Analyze adult snoring carefully

Condition is often a symptom of other serious problems
By Earl O. Bergersen, DDS, MSD

Snoring in an adult is considered to be a most important symptom that is strongly associated with daytime sleepiness, inattention, restlessness while sleeping, high blood pressure, stroke, atrial fibrillation, heart attacks and even diabetes. It is considered a frequent cause of auto accidents because of daytime drowsiness and lack of attention.

What should a doctor be asking to gain important diagnostic hints as to potential problems strongly related to snoring? Helpful questions can be summarized as follows:

1. Do you snore?
2. How often? Two to four nights a week — this is considered moderate snoring. If it is five to seven nights per week, or almost always when sleeping, it is considered habitual.
3. Is the snoring interrupted by a cessation in breathing? When the breathing resumes, the patient usually shifts the head to one side but may or may not wake up.
4. Count the number of seconds the breathing has stopped. If it is 10 seconds or more, and if these cessations occur at least 10 times per hour, this is considered a serious problem, usually involving sleep apnea.
5. Does the patient seem to have difficulty breathing while sleeping? This is a sign of hypopnea, another serious form of sleep disturbance that is very similar to apnea (the complete cessation of breathing).
6. Does the patient often fall asleep while watching television or while reading a book?

Most often (but not exclusively), it is a middle-aged male who is overweight and has a large neck size (usually 17 inches or more). There are, however, those who have serious sleep apneas and breathing problems who are not overweight and are not a typical candidate.

How should the doctor deal with a snoring patient? To simply issue an anti-snoring device will solve the irritating snoring problem but may ignore much more life-threatening symptoms as mentioned above.

The simplest way is to use a home-night study, which consists of a device (such as supplied by Res-Med) that can monitor not only the severity of snoring (intensity of sound, frequency and when it occurs), but the type and frequency of apnea, blood oxygen and number of breaths, etc. If there is evidence of apnea (a complete cessation of breathing) or hypopnea (laborated breathing), then a snoring device could be prescribed.

A simple device is called a Snore-Cure®, which is pre-formed and advances the mandible and tongue at different amounts (4 mm and 7 mm from an end-to-end incisal position). One important piece of advice is that you must wear the appliance for at least 4 hours nightly to make sure that the device provides enough advancement to overcome the problem.

Choosing the right sterilization process

By Peter O. Sildve, Director, Dentronix

It’s been well over a year ago that I had the privilege of having an article published in the Journal of Clinical Orthodontics (September 2012). The article was about the choices we have in infection control methods and how they impact the materials from which instruments are made.

I obviously have a dry heat sterilizer bias because of the groundbreaking developments Dentronix has made in this technology during the last 25 years, but our FDA-cleared, biologically verifiable dry heat system is no longer a compliant option in jurisdictions such as California and Nevada.

In these states, dental board regulations requiring mandatory bagging of instruments have overridden the reasonable “flash” sterilization choices of a vast number of orthodontists.

From an effectiveness standpoint, steam sterilization is a perfectly viable option, however, it can be damaging to hinged instruments, sharps and non-stainless materials — exactly the types of instruments orthodontists use.

Offices now using steam need to be aware of the implications of their process and what steps they need to take to preserve the integrity of their tools.

Not surprisingly there was some pushback on my approach to allowing orthodontists to make their own informed decision. Without these rules, infection control methods have become significantly compromised.

In my opinion, this is a solution in search of a problem. Until we thoroughly assess the microbiological implications of predominate non-invasive orthodontic treatment via a-v-a (a) the unsterile clinical environment, (b) unsterile barriers and personal protective equipment (PPE’s) and (c), in many cases, unsterile treatment components, there is no solution that can be had between the proponents of “sterile” instruments and those that accept “sterilized.”

The risks to instrument longevity and functional integrity are exponen-