SLEEP APNEA SYNOPSIS FOR CLIENT CARE

ACRONYMS

OSAHS- OBSTRUCTIVE SLEEP APNEA-HYPOPNEA SYNDROME
CPAP- CONTINUOUS POSITIVE AIRWAY PRESSURE (MASK)

EPIDEMIOLOGY: 5-15% OF THE ADULT POPULATION HAS OSAHS

COMMON QUESTIONS

1. WHAT IS PATHOPHYSIOLOGY OF OSAHS?
   IT IS THE BLOCKAGE OF THE UPPER RESPIRATORY TRACT DURING SLEEP WHICH THEN CUTS OFF OR DECREASE OXYGEN INTAKE DURING SLEEP

2. WHY THE CONCERN/ WHY DO WE NEED TO SCREEN FOR IT/ WHY DO WE NEED TO REFER?

   a. OSAHS IS A POTENTIAL FATAL DISORDER
      i. IT CAN LEAD TO HEART ATTACK
      ii. IT CAN LEAD TO STROKE
      iii. IT CAN LEAD TO SYSTEMIC INFLAMMATION JUST LIKE CHRONIC PERIODONTAL DISEASE (ACTIVATES THE SAME PRO-INFLAMMATORY MEDIATORS SUCH AS C-REACTIVE PROTIEN)

   b. OSAHS IS CLOSELY LINKED WITH OBESITY
      i. OBESITY IS A GLOBAL EPIDEMIC
      ii. WE USE BMI IN OUR NUTRITIONAL ANALYSIS TO DETERMINE IF OUR CLIENTS ARE A HEALTHY WEIGHT, OVERWEIGHT OR OBESE
3. DENTAL HYGIENISTS HAVE A RESPONSIBILITY TO REFER AND PRACTICE INTERPROFESSIONAL HEALTH CARE
   i. OSAHS IS FREQUENTLY UNDIAGNOSED
   ii. DENTAL HYGIENISTS ARE FRONT LINE, PRIMARY CARE PROVIDERS WHO CAN ASSESS THE NEED FOR A MEDICAL DIAGNOSIS OF SLEEP APNEA

4. WHAT ARE THE RISK FACTORS FOR SLEEP APNEA?
   a. HEALTH HISTORY INDICATORS:
      i. LOUD SNORING (NUMBER ONE INDICATOR)
      ii. WITNESSED ABRUPT GASPING AWAKENINGS (WITNESSED APNEAS)
      iii. EXCESSIVE DAYTIME SLEEPINESS/NARCOLEPSY
      iv. HYPERTENSION
      v. DIABETES
      vi. ASTHMA
      vii. GERD
      viii. BRUXISM
      ix. MALE GENDER
      x. AGE 35+

   b. EXTRA ORAL-INTRA ORAL ASSESSMENT INDICATORS
      i. LONG SOFT PALATE
      ii. LARGE TONSILS
      iii. MACROGLOSSIA
      iv. LARGE NECK CIRCUMFERENCE
      v. EDENTULOUS/PARTIALLY EDENTULOUS CLIENTS
         1. REMOVAL OF POSTERIOR TEETH COLLAPSES THE AIRWAY DURING SLEEP
         2. REMOVAL OF COMPLETE DENTURES COLLAPSES THE AIRWAY DURING SLEEP
         3. EDENTULOUS CLIENTS ADVISED TO KEEP DENTURES IN DURING SLEEP TO KEEP AIRWAY OPEN
5. **WHEN DO WE REFER FOR ASSESSMENT OF SLEEP APNEA?**
   a. **WHEN YOU FIND A COMBINATION OF RISK FACTORS IN THE CLIENTS ASSESSMENTS WHICH INCLUDE:**
      i. LOUD SNORING
      ii. EXCESSIVE DAYTIME SLEEPINESS
      iii. WITNESSED APNEAS
      iv. MEDICAL HISTORY RISK FACTORS
      v. INTRA/EXTRA ORAL RISK ASSESSMENTS

6. **WHO DO YOU REFER TO?**
   a. TO THE CLIENTS **FAMILY PHYSICIAN** FOR ASSESSMENT OF OSAHS
   b. THE MD WILL THEN REFER THE PATIENT TO A **SLEEP STUDY CENTER**
   c. **SLEEP STUDY IS THE GOLD STANDARD** TO DIAGNOSE SLEEP APNEA
   d. THE PHYSICIAN WILL THEN GIVE THE PATIENT A **PRESCRIPTION FOR A CPAP**
   e. PHYSICIAN MAY REFER TO **DENTIST** FOR AN INTRA-ORAL SLEEP APNEA APPLIANCE.

7. **DO YOU NEED TO SEND A WRITTEN REFERRAL?**
   a. **YOU CAN SEND A VERBAL REFERRAL OR A WRITTEN REFERRAL FOR THE ASSESSMENT OF SLEEP APNEA. (REFERRAL FOR AN ASSESSMENT, NOT A MEDICAL CONSULTATION)**
      YOU MAY PROVIDE A WRITTEN REFERRAL FOR COMMUNICATION PURPOSES ONLY. SLEEP APNEA **ALONE** DOES NOT IMPACT DENTAL HYGIENE TREATMENT. YOU MAY LIST THE INTRAORAL/HEALTH HISTORY RISK FACTORS YOU FIND ON THE REFERRAL TO THE PHYSICIAN TO NOTIFY THEM OF YOUR FINDINGS AND ASK THE PHYSICIAN TO ASSESS THE CLIENT FOR SLEEP APNEA.

   b. **THIS IS NOT** A MEDICAL CONSULTATION WHERE YOU CANNOT PROCEED WITH TREATMENT.