









Effectiveness of a Uniquely Designed Oral Appliance on Obstructive Sleep Apnea Control: A Pilot Study

Denise Fernandes Barbosa¹  Miguel Meira e Cruz^{2,3}  Marcelo Corrêa Alves⁴  Edilson Zancanella¹ 
Fausto Berzin⁵  Almiro José Machado Júnior¹ 

¹ Division of Surgical Sciences, Department of Otorhinolaryngology, School of Medical Sciences, University of Campinas, UNICAMP, São Paulo, Brazil

² Sleep Unit, Centro Cardiovascular da Universidade de Lisboa, Lisbon School of Medicine, Lisbon, Portugal

³ Research Laboratory on the Neuroimmune Interface of Pain São Leopoldo Mandic College, Campinas, São Paulo, Brazil

⁴ ESALQ, University of Sao Paolo, Piracicaba, São Paulo, Brazil

⁵ Department of Odontology, FOP – UNICAMP, Piracicaba, São Paulo, Brazil

Address for correspondence Almiro José Machado Júnior, PhD, Division of Surgical Sciences, Department of Otorhinolaryngology, Medical Sciences College, University of Campinas, UNICAMP, R. Tessália Vieira de Camargo, 126 - Cidade Universitária, Campinas, Sao Paulo 13083-887, Brazil (e-mail: almiromachadophd@gmail.com).

Eur J Dent 2022;16:564–572.

Abstract

Objectives Obstructive sleep apnea is an inflammatory, chronic, and evolutive disease often needing adequate treatment and follow-up. The oral appliance (OA) is an accepted alternative therapy for obstructive sleep apnea (OSA) control. Due to greater adherence, OA with mandibular advancement (OA_m) is being recommended treatment for patients who refuse or do not tolerate continuous positive airway pressure. The mode of action of OA_m is to promote the advancement of the mandible or tongue with a subsequent increase in the tone of the pharyngeal muscles and the permeability of the upper airway, but most OA_m use conventional models as reference, analogic, or digital, dissociating dental arches of the skull structures.

Materials and Methods A retrospective longitudinal study of 33 OSA patient treated with a different OA_m, that use Camper plane as reference with skull structures for dental arches disocclusion, where polysomnographic, cephalometric measures, and subjective data from questionnaires pre- and post-treatment were assessed and correlated. Descriptive analysis, correlated Chi-square tests, and basic statistics were used. Generalized linear mixed model for repeated measure and post hoc Tukey–Kramer test compares the variables pre- and post-treatment. Shapiro–Wilk test and Pearson’s correlation coefficients were used. All statistical tests were set in 5% level of significance.

Results Regarding polysomnography data, there was a significant association between apnea hypopnea index (AHI) with oxygen saturation, arousal index (AI) and the maximum heartbeats, and sleep improvement and health risk reduction. Additionally, from cephalometric data, it was found a significant association between the tongue posture with the soft palate, hioyd-C3 and, lower and posterior airway. When both

Keywords

- ▶ obstructive sleep apnea syndrome
- ▶ oral appliance therapy
- ▶ upper airway

published online
February 18, 2022

DOI <https://doi.org/10.1055/s-0041-1735933>.
ISSN 1305-7456.

© 2022. The Author(s).

This is an open access article published by Thieme under the terms of the Creative Commons Attribution License, permitting unrestricted use, distribution, and reproduction so long as the original work is properly cited. (<https://creativecommons.org/licenses/by/4.0/>)

Thieme Medical and Scientific Publishers Pvt. Ltd., A-12, 2nd Floor, Sector 2, Noida-201301 UP, India

parameters are correlated, there are a significant dependent association with hyoid bone position with AHI and AI. The limitation of this study was the two-dimensional image used without provide volumetric measurements, but this limitation was reduced with the follow-up polysomnography parameters.

Conclusion In this pilot study, DIORS OA_m as an uniquely designed device using Camper plane as a reference for disocclusion was effective in the control of OSA.

Introduction

Obstructive sleep apnea (OSA) is a chronic, inflammatory, and progressive disease.^{1,2} Its prevalence in the general population is between 9 and 38%, and varies according to age and gender.³ The diagnosis⁴ requires either signs/symptoms (e.g., associated sleepiness, fatigue, insomnia, snoring, subjective nocturnal respiratory disturbance, or observed apnea) or associated medical or psychiatric disorder (i.e., hypertension, coronary artery disease, atrial fibrillation, congestive heart failure, stroke, diabetes, cognitive dysfunction, or mood disorder) coupled with five or more predominantly obstructive respiratory events (obstructive and mixed apneas, hypopneas, or respiratory effort-related arousals, as defined by the American Academy of Sleep Medicine scoring manual) per hour of sleep during polysomnography (PSG). Alternatively, a frequency of obstructive respiratory events 15/hour satisfies the criteria, even in the absence of associated symptoms or disorders.

Clinical symptoms vary depending on the type, frequency, and intensity of the respiratory abnormality.^{5,6} Normal rates of apnea should also be treated when associated with snoring, although some controversial issues persist regarding the therapeutic criteria for snoring itself.⁷

The most recommended devices for usage by American Academy of Sleep Medicine and the American Academy of Dental Sleep Medicine⁸ are the oral appliance with mandibular advancement (OA_m) for the treatment of primary snoring, mild and moderate obstructive sleep apnea (OSA), and the continuous positive airway pressure (CPAP) to moderate to severe OSA. In addition, OA_m can be considered after CPAP has been failed in nonadherent patients treatment or in patient preference in therapy choosing.^{9,10}

The new generation of OA_m devices presents considerable advances in design, construction techniques, and individualization capacity. Considering the assumptions of design, construction, and individualization, OA_m can further impact the effectiveness of oral appliance therapy (OAT).⁸

One of the problems related to respiratory disorders is the maxillomandibular relationship, both vertically, sagittal and transversal,¹¹ significant differences existed in the craniofacial morphology of patients with OSA and the healthy population. In addition to this relationship, which is so important, most malocclusions are treated based on a conventional analog or digital model,¹² which does not faithfully reproduce their interrelationships with cranial structures. These therapeutic proceed can bring important repercus-

sions in the lives of these patients for not considering the intimate interrelationship of the dental arches with the craniofacial structures.¹³ Likewise, most OA_m are structured, using models dissociated from their relationship with craniometric structures and, consequently, with the muscles involved in mandibular protrusion movements.

