All About Options – Building Stronger Links Between Sleep Centers and Dentists

Sleep physicians who refer to dentists want to know that patients can choose based on experience of the dentist, number of appliances offered and levels of fees.

When it comes to dental sleep medicine, sleep physicians tend to be concerned about the same things. Oral appliances are not covered by insurance (they believe), they are too expensive, and patients don't come back for objective follow-up.

Jamison R. Spencer, DMD, MS, often hears these complaints during his many lectures across America. He even heard it across the Pacific during a recent presentation in Australia.

No matter where they happen to be, sleep docs want more treatment options for patients. Spencer, who heads the Craniofacial Pain Center of Idaho and Colorado, with locations in Boise and Denver, says referring physicians are looking to refer to dentists who not only offer the more expensive, custom appliances, but who have less expensive options available too.

Some sleep docs, however, don't seem to understand that often *you get what you pay for*. "Medical doctors often look for whoever is cheapest, and they assume that any dentist who says he can make an appliance knows what he is doing," said Spencer, an adjunct faculty member at Tufts University Dental School. "Just last weekend at Tufts, a physician commented that there was no evidence to prove that a $3,000 appliance is any better than a $1,500 appliance. That is absolutely true. Where there is a difference is between dentists who do a more comprehensive evaluation, provide multiple therapy options, have excellent follow-up and know how to handle potential side effects such as jaw and TMJ pain."

As a diplomate of the American Board of Dental Sleep Medicine and the American Board of Craniofacial Pain, Spencer and like-minded colleagues have spent more than a decade refining the skills and nuances of dental sleep medicine. Physicians generally appreciate the distinction of specialization in other realms, but that is not always the case when it comes to dental sleep medicine.

Dentists who merely offer dental sleep medicine as one of their many services may not have the expertise. "It is up to us to show through outcomes that we can get better results by knowing what we are doing," says Spencer, who invented an oral appliance called The Silent Sleep, which is offered by Cadwell Therapeutics. "All of the art and science must come together to provide the best outcomes."

Spencer's low-cost Silent Sleep is one option that can serve as a temporary bridge to a more permanent solution. For those who can't afford fully custom oral appliances, it can also be used as a long-term device under the guidance of a knowledgeable dentist.

The Silent Sleep costs the dentist under $100, and takes 10 to 15 minutes to fit—not including examination. "Patients can try it and see if they can tolerate an oral appliance," says Spencer. "We have a model where they use a temporary appliance, go back to a sleep lab, and see if the appliance is working. We can try three different jaw positions to determine which is most effective. From there, we have spent little money, determined they can tolerate an oral appliance, and confirmed it is helping. Referrals will typically increase because the medical doctors feel more comfortable referring when they know the dentist has options for the patient."

Dentists who devote the vast majority of their practice to dental sleep medicine are admittedly rare, perhaps two or three dozen in the entire country. Should the lack of specialists hinder the spread of the technology? Spencer believes that is not necessary, and many patients can still be helped.

Better Than Nothing?

With so many people who need relief, Spencer contends that the perfect should not get in the way of the good. "Some say dentists should not be doing any of this unless they get properly trained and educated," says Spencer. "On the other hand, you have patients who have given up on CPAP. Every night they may be getting closer to a heart attack or stroke. Isn't it better to try something that may yield a positive effect? This is why we have over-the-counter drugs. Sometimes something is better than nothing."

However, Spencer cautions that sometimes dentists may unintentionally do harm. After all, he says, dentists already treat sleep and breathing without really knowing it.

A Canadian researcher did a small scale study that showed AHI worsened in some patients when using a night guard that dentists typically fit to protect a patient's teeth from grinding. Dentists don't intend to treat breathing problems with night guards, but Spencer says that in many cases they are inadvertently making some people worse. He hopes that more and more dentists will start screening their patients for sleep apnea and refer them for proper medical evaluation.

Spencer uses such a screening tool in his practices, incorporating the Epworth sleepiness scale, the STOP BANG and a few questions regarding clenching and grinding. "In three cities now, we have given out that form to general dental offices," says Spencer. We ask that they give it to everyone who walks in the door, regardless of age. We find that 20% to 30% of people who walk through the door of these offices likely have sleep apnea, or bruxism, or both.

The correlation between TMJ and sleep apnea represents another exciting link. "In my TMJ-based practice, we typically refer three or four people every day for evaluation by a sleep doctor," explains Spencer. "Of those in the last year, we have had just one patient who did *not* have sleep ap nea." "The interesting thing is that when these patients have their sleep apnea effectively treated, either with CPAP or an oral appliance, their TMJ problems tend to improve dramatically."

"Dentists are the best people to be looking for these problems," continues Spencer. "We are right in the mouth. The airway is centimeters away from where the dentist is already looking. My little catchphrase when I speak to dentists is that I know you are looking at these pearly white things, so all

I ask is that you direct your gaze a couple centimeters posteriorly. If you can't see down that person's throat, then ask if he or she is snoring. Ask is he has been known to stop breathing during sleep. Look for wear patterns on the anterior teeth. A lot of people grind their teeth forward to possibly protect their airway."

Double Standard for Oral Appliances?

Spencer points out that medical doctors put a lot of people on CPAP, knowing full well that 20% to 40% are going to fail. Despite the sizable failure rate, CPAP remains a first choice due to its status as the "gold standard."

Oral appliances, on the other hand, seem to merit far less latitude. "Sleep physicians can have a stack of literature that says oral appliances are effective, but if they send a patient out and that patient has a bad experience, that doctor may not send people for oral appliances anymore," explains Spencer. "If they did that with CPAP, none of them would recommend it ever again. Sometimes it seems that CPAP is allowed to fail, but oral appliance therapy is not. However, I understand that physicians may feel this way since much of the time oral appliances have been an out of pocket expense. Dentists who are experienced in dental sleep medicine now know how to help patients receive insurance benefits, and many of these dentists have become Medicare and even Medicaid providers" (Spencer is).

In his work with Cadwell Therapeutics (www.ctisleep.com), Spencer hopes to build stronger links between sleep laboratories, dentists, and DME companies. "We are helping to train dentists and educate sleep professionals on the usefulness of oral appliance therapy," says Spencer. "We show how a liaison between the dentist and the sleep lab can be beneficial for improved patient care, while also improving the economic health of the sleep laboratory."