Letter to the Editor on “Comparative Effectiveness of the Different Treatment Modalities for Snoring”

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No sponsorships or competing interests have been disclosed for this article.

We read with interest the article written by Terryn and co-authors, “Comparative Effectiveness of the Different Treatment Modalities for Snoring.”1 Primary snoring is a common situation, and the authors give a good opinion about how to manage this problem. There are some points that we would like to emphasize that are not stated in the article.

First, patients whose apnea-hypopnea index (AHI) was <20 were referred to surgery or managed by a mandibular advancement device; yet, the REM, non-REM, supine, and nonsupine AHI results are not presented, which would change the treatment protocol. For instance, a patient with an AHI <20 may have an REM AHI >40. Second, treatment success was evaluated through 4 questionnaires. However, polysomnography results would have been more helpful to obtain objective results.2 Third, patients with an AHI >20 were referred to use nasal continuous positive airway pressure (CPAP). Since CPAP is the standard therapy for sleep apnea, it is known that patient compliance may limit the efficacy.3 In this study, 37% of the patients felt discomfort wearing the mask, and 26% of the patients described intolerance to CPAP after 6 months of treatment. The patients’ rhinologic findings are not mentioned, which could be one of the most important factors for patient intolerance.4 Finally, obese patients (body mass index >32) were managed with a mandibular advancement device. A published meta-analysis showed that weight loss would reduce the severity of obstructive sleep apnea.5 From this point of view, dietary modification or consultation to a dietician should be recommended at first.

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We thank Ugur and colleagues for their interest in our study and their comments.

They argue that additional information obtained from the polysomnography (PSG) could have changed the treatment protocol. Although we certainly agree, for instance, that supine versus nonsupine apnea-hypopnea index would have...
been an interesting parameter to look at, we did not take this into account for this study. The PSG data were mainly used to identify patients with an apnea-hypopnea index >20. These patients were referred for continuous positive airway pressure (CPAP). Body posture affects the severity of sleep apnea and can lead to “misclassification.”1 Positional sleep apnea has also been shown to be a positive predictive factor for treatment success of mandibular advancement devices.2 Recent literature suggests that other parameters could be useful. Clinical predictors of arousal threshold (lowest oxygen saturation, hypopnea fraction) might identify patients with severe sleep apnea due to a small airway and a low threshold.

As snoring was the primary complaint in our study, PSG was used only to identify OSA patients. Repeat PSG was not performed (except in OSA syndrome patients). This is indeed a limitation of our study. Palatal surgery could alter the sound spectrum of snoring, leading to subjective improvement.3 Yet, objective evaluation of snoring is not well standardized. Use of a sound level meter is considered to be the gold standard, but parameters such as sharpness, A-weighted sound pressure level, and fluctuation strength should be taken into account. Further study is needed on how to objectively measure degree of snoring annoyance. As the most important measure in snoring evaluation, annoyance level correlates well with subjective ratings.4

Dr Ungar asks for the nasal findings in patients intolerant for CPAP. All 7 patients who did not tolerate CPAP had at least a minor septal deviation. However this is not a predictor since we observed septal deviation in 65% of the patients that did tolerate CPAP. Three patients underwent surgery to correct nasal patency (1 patient, septoplasty and functional endoscopic sinus surgery; 1, septoplasty, conchotomies, and adenotomy; 1, only conchotomies); however, this did not prevent intolerance of the CPAP device in 2 of 3 cases.

Finally, Ugur et al emphasize the importance of weight loss and dietary modification. It is well known that weight loss reduces severity of OSA and improves snoring.3 We did advise overweight patients to lose weight. Despite our recommendations, the average body mass index did not decrease in our study, so our positive results cannot be attributed to weight loss.

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