The functional anatomic factors leading to oropharynx and hypopharynx airway collapse in OSA,^{14,15} are in part related to the retracted position of the mandible and tongue with sagging soft palate. The principal mechanism of action of OA_m is by promoting the advancement of the mandible or tongue^{14,16} because simple active anterior movement of the tongue or mandible can increase cross sectional airway size in subjects with and without OSA^{17,18} and, increasing the pharynx muscles tone and therefore the airway patency. Ideally, these situations could be achieved in the OA_m mode of action simultaneously.^{14,19-22}

One of the first functional mandibular activator devices was developed in Europe in the early 20th century which became a universal device widely used, thanks to Viggo Andresen. The removable activator devices were built to redirect the pressure of facial muscles and masticatory onto teeth and support structures to improve dental arrangement and occlusal relationships. This author used the Camper plane for diagnosis and follow-up. The Camper plane is a plane established by superior border of the tragus left and right to the lowest point of ala border.²³

In OAT, the neuromuscular system will be activated through OA_m maintaining upper airway patency, toning the oropharynx muscles, thus preventing collapse between the tissues of the oropharynx and tongue base,²⁴ and improving tongue posture.²⁵ The OA_m cannot exceed anatomical physiological limits. Therefore, the choice of OA_m for the treatment of OSA should be considered by Dental Sleep Medicine.^{21,24,26-28}

In searching for functional balance, the DIORS OA_m design²⁹ considered these two situations because it was designed based on functional anatomy of bucco-dental biology. The OA_m disocclusion is guided to Camper plane based on fixed individual skull structures. At same time, it stimulates the tongue for advancement, promoting lip sealing which further improve the airway patency.

In Dental Sleep Medicine clinical practice,⁸ there are diagnostic and complementary exams with objective and subjective parameters need for records as polysomnography exam for diagnosing OSA, intra- and extraoral photographic examination to assess facial patterns, oral conditions, and

follow-up cephalometric analyze of the airway space, which makes it possible to check the mandible and tongue position in relation bone structures^{14,30-33} and models of the dental arches for recording and making the OA_m . In addition to these objective parameters, the Epworth sleepiness scale is a subjective parameter, of proven validity, used for the evaluation and monitoring of the patient after treatment.⁸

Thus, the aim of this pilot study is to compare the impact of OA_m that use Camper plane for reference to disocclusion, on the upper airways in snore and OSA patients, in the pre- and post-treatment in a private dental office through cephalometric analysis, and the effectiveness of this different OA_m through polysomnographic parameters. Also, verify if there is a correlation with these variables associated with clinical practice.

Materials and Methods

Study Design

A retrospective longitudinal study was developed from dental sleep medical records of OSA patients treated with DIORS OA_m , manufactured by the first author in her dental office, Jundiá, SP, Brazil. The results were measuring and comparing by objective (polysomnography and cephalometric data) and subjective (Epworth sleepiness scale and adherence, symptoms, satisfaction, and safety questionnaires) data pre- and post-treatment. The data analysis was conducted by applying quantitative techniques and multiple comparisons (► Fig. 1).

The study was approved by the School of Odontology of Piracicaba UNICAMP Ethics Committee, SP, Brazil (CAAE: 20672219.3.0000.5418 P.N. /4.034.661). This study counted patients attending in private dental office with authorized and formalize participation with the informed consent.

Sample

In view of the nature of the variables to be analyzed, a sample size calculation was made based on the application of the Student *t*-test for paired data where the mean referring of null hypothesis was 0; the significant average, of two different units; the standard deviation of 4; and the desired power, 80%, resulting in a total sample of 34 patients.

The inclusion criteria were both genders adult patients with snoring and mild, moderate and severe OSA prescribed by Sleep Physician treated with DIORS OA_m in the first author dental office from 2011 to 2019 period, with completed medical records and protocol of 2 to 3 months of OA_m adjustment. The records needed to have Epworth sleepiness scale, polysomnography and cephalometry pre- and post-treatment. The exclusion criteria were incomplete dental sleep medical records and patients that not permitted used the data for research.

The success criteria established in this study regarding elimination or decreasing of AHI symptoms^{17,29} were (1) successful (AHI < 5/hour); (2), partly successful (at least 50% reduction in AHI, but AHI > 5/hour; and (3) failure (persisting clinical symptoms, and/or less than 50% reduction in baseline AHI).

