



Debunking the Myths of Oral Appliances for Obstructive Sleep Apnea

Oral appliances effectively treat obstructive sleep apnea (OSA) and are recommended for patients diagnosed with OSA who prefer a therapy other than CPAP or are intolerant of CPAP. Oral appliances should be adjustable and customizable and provided by a qualified dentist who has training in treating obstructive sleep apnea.

This page debunks the myths surrounding oral appliance therapy (OAT) and provides referring physicians the most current information.

Myth: CPAP is the only therapy for sleep apnea

Not accurate. Oral appliance therapy uses a “mouth guard-like” device worn during sleep to maintain an open, unobstructed airway. Effective oral appliances are formed from custom dental impressions made by a qualified dentist. An oral appliance is fitted and adjusted by a qualified dentist to ensure proper fit and maximum effectiveness. Patients like that oral appliances are easy to use, clean and transport. They are also comfortable, noninvasive, noise-free and less obtrusive compared to CPAP. ¹

Myth: Oral appliance therapy isn’t as effective as PAP therapy

OAT has similar effectiveness and better rates of patient compliance. ² Although CPAP has greater efficacy in laboratory settings, at home, patients are more compliant with OAT. OAT is more effective in the “real world.” ³ OAT reduces sleepiness and improves quality of life. In simulated driving tests, patients using oral appliances perform equally compared to patients using CPAP. OAT also reduces the risk of cardiovascular mortality and reduces blood pressure. ^{4,5} OAT is comparable to CPAP when it comes to patient satisfaction, compliance and effectiveness of therapy.

Myth: Oral appliance therapy should not be used for treating severe OSA

OAT is effective in managing severe OSA on its own or, in some cases, in combination with CPAP. Similar health outcomes were found between CPAP and OAT used among patients with moderate to severe sleep apnea. ² When combining OAT and CPAP, CPAP pressure may be lowered substantially as an oral appliance increases upper airway patency. ^{6,7} Both lower pressure and increased comfort may improve patients’ compliance with therapy, thereby improving therapeutic effectiveness. ⁸

Myth: Oral appliance therapy can be provided by any dentist

OAT should only be provided by a qualified dentist who has appropriate training in the field of dental sleep medicine. ¹¹ When a dentist without the appropriate education and training attempts to treat a patient’s sleep apnea, it can lead to inappropriate care and physician-dentist communication failures. This can lead to poor health outcomes for the patient. ¹² Organizations such as the ADA recommend that dentists routinely update their training to treat patients with OAT. ¹³ The AADSM maintains a directory of qualified dentists at [Find an AADSM Dentist](#).

Myth: OAT causes extreme tooth movement

OAT’s side effects are so mild patients often do not notice them or are not bothered by them. For most patients, treating their sleep apnea is so important that the side effects do not dissuade them from using their oral appliance. Qualified dentists are trained to mitigate side effects. Even when they do occur, most interventions are palliative, involve slight modifications of the oral appliance, or require no active therapy. ^{9,10}

Myth: Oral appliances are more expensive than CPAP

OAT can be less expensive than CPAP. CPAP requires patients to replace masks, filters and tubes regularly, meaning that the ongoing costs of CPAP add up over a 5-year period.

Myth: Oral appliance therapy isn't covered by insurance

OAT is covered by most commercial insurance and Medicare. OAT is covered by medical insurance – not dental insurance. Qualified dentists have familiarity with medical insurance and the necessary documentation, pre-authorization and other requirements.

Want to learn more about oral appliance therapy? Find a local qualified dentist to discuss how oral appliance therapy may be appropriate for your patients at [Find an AADSM Dentist](#), by calling 630- 686-9875, or emailing info@aadsm.org.

References:

1. Le JQ, Rodgers JL, Postol K. Oral appliance therapy should be reimbursed as a first-line therapy for OSA. *J Dent Sleep Med*. 2019;6(1)
2. Phillips CL, Grunstein RR, Darendeliler MA, et al. Health outcomes of continuous positive airway pressure versus oral appliance treatment for obstructive sleep apnea: A randomized controlled trial. *Am J Respir Crit Care Med*. 2013;187(8):879-887.
3. Sutherland K, Phillips CL, Cistulli PA. Efficacy versus effectiveness in the treatment of obstructive sleep apnea: CPAP and oral appliances. *J Dent Sleep Med*. 2015;2(4):175–181.
4. Iftikhar IH, Hays ER, Iverson MA, Magalang UJ, Maas AK. eEffect of oral appliances on blood pressure in obstructive sleep apnea: A systematic review and meta-analysis, *J Clin Sleep Med*. 2013; 9(2): 165-174.
5. Anandam A, Patil M, Akinnusi M, Jaoude P, El-Solh AA. Cardiovascular mortality in obstructive sleep apnoea treated with continuous positive airway pressure or oral appliance: An observational study. *Respirology*. 2013;18(8):1184-1190.
6. Liu HW, Chen YJ, Lai YC, et al. Combining MAD and CPAP as an effective strategy for treating patients with severe sleep apnea intolerant to high-pressure PAP and unresponsive to MAD. *PLoS One*. 2017;12(10).
7. El-Solh AA, Moitheennazima B, Akinnusi ME, Churder PM, Laforanara AM. Combined oral appliance and positive airway pressure therapy for obstructive sleep apnea: A pilot study. *Sleep Breath*. 2011;15(2):203-208.
8. Prehn RS, Swick T. A descriptive report of combination therapy (custom face mask for CPAP integrated with a mandibular advancement splint) for long-term treatment of OSA with literature review. *J Dent Sleep Med*. 2017;4(2):29–36.
9. Sheats RD. Management of side effects of oral appliance therapy for sleep-disordered breathing: summary of American Academy of Dental Sleep Medicine recommendations. *J Clin Sleep Med*. 2020;16(5):835.
10. Sheats RD, Schell TG, Blanton AO, Braga PM, Demko BG, Dort LC, Farquhar D, Katz SG, Masse JF, Rogers RR, Scherr SC, Schwartz DB, Spencer J. Management of side effects of oral appliance therapy for sleep-disordered breathing. *Journal of Dental Sleep Medicine*. 2017;4(4):111–125.
11. Dort LC. A little knowledge is a dangerous thing. *J Dent Sleep Med*. 2016;3(3):79.
12. Levine M, Bennett K, Cantwell M, Postol K, Schwartz D. Dental sleep medicine standards for screening, treating, and managing adults with sleep-related breathing disorders. *J Dent Sleep Med*. 2018;5(3):61-68
13. ADA Adopts Policy on Dentistry's Role in Treating Obstructive Sleep Apnea, Similar Disorders. American Dental Association. <https://www.ada.org/en/press-room/news-releases/2017-archives/october/ada-adopts-policy-on-dentistry-role-in-treating-obstructive-sleep-apnea>. Accessed January 25, 2021.