examination that reviews oral/craniofacial condition risks and predictive factors for successful OAT.[10] This examination should include informed consent and financial arrangements necessary to commence OAT. Upon patient acceptance of the treatment plan, relevant dental records and imaging may be obtained to determine the appropriate OA within the context of the patient's oral presentation. Upon resolution of the signs and symptoms of OSA, the QD may elect to utilize pulse oximetry or HSAT, in accordance with applicable laws, to aid in identifying the appropriate therapeutic position of the appliance.[11] Ultimately, the patient is referred to the medical provider for verification of treatment efficacy and long-term follow-up. If signs and symptoms do not resolve and treatment modifications do not lead to resolution, the patient should be referred to the medical provider for adjunct treatment or treatment alternatives.

In the second pathway, a medical provider may refer a patient with a diagnosis of OSA to the QD for OAT to manage the OSA. The QD should determine whether the patient is a candidate for OAT through a comprehensive examination and follow the same steps outlined in the first pathway.

Optimal outcomes are often best realized when the QD, medical providers, and general dentist (if not the QD) collaborate to achieve the shared goal of successful treatment. The QD should frequently and openly communicate with these providers throughout treatment.

PRETREATMENT EXAMINATIONS

Screening Examination

Patients should be screened for OSA using validated screening tools. The goal of pretreatment examination or initial screening is to identify patients with increased suspicion of having OSA. The use of validated tools (e.g. Epworth Sleepiness Scale, STOP-BANG Questionnaire), which focus on subjective and objective criteria, offer increasing predictive value with increasing OSA severity.[12,13] Certain aspects of this screening visit may be completed by appropriately trained dental team members. Snoring cannot be distinguished from OSA and patients who snore should not be treated in the absence of a diagnosis.

Table 1. Components of Screening for Sleep-Related Breathing Disorders

General observations to identify patients suspected of having obstructive sleep apnea

- Record physical assessment baseline values for each patient (e.g., body mass index, blood pressure, neck circumference)
- Use one or more validated screening questionnaires/tools (examples include)
  - Epworth Sleepiness Scale (ESS)
  - STOP-Bang Sleep Apnea Questionnaire
- Medical History and Clinical Findings:
  - Chief complaint and history of current sleep problems including snoring, witnessed apneas, nocturia, morning headaches, and hypersomnolence
  - Medical history including cardiovascular disease, metabolic and neurologic disorders, and family history of sleep disorders
  - Medications
  - Dental history and findings
  - Clinical oral assessment, e.g., general assessment of the maxillomandibular relationship, posterior pharyngeal crowding, tongue size, signs of sleep bruxism, mouth breathing, nasal patency, signs of gastroesophageal reflux disease such as enamel erosion