In ► Table 1, the characteristics of 33 adults with anthropometrics and polysomnographic and cephalometric data

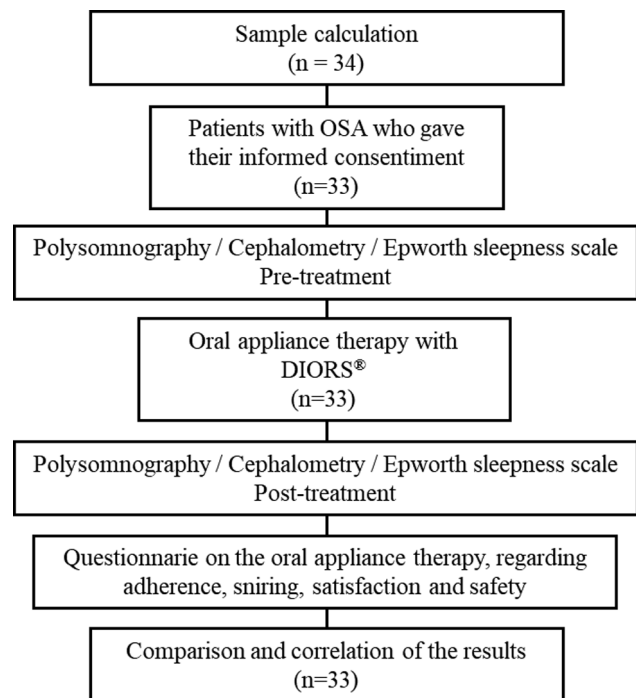


Fig. 1 Diagram of study development.

are showed. The anthropometric data consist in 25 men and 8 women pre- and post-treatment with mean (standard deviation) of 50.53 (10.29) years old and body mass index (BMI) of 27.70 (3.27). The angle occlusal classification of these sample is 86.96% of Class I and 13.04% of Class II. The AHI variation was 11.92 (12.80). Based on OSA severity, the sample consisted in simple snoring or normal apnea (AHI < 5) in 2.17%, mild ($5 \leq$ AHI < 15) in 26.09%, moderate ($15 \leq$ AHI < 30) in 13.04%, and severe (AHI \geq 30) in 8.7%.

Polysomnography

Each subject underwent polysomnography all-night recordings in the sleep laboratory in two phases pre- and post-treatment. The polysomnographic study used was Brain Wave II Polysomnography (Neurovirtual, Barueri – SP/Brazil) performed by physicians specially trained in sleep medicine. The AHI was defined as the number of episodes of apnea plus episodes of hypopnea per hour of sleep. OSA was defined as AHI \geq 5.

Cephalometry

Cephalometric parameters were taken for the location of obstruction sites and to clarifying specific parameters to the upper airway with the software Radio Memory Studio 3.0 Release 7.80 (Radio Memory LTDA, Belo Horizonte – MG/Brazil). Several analysis has been widely described in literature.^{14,30-33} The cephalometric analysis of airway space used and covered in two phases: without and with OA_m pre- and post-treatment. The majority teleradiographs and cephalometric analysis (91.3%) was performed by a single evaluator of Speed X Dental Documentation Center with Instrumentarium OC 200 Xray (KaVo company, Finland).

Table 1 Mean, standard deviation, and confidence limits of the mean (95%) that characterize sample data (n = 33)

Characteristics	Mean	Standard deviation	95% confidence limit		Minimum	Maximum
			Upper	Lower		
Anthropometric data						
Cervical waist	40.76	4.59	42.44	39.07	33.50	55.00
Abdominal waist	98.98	10.21	102.73	95.24	74.00	117.00
Age	50.53	10.29	54.18	46.88	29.54	70.92
Weight (kg)	83.65	14.54	87.31	79.99	58.00	115.00
BMI (kg/m ²)	27.70	3.27	28.53	26.88	20.05	37.10
Polysomnographic data						
Epworth sleepiness scale	8.22	4.53	9.36	7.08	1.00	20.00
Arousal index	9.05	8.90	11.29	6.81	0.40	53.13
SaO ₂ minimum (%)	85.57	5.65	86.99	84.15	64.00	93.00
Sleep efficiency	76.83	12.38	79.95	73.72	45.60	96.00
Apnea	4.89	8.56	7.05	2.74	0.00	43.40
Hypopnea	7.02	6.78	8.73	5.32	0.00	33.72
AHI	11.92	12.80	15.14	8.70	0.20	64.18
Minimum heartbeat	54.71	7.60	56.71	52.71	44.00	78.00
Maximum heartbeat	78.06	13.20	81.53	74.59	57.00	137.00
Legs movements	3.29	7.83	5.30	1.29	0.00	36.20
Cephalometric data						
Upper pharyngeal space	17.74	4.14	18.76	16.72	9.83	27.07
Soft palate length	41.90	5.88	43.34	40.45	28.23	58.57
Posterior air space	13.85	4.20	14.88	12.82	6.05	25.61
Hyoid distance mandibular plane	22.89	7.54	24.75	21.04	10.31	41.39
Tongue length	78.84	9.27	81.12	76.56	57.46	97.30
Tongue height	29.30	5.46	30.64	27.95	14.47	44.75
Lower air space	12.79	4.65	13.94	11.65	5.14	24.69
Hyoid distance third cervical vertebrae	42.81	5.42	44.15	41.48	32.40	53.32

Abbreviations: AHI, apnea-hypopnea index; BMI, body mass index; SaO₂, oxygen saturation.

Patients were instructed to swallow and to close their mouths with maximal intercuspation and the lips in a relaxed position when they were without and with OA_m.

Anatomically, the pharyngeal airway is divided in nasopharyngeal, oropharyngeal, and hypopharyngeal.³² The cephalometric variables analysis of airway space used were mapped in **Fig. 2A** (pre-treatment) and **2B** (pre-treatment) showing the mode of action of OA_m used in the study to identify tongue, soft palate, and pharyngeal airway.

Oral Appliance Therapy

Impressions of the dental arches and face bow to construct the gnathostatic study model based on Camper plane were made, and the constructive bite was determined by using George Gauge® bite fork.

The initial protocol of OA_m construction were with 65 to 75% maximum protrusion and a vertical opening of 3 to 4 mm between incisor edges. The efficacy of OA_m was deter-

mined by using additional PSG with OA_m in situ after a minimum of 3 months.

