TO SERVE AND PROTECT

May 5th, 2015, Vancouver BC

Dr. Wayne Halstrom

The debate on whether or not there is a place in the practice of sleep medicine for oral appliance therapy is long over. The goal of oral appliance therapy, as with other modalities in health care is to **"serve"** the needs of our patients as well as **"protect"** them from the threats to health that come as a result of sleep disordered breathing. As ``sleep dentists`` we have ventured out from our usual and customary dental roles into a field of medicine. *What protection does the sleep dentist need, and protection from whom?*

A fact of life for the sleep dentist is the statistical probability of tooth movement and bite change.

The "sleep dentist" will be routinely treating the patients of other dentists. Is the patient's regular dentist informed as to the relative benefits of a life saving therapy vs the potential oral changes that may become involved? If not, then what may be that dentist`s reaction to a substantial bite change that may or may not have challenged some restorative procedures over which that general dentist may be very sensitive? Is that dentist likely to be ``friendly`` when called by the patient`s lawyer? It would be folly to believe that everyone in the sand box is our friend. It is not enough to seek shelter behind the fact that MAD is a therapy for a serious life threatening medical condition - <u>"Get over it" is not a good answer!</u>

The first question will be ``do you have models``?

How many of us keep all models – and for how long?

Sometimes these dental changes are only brought into play when the general dentist freaks out over a bite change and alarms an otherwise happy patient. In the interim between undertaking therapy and the moment a patient becomes concerned about tooth or bite issues, considerable time may have passed. Often our follow up protocols will have picked up this issue, however not all patients comply with our requests to attend follow up appointments.

Further and beyond the reaction of other dental professionals - what about a general physician who may not be as well informed about dental sleep medicine as he/she could be? Particularly, when not the source of the original referral? Will that MD be ``friendly`` on a witness stand if/when something goes wrong with the medical end of the therapy?

The bottom line is that when push inevitably comes to shove the only true ``friend`` available to ``protect`` the sleep dentist is records.

Meticulous record keeping is something we are taught from our first encounters with providing health care. In the world of sleep medicine we manage patients who may/will die with an appliance in their mouth.

So what record keeping do we need to focus upon?

Beyond the general and obvious health considerations, there are a number of issues particularly important to the sleep dentist.

MEDICAL

``Informed consent`` - and all that the term infers, including the collection, completion and retention of all necessary medical information and procedures.

DENTAL

1. Pictures – full frontal face – both lateral views – dental full frontal – both lateral views.
2. Pre-treatment Models
3. Records of jaw movements (protrusive and lateral excursions) along with the therapeutic positioning of the MAD.

After 25 years of practice limited to the provision of oral appliances for the treatment of snoring and obstructive sleep disordered breathing I have come to rely upon a tried, trusted and true methodology – a gothic arch tracing.

Beyond the identification of important mandibular movement features there is the opportunity to record, in detail, various mandibular positions that may be essential to structuring a defence against actions that may result from either tooth movement or bite change. I emphasize that all dentists providing MADs will over time and numbers have patients for whom these changes will occur! It is truly inevitable that on some of our patients we will see these problems. Can we prevent these changes? Likely in the pressure filled medically necessary pursuit of a positive therapeutic result we cannot! Can we accurately predict such changes? Perhaps one day, but not today.

Unfortunately there is no “protection” to such commentary!

Only through the ability to present adequate records as to the ``before` conditions, including tooth relationships and jaw position, can we gain protection when aberrations occur. When a change in bite occurs, a completely reasonable question even for a layperson is - where did it change from?

At the outset of my journey in dental sleep medicine I invented and patented a product called the GAT™ Gothic Arch Tracer[1].

The GAT™ – is an external to the oral cavity diagnostic tool that enables the practitioner to record:

1. Range of AP motion
2. Range of lateral motion
3. Identification of Mid line
4. Detection of aberrations in jaw movements that may indicate TMJ issues and impact upon the choice of appliance as well as therapeutic decisions.
5. Identify the specific position in which the practitioner has decided is the “start point” for the MAD therapy.
6. Enable, by measurement, to identify the exact amount of advancement of the mandible undertaken.

[1] www.silencerproducts.com

7. Provide the bite registration for fabrication of the device in the exact position selected.

The GAT enables the dentist to preserve records of:

1. Centric Relation - anatomical landmark;
2. Starting point of therapy; and
3. Ability to accurately identify the therapeutic position in which the patient has been wearing the device.

The GAT™ allows for the preservation of all of the records comprising the bite registration and tracing. By the pouring of dye stone into the polyvinylsiloxane bite registration a model may be created that, when retained within the bite registration, will allow the remounting of the case into all recorded positions to enable reconstruction of the actual pre-treatment positioning of both the teeth and the jaw relationship.

Bio:

Dr. L. Wayne Halstrom
B.A., D.D.S., Dip.ABDSM, Dip.ASBA
F.A.D.I., F.P.F.A., F.A.C.D.
Diplomate, American Board of Dental Sleep Medicine
Diplomate, American Sleep & Breathing Academy
Adjunct Professor – Respiratory Therapy & Sleep Science
Thompson Rivers University

Dr. Halstrom graduated from the University of Alberta with his D.D.S. in 1960, after obtaining his B.A. from the University of Saskatchewan in 1956. He maintained a practice in North Vancouver, B.C. from 1961 to 1991. Since 1991, Dr. Halstrom has solely focused his practice to the treatment of Snoring and Sleep Apnea.

He is the Past-President of The Canadian Dental Association (CDA) and The Association of Dental Surgeons of British Columbia (BC Dental Association). He has served as a member of the Board of Governors and a Director of the CDA.

Currently an Adjunct Professor, Respiratory Therapy at Thompson Rivers University, Dr. Halstrom had also served with the University of British Columbia (UBC) as a part-time clinical instructor in the Department of Prosthodontics at various times over the years. Prior to his position of Diplomate of the American Board of Dental Sleep Medicines, he was a member of the UBC Joint Medical-Dental sleep research team from 1989 to 1993, and carried a rank of Clinical Assistant Professor.

As a visionary and leader in the field of Sleep Apnea Therapy Dr. Halstrom has traveled the world speaking to health professionals on how best to offer therapy to one of the world's most serious undiagnosed medical conditions.

Contact:

Tel 604-876-8993

Email: wayne@drhalstrom.com