Sleep, Wellbeing & the Airway

Sleep hygiene for the clinician and the patient · screen every patient for sleep-disordered breathing · refer before you restore

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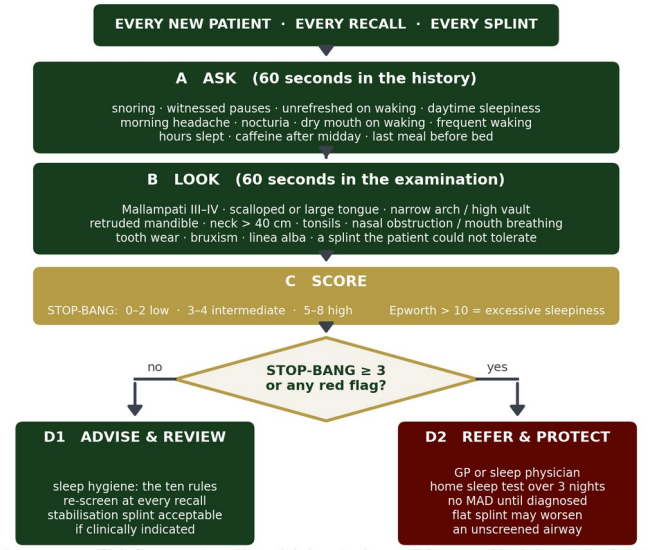

Screen, score, refer before you restore. Diagnosis belongs to sleep medicine; recognition belongs to the dentist.

Say it to the patient: *"How you sleep is part of your dental examination. If you snore, wake tired or get morning headaches, I want to know before I make anything for your teeth."*

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Elevate Airway, dental sleep medicine for general practice: **elevate-dent.com**

The one-sentence rule

Poor sleep is a clinical finding, not a lifestyle footnote. It drives bruxism, TMD flare-ups, pain sensitivity and poor healing, and most obstructive sleep apnoea is still undiagnosed. The dentist looks into the airway more often than any other clinician.

Red flags: refer if any one is present

- **Loud habitual snoring** with witnessed pauses, choking or gasping
- **Excessive daytime sleepiness** (Epworth above 10), or sleepiness when driving
- **Morning headache** on most days, with unrefreshing sleep however long
- **Nocturia** two or more times a night with no urological cause
- **Hard-to-control hypertension,** atrial fibrillation or type 2 diabetes in a snorer
- **A splint the patient could not tolerate,** or one that made the sleep worse

STOP-BANG: one point each

S Snoring	loud enough to be heard through a closed door
T Tired	tired, fatigued or sleepy during the day
O Observed	someone has seen the patient stop breathing
P Pressure	treated or untreated high blood pressure
B BMI	above 35 kg/m²
A Age	over 50 years
N Neck	circumference above 40 cm (collar 16 inches or more)
G Gender	male
Score	0 to 2 low · 3 to 4 intermediate · 5 to 8 high risk

Score 3 or more, or any red flag: refer to the GP or a sleep physician for a home sleep test. Diagnosis belongs to sleep medicine; recognition belongs to the dentist.

Sleep hygiene: the ten rules

1. **Fixed wake time,** seven days a week. The wake time anchors the clock, not the bedtime.
2. **Daylight within 30 minutes of waking,** outdoors if possible, ten minutes minimum.
3. **Caffeine cut-off at midday.** Its half-life is about five hours; a 3 pm coffee is still a quarter present at 1 am.
4. **Last meal three to four hours before bed.** The stomach needs about four hours to empty (see the stress sheet).
5. **Alcohol is a sedative, not a sleep aid.** It fragments the second half of the night and worsens snoring.
6. **Move every day,** but finish hard exercise at least three hours before bed.
7. **Screens off an hour before bed** and lights dimmed; blue light suppresses melatonin.
8. **Bedroom cool, dark and quiet:** about 18 °C, blackout, no phone by the pillow.
9. **The bed is for sleep.** Awake for twenty minutes: get up, sit in dim light, return when sleepy.
10. **A wind-down ritual,** the same every night, so the brain learns the cue.

Why it matters in the mouth

- **Sleep bruxism** is an arousal-related activity: the more fragmented the sleep, the more the jaw moves (Lavigne 2008).
- **A flat stabilisation splint** can worsen apnoea in an unscreened patient (Gagnon 2004). Screen first, then choose the appliance.
- **A mandibular advancement device** is treatment for a diagnosis, not a substitute for one: sleep test first, MAD second.
- **Chronic pain and TMD** are amplified by short sleep; a night's sleep lost lowers the pain threshold the next day.
- **Sleep architecture:** four to six cycles of about 90 minutes; deep sleep restores the body early in the night, REM restores mood and memory late. Cutting the night short cuts REM first.