Questionnaires

Subjective daytime sleepiness was evaluated by applying the Epworth sleepiness scale pre- and post-treatment, and a questionnaire to assess snoring, adherence, satisfaction, and safety of OA_m usage to partners and to the patient follow-up. The adapted questionnaire²⁹ consisted in following questions: Are you using OA_m? If yes, mark on a scale of 1 to 3 (where: 1 = little, 2 = medium and 3 = a lot); Is your partner snoring with OA_m? If yes, mark on a scale of 1 to 3 (where: 1 = little, 2 = medium and 3 = a lot); and Are you totally satisfied with OA_m? Has OA_m already broken?

Success Criteria

We evaluated the successful criteria of therapies with arousal index in addition to respiratory parameters, as AHI and SaO₂,

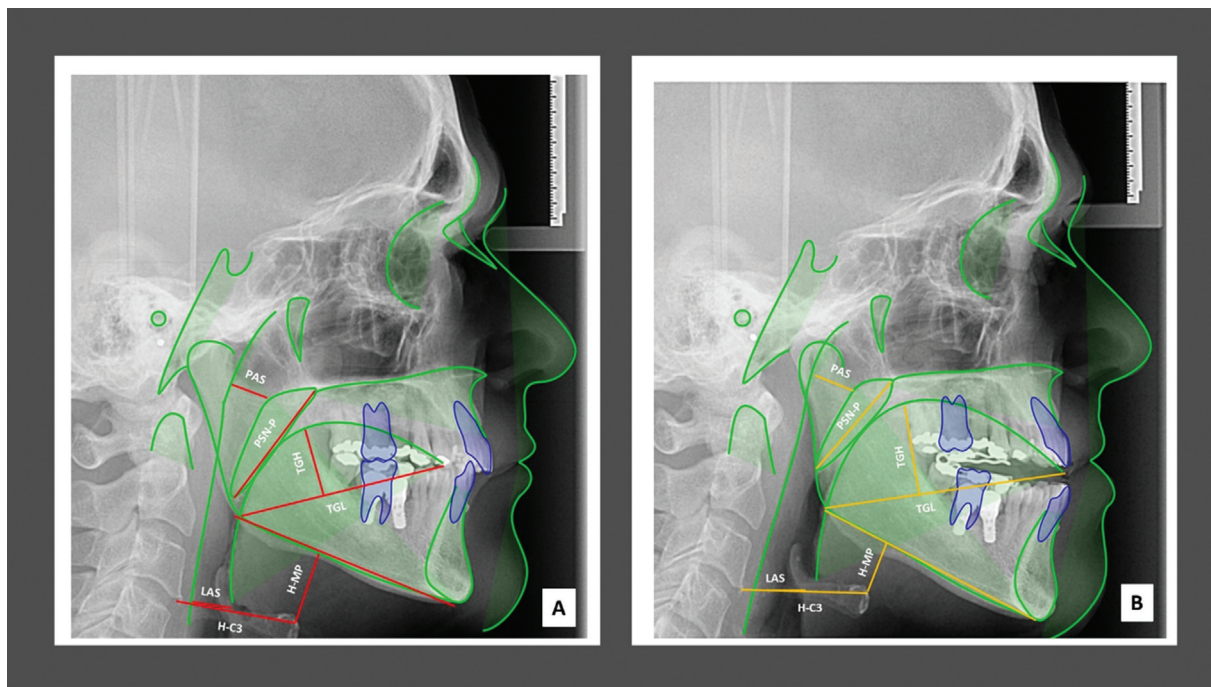


Fig. 2 The mode of action of oral appliance with mandibular advancement used are mapped in (A) (pre-treatment) and (B) (post-treatment) in of airway space to identify tongue, soft palate, and pharyngeal airway. Lines and plans used in cephalometric variables analysis: soft palate length; posterior air space; hyoid distance third cervical vertebrae; hyoid distance mandibular plane; tongue length; tongue height; and lower air space.

and daytime sleepiness. Despite the lack of consensus regarding the definition of a successful criteria,¹⁷ three successful criteria were adopted as a resolution of symptoms plus reduction of AHI: (1) success in AHI to <5/hour; (2) partial success at least 50% reduction in AHI, but AHI >5/hour; and (3) failure ongoing clinical symptoms and/or less than a 50% reduction in baseline AHI.

Synthesis of Statistical Analysis

Descriptive analysis based in contingency tables and correlated Chi-square tests and basic statistics was used to characterize the sample. Generalized linear mixed model for repeated measure and post hoc Tukey–Kramer test compares the variables pre- and post-treatment. Residual normality was accessed by the Shapiro–Wilk Test and Pearson correlation coefficients was used to test and quantify the association between polysomnographic and cephalometric data. All analysis was calculated by using the SAS System (SAS Institute Inc. The SAS System, release 9.4. SAS Institute Inc., Cary, North Carolina, United States, 2012) and in all statistical tests the level of significance was set in 5%.

Results

The polysomnographic data comparison pre- and post-treatment with OA_m (–Table 2) of sleep efficiency, AHI, AI, SaO_2 , and maximum heartbeats are the greatest significance ($p < 0.0001$). In the same way, the cephalometric data comparison regarding to the hyoid distance mandibular plane (H-MP) and upper pharyngeal space. Accompanied by other variables with significant results as the tongue length (TGL;

$p = 0.01$), tongue height (TGH; $p = 0.003$), posterior air space (PAS; $p = 0.002$), and lower air space (LAS; $p = 0.01$).

The mean OA_m adjustment pre- and post-treatment was conducted for 61.12% (15.44) to 100.70% (31.11) showing an important advancement ($p < 0.0001$) associated with the results.

