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

The 2019 NC Dental Society House of Delegates Approved Resolution 4H as follows: RESOLVED, that the NCDS House of Delegates approved the Amended Report on Management and Sleep-Related Breathing Disorders and adopt the policy statement as the NCDS official position statement on Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders.

Background
In October 2017, the American Dental Association House of Delegates approved a policy statement on the “Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders (SRBDs).” Subsequently, the NC Dental Society Board of Trustees charged a task force to examine the ADA policy and develop clarifications to guide NC dentists in the management of patients diagnosed with SRBDs and in identifying undiagnosed patients at risk of having these disorders. The task force developed a set of recommendations for the “Role of North Carolina Dentists in the Management of Sleep-Related Breathing Disorders,” which was reviewed in 2019 by the current NC Dental Society Board of Trustees and then approved by the House of Delegates at Annual Session.

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. Annual review is recommended.

Approved NC Dental Society Policy Statement
Note: In the policy statement, “physician” refers to a NC licensed medical provider with an MD, DO, PA (physician assistant) or NP (nurse practitioner) degree. “Sleep physician” refers to NC licensed medical provider (MD or DO) who is board-certified in sleep medicine. It also refers to a PA or NP who works with the board-certified provider.

The dentist’s role in the treatment of sleep-related breathing disorders (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 or their managing physician for follow-up evaluation and diagnosis.

   Working with a NC licensed physician (preferably a sleep physician), dentists may elect to administer high-resolution pulse oximetry as part of screening for SRBD, with the interpretation of such testing remaining the sole responsibility of the physician.

   Dentists’ use of other unattended Home Sleep Apnea Testing devices should be in compliance with the opinion of the North Carolina State Board of Dental Examiners.

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 identified, referral is indicated for evaluation by a pediatrician, preferably a
pediatric sleep specialist, or a pediatric otolaryngologist. Dental intervention should not be undertaken without consultation with the medical provider.

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 physician is required. When the diagnosis is obstructive sleep apnea, the patient must be referred by a physician for oral appliance therapy.

4. When oral appliance therapy 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. 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 unattended home sleep apnea testing devices 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 by the patient’s physician is indicated to assess OSA improvement or to confirm oral appliance treatment efficacy. Dentists should monitor and re-assess treatment efficacy at least annually.

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 recommended for the dentist to provide safe, quality care to patients using oral appliances for SRBDs. Dentists treating SRBDs should continually update their knowledge and training in dental sleep medicine with appropriate continuing education.

Additionally, the 2019 NC Dental Society House of Delegates approved the following resolutions at this year’s Annual Session.

**Committee on Rules and Order**

1H – 2019: RESOLVED, that the agenda proposed herewith be adopted as the official order of business for this session of the House of Delegates.

2H – 2019: RESOLVED, that the report of the Committee on Rules and Order by adopted.

3H – 2019: RESOLVED, that the report of the Committee on Rules and Order constitute the rules for the proper conduct of business at this session of the House of Delegates

**Additional Approved Resolutions**

4H – 2019: RESOLVED, that the NCDS House of Delegates approved the Amended Report on Management and Sleep-Related Breathing Disorders and adopt the policy statement as the NCDS official position statement on Role of Dentistry in the Treatment of Sleep-Related Breathing Disorders (SRBDs).

5H – 2019: RESOLVED, that the NCDS House of Delegates commends the NCDS Council on Prevention and Oral Health in its efforts to:

- a. Become better educated regarding the results of peer reviewed clinical research related to preventive programs and techniques that have been proven successful in arresting or preventing decay.
- b. Work with the North Carolina State Board of Dental Examiners and the North Carolina Oral Health Section to develop regulatory language that facilitates the provision of preventive treatment programs in school-based and other public health settings
- c. Evaluate pilot programs in other states, including those utilizing tele-dentistry, that increase access to care in rural communities while maintaining the dentist as the leader of the dental team.

For more information about any of the approved resolutions or additional details on the SRBD policy, please email pallen@ncdental.org.

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.