiation of treatment. However, the AASM recognizes that patient consultations may be restricted by some health plans or prevented by a variety of other reasonable and unavoidable circumstances. Every effort should be made to manage these conditions in the best interest of the patient and in a way that promotes high quality care.

## Can a sleep physician treat the OSA with an OAT without a dentist?

The successful delivery of oral appliances requires the technical skill, acquired knowledge and judgment of a qualified dentist. An active collaboration between the sleep physician and the qualified dentist best serves the needs of the patient. Also, the studies analyzed to

prepare the clinical practice guideline were conducted by dentists with considerable experience in dental sleep medicine, and not by sleep medicine physicians.

## Is there a time period to wait after an OA is set up to follow up with a PSG or overnight oximetry?

The clinical practice guideline did not address this issue due to lack of research data. Based on the experience of the task force, follow-up testing with the OA should be done when adjustments to mandibular position appear to have resolved subjective symptoms or maximum tolerable mandibular protrusion has been achieved. Ideally this may be within one month of the patient beginning to use the device but may take longer depending on an individual's ability to accommodate to the device.

## Are home sleep studies as effective for determining OAT success?

The guideline paper did not address this issue due to lack of research data. However, the AASM's Clinical Guideline for the Evaluation, Management and Long-term Care of Obstructive Sleep Apnea in Adults recommends that patients with OSA should undergo PSG or an attended cardiorespiratory (type 3) sleep study with the oral appliance in place after final adjustments of fit have been performed. In clinical practice, if OSA was diagnosed by a home sleep apnea test (HSAT), it may be reasonable to retest that patient with the same HSAT to determine OAT effectiveness after the adequate adjustments are made to the oral appliance.



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## Any special considerations for pediatric patients?

This particular clinical practice guideline addressed oral appliance therapy in the adult population only, and specifically excluded articles associated with the pediatric population. However, because oral appliance devices exert orthodontic forces on teeth, they are not commonly used in children under 18 years old.