Based on severity of AHI, the pre- and post-treatment with OA_m are represent in –Table 3 and –Fig. 3. The frequencies and percentages in line show a significant result in different levels of AHI ($p = 0.0001$), with 17 total success (51.51%), 9 partial success (27.27%), and 7 unsuccessful (21.21%). In four patients with severe AHI, three reduce the AHI to mild and one to normal.

The improvement in respiratory parameters was confirmed not only by comparing the polysomnographic data ($p < 0.0001$) but also through direct associations (–Table 4) between AHI and both AI and maximum hazard ratio (HR), with correlation indices for AHI and AI ($r = 0.87601$, $p = 0.0001$) and for AHI and the maximum HR ($r = 0.51025$, $p = 0.0001$), respectively; and an indirect association between AHI and SaO_2 ($r = -0.54760$; $p = 0.0008$).

The pharyngeal space was expanded by considering the comparison and correlation of the cephalometric measurements (–Tables 2 and 4). The hyoid bone presented movement in the upward and forward –Table 5, confirmed by the H-MP ($p < 0.0001$). The greater the PAS score, the greater the LAS ($r = 0.88151$; $p = 0.0001$) achieved through OAT. Moreover, the correlation of the mandible-tongue relationship with the hyoid bone showed that the position of the H-MP directly correlated with the H-C3 ($p = 0.0034$) and with the TGL ($p = 0.0268$), pre- and post-treatment. In addition, when

Table 2 Cephalometric comparison of the mean (standard deviation) of the pre- and post-treatment variables with the mandibular oral appliance ($n = 33$)

Characteristics	Phase		p-Value
	Pre-treatment	Post-treatment	
Anthropometric data			
BMI (kg/m ²)	27.63 (3.24)	27.77 (3.24)	0.4172
Polysomnographic data			
Epworth sleepiness scale	9.70 (4.97)	6.88 (3.68)	0.0004
Arousal index	12.90 (10.91)	5.55 (4.38)	<0.0001
SaO ₂ minute (%)	82.87 (6.24)	88.03 (3.67)	<0.0001
Sleep efficiency	76.09 (11.92)	77.51 (12.93)	<0.0001
Apnea	8.57 (10.94)	1.56 (3.09)	0.0058
Hypopnea	9.28 (7.76)	4.97 (5.06)	0.0318
AHI	17.86 (15.45)	6.52 (6.19)	<0.0001
Minimum heartbeat	54.63 (7.20)	54.77 (8.06)	0.9655
Maximum heartbeat	81.42 (9.99)	75.13 (15.02)	0.0140
Legs movements	2.20 (5.17)	4.29 (9.61)	0.7172
Cephalometric data			
Upper pharyngeal space	15.90 (3.69)	19.58 (3.77)	<0.0001
Soft palate length	40.76 (5.83)	43.03 (5.80)	0.0206
Posterior air space	12.71 (4.21)	14.99 (3.94)	0.0024
Hyoid distance mandibular plane	26.51 (7.44)	19.28 (5.77)	<0.0001
Tongue length	77.75 (9.23)	79.93 (9.32)	0.0153
Tongue height	27.84 (5.20)	30.75 (5.41)	0.0039
Lower air space	11.99 (4.63)	13.60 (4.60)	0.0192
Hyoid distance third cervical vertebrae	42.41 (5.60)	43.22 (5.29)	0.3052
Oral appliance therapy			
OA _m advancement (%)	61.12 (15.44)	100.70 (31.11)	<.0001

Abbreviations: BMI, body mass index; OA_m, oral appliance with mandibular advancement; SaO₂ minimum, minimum oxygen saturation.

the mandible and tongue were protracted, there was a functional relationship between the hyoid bone and airway.

When cephalometric with polysomnographic variables were correlated, the H-MP is significantly with AHI ($r = 0.44025$; $p = 0.0003$) and with AI ($r = 0.37683$; $p = 0.0023$).

In Epworth sleepiness scale questionnaire used for evaluating subjective parameters (► **Table 2**), we observe a significant response in daytime sleepiness ($p = 0.0004$). Furthermore, we used a questionnaire to evaluate the adherence, usage, and security of OA_m (► **Table 6**) showing a significant response ($p = 0.001$) for all questions except those related to snoring. Although 12 patients continued to present snoring, it was of low intensity ($p = 0.0017$).

Regarding adverse effects and symptoms from using the OA_m, 12 patients experienced mild and transitory adverse effects at the start of the treatment, which were resolved through massage in two patients, asymmetric adjustment in OA_m to adjust the mandibular posture in eight cases, and specific occlusal adjustments of imbalanced occlusion in four cases.

Discussion

Here we provide the effectiveness of DIORS OA_m on the outcome of OAT by expertise of the professional and the compliance of the patient. The positive effects of OA_m that use Camper plane for disocclusion reference were demonstrated through comparison and correlation of objective data from polysomnography and cephalometry. In a sample of 33 patients of both genders, with primary snoring to severe OSA, we adopted the most impartial success criteria for apnea (AHI <5ev/hour)¹⁷ resulting in 51.51% total successes to 27.27% partial success cases. Even so, the results are quite significant ($p < 0.0001$) for AHI, AI, SaO₂ minimum, and for the maximum heartbeats (► **Table 2**).

