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.

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