

Commentary on “A New Definition of Dental Sleep Medicine”

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In “A New Definition of Dental Sleep Medicine”, Lobbezoo and co-authors propose to redefine Dental Sleep Medicine (DSM) as “the discipline concerned with the study of the oral and maxillofacial causes and consequences of sleep-related problems.”¹ The authors suggest that the proposed definition broadens the 2008 definition of the American Academy of Dental Sleep Medicine (AADSM): “Dental Sleep Medicine focuses on the management of sleep-related breathing disorders (SDB), which includes snoring and obstructive sleep apnea (OSA), with oral appliance therapy (OAT) and upper airway surgery.” In proposing the new definition, the authors recommend that dentistry play a role in other disorders that, like SDB, affect sleep or are affected by disturbed sleep. They credit the proposed definition to the visionary work of Professor Gilles Lavigne and his colleagues, published 20 years ago. The authors are internationally recognized, leading experts in orofacial pain and sleep disorders and have contributed much to our understanding in these areas. The paper was first published in 2016 in the *Journal of Oral Rehabilitation*.²

From an academic perspective, the proposed redefinition is logical. Similar to the categories of disorders in the field of Sleep Medicine, the proposed redefinition of Dental Sleep Medicine would include Sleep Movement Disorders or behaviors (bruxism, dyskinesia, and dystonia), insomnia-related disorders (orofacial pain, oral moistening disorders, gastroesophageal reflux disease--disorders that affect sleep duration or quality), as well as Sleep-Related Breathing Disorders (snoring, upper airway resistance, and obstructive sleep apnea). The authors note that some of these conditions are linked. Specifically, gastroesophageal reflux disease or mouth dryness coexist with OSA in some patients, and nocturnal bruxism may evoke salivation and improve airway patency. The authors further distinguish a disorder from a behavior, noting that primary snoring and bruxism may constitute behaviors only, causing no harm and requiring no treatment. Similar distinctions are made in the field of Sleep Medicine; for example, during polysomnography a patient can exhibit periodic limb movements (periodic limb movements of sleep, a behavior) without suffering from disturbed sleep as their result (periodic limb movement disorder, a disorder).³

Because of the medical knowledge and medical management required for the study of the oral and maxillofacial causes and consequences of sleep-related problems, the authors further suggest that Dental Sleep Medicine be considered a branch of Oral Medicine. Moreover, the authors’ redefinition places emphasis on the study of these problems. It can be assumed that ‘study’ in this context refers to the acquisition of new knowledge (research) pertaining to oral and maxillofacial relevant sleep-related problems or to other scholarly activity or the mastery of existing knowledge about the problems.

From a clinical perspective, the proposed redefinition does not recognize current and evolving trends in DSM practice and policy in the United States. During the past year alone, DSM stakeholders and policy makers have refined the Academy’s 2008 definition of DSM. Position statements issued by the American Dental Association⁴ and the AADSM,⁵ and Standards of Practice issued by the AADSM⁶ clarify and expand the role of dentists in the management of SDB. New issues that have been addressed include screening and referral of patients at risk of SDB to other clinicians, use of home sleep apnea testing devices by dentists, and management and treatment of pediatric SDB. An increasing number of dentistry state boards are beginning to issue opinions regarding these matters as they pertain to the lawful practice of dentistry in the respective states. Differences in rulings among states and differences in position between the dental and medical sleep professions pertain to the management of SDB. Means by which a dentist can become qualified or certified in DSM have been redefined, but competencies still pertain largely to the management of SDB and its comorbidities. In no way to devalue the importance of the study of the oral and maxillofacial causes and consequences of sleep-related problems, this is not the focus nor direction of policy that is currently shaping the clinical landscape of DSM practice in the United States. In the United States the disciplines of Prosthodontics,⁷ Oral Surgery,⁸ and Orofacial Pain⁹ (not Oral Medicine) have incorporated DSM in their advanced education programs and accreditation standards. The DSM emphasis in these residency programs is on the management of SDB.

Given these trends, the implications of the proposed

redefinition of DSM are unclear. Would dentists who practice DSM, and in particular those certified in DSM, be expected to be proficient in the assessment and management of all sleep-related problems, going forward? Alternatively, could all dentists who fabricate dental night guards for their patients rightfully profess to practice DSM? Is the main intention of the redefinition to bring greater recognition of DSM by dentistry at a time when policy makers, educators, and clinicians are largely focused on the management of one condition, SDB? Considering the uncertainty in its implications, the authors' redefinition would seem best suited as an amendment to the Academy's 2008 definition of DSM: "Dental Sleep Medicine focuses on the management of sleep-related breathing disorders (SDB), which includes snoring and obstructive sleep apnea (OSA), with oral appliance therapy (OAT) and upper airway surgery. It is also the discipline concerned with the study of the oral and maxillofacial causes and consequences of sleep-related problems."

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DISCLOSURE STATEMENT

The author has no conflicts of interest to disclose.