The OA_m design, construction, and individualization influence the efficacy of OAT.³ We agree that one of the problems related to respiratory disorders is the skull structures relationship.^{11,13} In addition, the dental arches must be considered with to craniofacial structures. Unfortunately, most OA_m are structured, using models dissociated from their relationship with craniometric structures and,

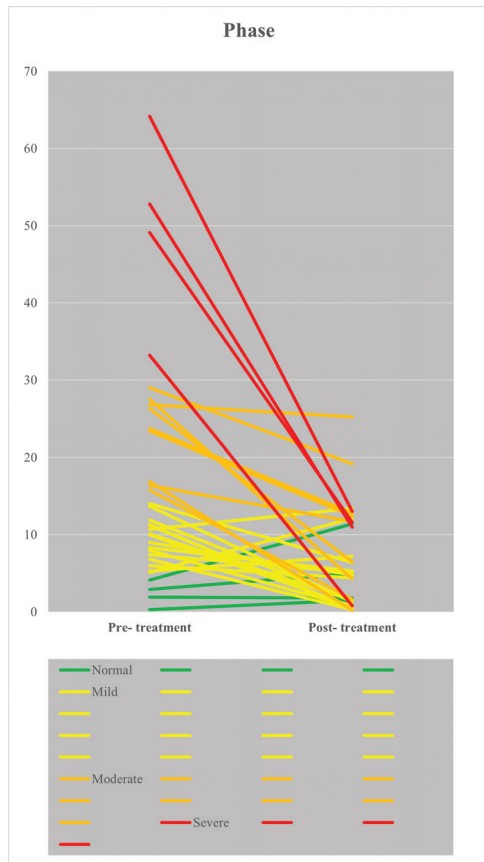


Fig. 3 Pre- and post-treatment of obstructive sleep apnea patients without and with oral appliance with mandibular advancement.

consequently, without respecting the muscles involved in mandibular protrusion movements. Here, we show an OA_m that considers the morpho functional anatomy when seeking equilibrium for the stomatognathic system.

In polysomnographic variables, we observed the higher AHI the greater the arousal index and the greater the maximum heartbeats. In contrast, the higher the AHI, the lower the SaO₂. In a study of various types of OA_m³⁴ showing variable of success in the treatment of mild-to-moderate OSA to distinguish treatment responder from nonresponder patients, the authors observed that definitive device was effective in improving respiratory parameters as AHI as we observed in our data, but in the SaO₂, they do not observed the same result that we had observed in our findings ($p < 0.0001$). When correlating heartbeats, both variables increase (► **Table 4**). Based on these correlations together with comparison results, the effectiveness of OAT is confirmed in the upper airway permeability improvement. In addition, contributing to the AHI and AI, it

Table 3 Chi-square likelihood ratio test with frequency and percentage in line of the apnea-hypopnea index classification and treatment phase ($n = 33$)

AHI classification	Phase	
	Pre-treatment	Post-treatment
Normal	4 (6.06)	17 (25.76)
Mild	16 (24.24)	14 (21.21)
Moderate	9 (13.64)	2 (3.03)
Severe	4 (6.06)	

Abbreviations: AHI, apnea-hypopnea index.
Note: p -Value = 0.0001.

also contributed to heartbeats improvement.⁸ All patients with severe OSA in this sample were treated, with three patients achieving a reduction of more than 50% in AHI and one patient reaching a normal level. In this sample, only two patients with moderate OSA did not respond to OAT. These patients presented clinically angle occlusal classification of Class I, large volume of tongue, flaccid soft palate, and cervical waist more than 40 cm. In these cases of nonresponders patients to OAT, an alternative combined treatment with positive airway pressure^{10,34} or myofunctional therapy³⁵ and BMI control³⁶ can be prescribed to improve the AHI responses and patency of air space.

Based in cephalometric studies,^{14,30-33} here we also demonstrate the impact of OA_m in upper airways with the uniquely designed OA_m that advances the jaw and tongue simultaneously. Our findings reinforce former studies that showed that craniofacial morphology, which included bone and soft tissues, predisposed to OSAS, reducing the permeability of the upper airways.

Anatomically, the tongue maintains several relationships with the hyoid bone²⁵ and, therefore, with the hyoid muscle. Several muscles of the tongue are inserted directly into the hyoid bone. Thus, the displacement of the tongue forward acts on the hyoid bone and vice versa, influencing the upward (cranial) displacement of the hyoid bone. The protrusion of the tongue or mandible, increasing the size of the airway cross-section in individuals with and without OSA, was already showed with the OAT.^{14,17,37} Furthermore, the significant increase in the upper airway permeability is probable related to OA_m design.¹⁸ In our findings, we demonstrate that the OA_m used in this study that use Camper plane as reference to disocclusion permits the jaw and the tongue simultaneous advancement and significantly increase the upper airway in OSA patients (► **Fig. 2**), confirming the

Table 4 Pearson’s correlation index (p -value) for quantifying the association between polysomnographic variables

	AHI		SaO ₂ (min) %		Minimum heartbeats	
SaO ₂ (min)%	-0.54760	(0.0001)				
Arousal index	0.87601	(0.0001)	-0.41245	(0.0008)		
Maximum heartbeats					0.51025	(0.0001)

Abbreviations: AHI, apnea and hypopnea index; SaO₂ (min), minimum oxygen saturation.

Table 5 Persson’s correlation index (*p*-value) to quantify the association between cephalometric variables

Variables	TGH		TGL		LAS		H-C3	
PAS	0.49702	0.0001 ^b	0.26976	0.0285 ^a	0.88151	0.0001 ^b	0.52311	0.0001 ^b
PNS-P	0.47445	0.0001 ^b	0.63226	0.0001 ^b	NS		0.38235	0.0015 ^b
TGH			0.65813	0.0001 ^b	0.30195	0.0137 ^b	0.43336	0.0003 ^b
H-MP	NS		0.27259	0.0268 ^a	NS		0.35549	0.0034 ^b
H-C3	0.43336	0.0003 ^b	0.55623	0.0001 ^b	0.47060	0.0001 ^b	.	

Abbreviations: H-C3, hyoid distance third cervical vertebra; H-MP, hyoid distance mandibular plane; LAS, lower air space; NS, not significant; PAS, posterior air space; PNS-P, soft palate length; TGH, tongue height; TGL, tongue length.

^a*p* < 0.05.

^b*p* < 0.01.

Table 6 Frequency, percentage on the line, and Chi-square test (*p*-value) of the answers obtained in the questionnaire applied to assess adherence, satisfaction and safety of oral appliance with mandibular advancement

Questions	Frequency	%	<i>p</i> -Value
Are you using OA _m ?			
No	2	6.06	<0.0001
Yes	31	93.94	
Score use of 1 to 3			
1	1	3.23	<0.0001
2	3	9.68	
3	27	87.1	
Are you using it every night?			
No	2	6.45	<0.0001
Yes	29	93.55	
Do you use OA _m every night in week?			
No	3	9.67	<0.0001
Yes	28	90.32	
Is your partner snoring with OA _m ?			
No	19	61.29	0.2087
Yes	12	38.71	
On what snoring score?			
0	18	60	0.0017
1	10	33.33	
3	2	6.67	
Are you totally satisfied with OA _m ?			
No	2	6.67	<0.0001
Yes	28	93.33	
Has OA _m ever broken?			
No	26	83.87	0.0002
Yes	5	16.13	

Abbreviation: OA_m, oral appliance with mandibular advancement.

Note: Score = 0 = none, 1 = little, 2 = medium and 3 = much/many.

effectiveness of this OA_m (→ Fig. 3). This affirmative is correlating to cephalometric and polysomnographic variables, demonstrating that the position of the hyoid bone is partly

a factor that can interfere with airway permeability and sleep quality contributing to the significant reduction of these indexes (*p* < 0.0001).

In the subjective parameters, the Epworth sleepiness scale presents a significant result (*p* < 0.0005). The questionnaire applied associated with adherence, satisfaction, symptoms, and safety of using OA_m (→ Table 6), we found significant results in terms of satisfaction and adherence (*p* = 0.0001), although there is still snoring presence, the results show an extremely low score, without disturbing the bed partner. Finally, safety of use shows that this OA_m is safe to use (*p* = 0.0006).

The limitation of this study was the two-dimensional image used without provide volumetric measurements as OSA diagnostic tool, but this limitation was reduced with the follow-up polysomnography parameters. In addition, this sample was obtained in a private dental office that uses on protocol the cephalometry as a complementary diagnose tool, accessible to assist in the general assessment of soft tissues and bone configuration in the OAT.^{14,30-33} Even though, the statistical data obtained are encouraging, they need to be reinforced through further investigation about OA_m design in larger studies to evaluate the clinical importance regard to the tongue, hyoid, mandibular posture, and the soft palate length in apneic patients pre- and post- treatment.

Conclusion

The OAT is an important determinant in the upper airway permeability in OSA treatment, reducing snoring and daytime sleepiness. In this pilot study, DIORS OA_m as an uniquely designed device using Camper plane as a reference for disocclusion was effective in the control of OSA. Future studies should test and compare other OA_m with DIORS OA_m to confirm such important findings.

Funding

None.

Conflict of Interest

D.F.B. had a conflict of interest regarding the DIORS OA_m, which was created, registered, and patented by the author at National Institute of Industrial Property. Rest authors declare no conflict of interest.

References

- 1 Drager LF, Genta PR, Pedrosa RP, et al. Characteristics and predictors of obstructive sleep apnea in patients with systemic hypertension. *Am J Cardiol* 2010;105(08):1135–1139
- 2 Kheirandish-Gozal L, Gozal D. Obstructive sleep apnea and inflammation: proof of concept based on two illustrative cytokines. *Int J Mol Sci* 2019;20(03):459
- 3 Senaratna CV, Perret JL, Lodge CJ, et al. Prevalence of obstructive sleep apnea in the general population: a systematic review. *Sleep Med Rev* 2017;34:70–81
- 4 Sateia MJ. *International Classification of Sleep Disorders*. 3rd edition. Chest; 2014
- 5 Flemons WW, Buysse D, Redline S, et al. Sleep-related breathing disorders in adults: recommendations for syndrome definition and measurement techniques in clinical research. The Report of an American Academy of Sleep Medicine Task Force. *Sleep* 1999;22(05):667–689
- 6 Zancanella E, Haddad FM, Oliveira LAMP, et al; Associação Brasileira de Otorrinolaringologia e Cirurgia Cérvico-Facial Academia Brasileira de Neurologia Sociedade Brasileira de Cardiologia Sociedade Brasileira de Pediatria Sociedade Brasileira de Pneumologia e Tisiologia. Obstructive sleep apnea and primary snoring: diagnosis. *Rev Bras Otorrinolaringol (Engl Ed)* 2014;80(1, Suppl 1):S1–S16
- 7 Meira E Cruz M, Soca R, Kryger M. How much is too much after all? Primary snoring as a remaining unsolved issue. *J Clin Sleep Med* 2020;16(06):991
- 8 Ramar K, Dort LC, Katz SG, et al. Clinical practice guideline for the treatment of obstructive sleep apnea and snoring with oral appliance therapy: An update for 2015. *J Clin Sleep Med* 2015;11(07):773–827
- 9 Alkhader M, Saadeh R. The knowledge of sleep medicine among dental interns in Northern Jordan. *Eur J Dent* 2021;15(02):193–196
- 10 Premaraj TS, Stadiem J, Premaraj SA, Davies CR, Dennis M, Harrington JJ. Continuous positive airway pressure-mandibular advancement device combination therapy for moderate-to-severe obstructive sleep apnea: a preliminary study. *Eur J Dent* 2021;10.1055/s-0040-1719220. Doi: 10.1055/s-0040-1719220
- 11 Gungor AY, Turkkahraman H, Yilmaz HH, Yarikas M. Cephalometric comparison of obstructive sleep apnea patients and healthy controls. *Eur J Dent* 2013;7(01):48–54
- 12 Aly P, Mohsen C. Comparison of the accuracy of three-dimensional printed casts, digital, and conventional casts: an in vitro study. *Eur J Dent* 2020;14(02):189–193
- 13 Kurt G, Sisman C, Akin E, Akcam T. Cephalometric comparison of pharyngeal airway in snoring and non-snoring patients. *Eur J Dent* 2011;5(01):84–88
- 14 Sutherland K, Deane SA, Chan ASL, et al. Comparative effects of two oral appliances on upper airway structure in obstructive sleep apnea. *Sleep (Basel)* 2011;34(04):469–477
- 15 Lim J, Lasserson TJ, Fleetham J, Wright JJ. Oral appliances for obstructive sleep apnoea. *Cochrane Database Syst Rev* 2006;2006(01):CD004435
- 16 Ngiam J, Balasubramaniam R, Darendeliler MA, Cheng AT, Waters K, Sullivan CE. Clinical guidelines for oral appliance therapy in the treatment of snoring and obstructive sleep apnoea. *Aust Dent J* 2013;58(04):408–419
- 17 Ferguson KA, Cartwright R, Rogers R, Schmidt-Nowara W. Oral appliances for snoring and obstructive sleep apnea: a review. *Sleep* 2006;29(02):244–262
- 18 Liu C, Kang W, Zhang S, et al. Mandibular advancement devices prevent the adverse cardiac effects of obstructive sleep apnea-hypopnea syndrome (OSAHS). *Sci Rep* 2020;10(01):3394
- 19 Scherr SC, Dort LC, Almeida FR, et al. Definition of an effective oral appliance for the treatment of obstructive sleep apnea and snoring. *J Dent Sleep Med* 2014;1(01):39–50
- 20 Almeida FR, Vanderveken OM, Cistulli PA, et al. Oral appliance network on global effectiveness (ORANGE): start-up and design description. *J Dent Sleep Med* 2014;1(01):17–20
- 21 Marklund M. Update on oral appliance therapy for OSA. *Curr Sleep Med Rep* 2017;3(03):143–151
- 22 Marklund M, Braem MJA, Verbraecken J. Update on oral appliance therapy. *Eur Respir Rev* 2019;28(153):190083
- 23 Venugopalan SK, SatishBabu CL, Rani MS. Determination of the relative parallelism of occlusal plane to three ala-tragal lines in various skeletal malocclusions: a cephalometric study. *Indian J Dent Res* 2012;23(06):719–725
- 24 Bamagoos AA, Cistulli PA, Sutherland K, et al. Dose-dependent effects of mandibular advancement on upper airway collapsibility and muscle function in obstructive sleep apnea. *Sleep (Basel)* 2019;42(06):1–10
- 25 Bérzin F. Electromyographic analysis of the sternohyoid muscle and anterior belly of the digastric muscle in head and tongue movements. *J Oral Rehabil* 1995;22(11):825–829
- 26 Ahrens A, McGrath C, Hägg U. A systematic review of the efficacy of oral appliance design in the management of obstructive sleep apnoea. *Eur J Orthod* 2011;33(03):318–324
- 27 Haviv Y, Bachar G, Aframian DJ, Almozni G, Michaeli E, Benoliel R. A 2-year mean follow-up of oral appliance therapy for severe obstructive sleep apnea: a cohort study. *Oral Dis* 2015;21(03):386–392
- 28 Schwartz M, Acosta L, Hung YL, Padilla M, Enciso R. Effects of CPAP and mandibular advancement device treatment in obstructive sleep apnea patients: a systematic review and meta-analysis. *Sleep Breath* 2018;22(03):555–568
- 29 Barbosa DF, Giannasi LC, Ferreira LMDB, Cruz MME, Alves MC, Berzin F. A singular oral appliance to treat obstructive sleep apnea in CPAP non-adherent patients. *Dental Press J Orthod* 2020;25(05):44–50
- 30 Chan ASL, Lee RWW, Cistulli PA. Dental appliance treatment for obstructive sleep apnea. *Chest* 2007;132(02):693–699
- 31 Guillemineault C, Riley R, Powell N. Obstructive sleep apnea and abnormal cephalometric measurements. Implications for treatment. *Chest* 1984;86(05):793–794
- 32 Lowe AA, Ono T, Ferguson KA, Pae EK, Ryan CF, Fleetham JA. Cephalometric comparisons of craniofacial and upper airway structure by skeletal subtype and gender in patients with obstructive sleep apnea. *Am J Orthod Dentofacial Orthop* 1996;110(06):653–664
- 33 Cunha TCA, Guimarães TM, Schultz TCB, et al. Predictors of success for mandibular repositioning appliance in obstructive sleep apnea syndrome. *Braz Oral Res* 2017;31:e37
- 34 Segù M, Cosi A, Santagostini A, Scribante A. Efficacy of a trial oral appliance in OSAS management: a new protocol to recognize responder/nonresponder patients. *Int J Dent* 2021;2021:8811700
- 35 Mediano O, Romero-Peralta S, Resano P, et al. Obstructive sleep apnea: emerging treatments targeting the genioglossus muscle. *J Clin Med* 2019;8(10):1754. Doi: 10.3390/jcm8101754
- 36 Stavrou VT, Vavougiou GD, Astara K, Siachpazidou DI, Papayianni E, Gourgoulis KI. The 6-minute walk test and anthropometric characteristics as assessment tools in patients with obstructive sleep apnea syndrome. a preliminary report during the pandemic. *J Pers Med* 2021;11(06):563
- 37 Schwab RJ, Pasirstein M, Pierson R, et al. Identification of upper airway anatomic risk factors for obstructive sleep apnea with volumetric magnetic resonance imaging. *Am J Respir Crit Care Med* 2003;168(05):522–530