Not Your Grandfather’s Hearing Aids - Sara Lerner, AuD., CCC-A, F-AAA
Food Tolerance Vs Food Allergy – Stacey Galowitz, DO
Everything You Wanted to Know About the Ear – But Were Afraid to Ask – Sujana Chandrasekhar, MD, FACS
Partial Tonsillectomy for Children – Joseph Haddad, MD
Untreated Obstructive Sleep Apnea – Ofer Jacobowitz, MD, PhD and Lee Shangold, MD
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Greetings from the President of
ENT and Allergy Associates, LLP (ENTA)!

Welcome to the 2018 edition of the ENT and Allergy Associates, LLP Magazine.

ENTA was formed in 1998 when a dozen partners in eight locations determined that they could provide better care for their patients by joining to form an even greater center of clinical excellence and expertise. And today, 20 years later, we are proud to have become the largest otolaryngology and allergy specialty and sub-specialty practice in the nation, offering patients state-of-the-art care from more than 200 board certified physicians at over 40 locations in the New York/New Jersey area.

What hasn't changed is our mission: to deliver exceptional care and exceptional outcomes to each of our patients.

In recent times, we have worked hard to ensure that we are able to deliver that care with the immediate access many patients desire, so they may receive the treatment they need, when they need it. As a result, each patient who calls or goes online to connect with us has the opportunity to get an appointment that very same day.

And please be assured that the patients you entrust to us will receive the superb level of care and expertise that they, and you, expect and deserve. Patients of all ages can avail themselves of general otolaryngology and allergy care as well as any of the sub-specialties we offer, from Voice and Swallowing, Facial Plastics/Reconstructive Surgery and Disorders of the Inner Ear and Dizziness to Diagnostic Audiology, Amplification services, Rhinology and Sleep Medicine.

In the following pages, we hope to provide you with clinical information that you can use in your practice. We recognize that as primary care physicians, your diagnostic expertise is key to early intervention and favorable patient care outcomes, and we believe the articles in this issue can add to your ability to provide the best solutions for your patients.

ENTA holds you in the highest esteem, and thanks you for continuing to place your trust in us!

We would like to thank our vendor sponsors who have helped to make this magazine possible. We recognize the ongoing commitment of our business partners in the healthcare community.

Sincerely,

Robert P. Green, M.D., F.A.C.S.
President
ENT and Allergy Associates, LLP
In my practice as a pediatric otolaryngologist for almost 30 years, I have been impressed by the benefits of partial tonsillectomy for both the patient and the surgeon. After overcoming my initial skepticism and fear of tonsil regrowth and recurrent symptoms, the technique has become the most common operation that I perform in children. The following FAQs summarize my experience.

**Why partial tonsillectomy in children?**

The majority of kids who need tonsil surgery are seeking relief for sleep and breathing problems, and are under the age of six. Their breathing and sleep issues can be alleviated in most cases by removing the adenoids and shaving the tonsils, the so-called partial or intracapsular tonsillectomy. The advantages include a quicker and less painful recovery, and one that usually avoids the need for narcotic pain medications and their attendant risks (an important consideration now that the FDA has banned the use of codeine for children after T and A).

In addition, the risk of bleeding post-op is reduced, and the children are much less likely to get dehydrated and be readmitted to the hospital for pain control and IV fluids.

**How do patients feel about the surgery?**

Most families are relieved to know that there is an effective surgery that is potentially safer. Some children have recurrent strep in addition to tonsil and adenoid hypertrophy, and parents in that situation might opt for total tonsillectomy. Some parents prefer the traditional total tonsillectomy, based on personal or family experience. On the other hand, many parents like the idea of leaving a little tonsil tissue in the throat, especially if they have read that the lymphoid tissue may afford some immune protection.

**Is there a best technique?**

The surgical microdebrider is my preferred instrument, but others use a coblator. The key in my experience is not to just trim the tonsil back to the pillars, but to evert the tonsil and debulk the tonsil mass; my goal is to leave less than 10% of the lymphoid tissue over the muscle bed. The suction cautery is then used to control surface oozing, and can be used to shrink the tissue further, especially in the upper pole region where the tonsil is often thicker.

**What is the risk of tonsil regrowth?**

My personal experience in following patients for approximately 15 years is that the risk of both tonsil regrowth and recurrence of sleep and breathing symptoms is exceedingly low. Since the surgery is most commonly performed in children under age 6, their growth in the ensuing years helps to minimize the risk. I have also observed that children get strep throat infections less frequently after the surgery.

**What if a sleep study shows obstructive sleep apnea?**

Severe sleep apnea demonstrated on a sleep study probably warrants a complete tonsillectomy, or at least a discussion of the risks and benefits of the two techniques. A child with mild OSA will probably do well with either technique.

**When is a total tonsillectomy warranted?**

In my practice, I still recommend total tonsillectomy for recurrent or chronic strep tonsillitis; in children with PANDAS or suspected PANDAS, especially if they have high ASO titers; in children with Trisomy 21 and other craniofacial abnormalities; in children who have had previous tonsil surgery, and symptoms have recurred; in patients with a history of peritonsillar abscess; and in patients with OSA who are overweight, or who have other anatomic or family predisposition to suggest that recurrent symptoms might be a future problem.
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Quick appointments! Both centers are open Monday-Saturday with early morning and late evening time slots available during the work week.
“M y hearing isn’t bad enough,” “I’m getting by fine,” and “I’m too young for hearing aids” are all common excuses I hear daily from patients, whether they have a mild hearing loss or a significant one. Many patients are willing to admit the communication difficulties that stem from their hearing loss, but are not willing to accept that they would significantly benefit from hearing aids. The resistance to hearing aids often comes from a perceived stigma or stories of friends’ and family’s hearing aid woes, which frequently date back to their parents’ and even grandparents’ experiences with hearing aids.

As an audiologist, I am excited to share with patients that hearing aid technology has improved dramatically. Once patients see what hearing aids look like today and are made aware of the technological advances, they are much more open to using them. Overcoming preconceived notions and embracing hearing aids will improve not just patients’ hearing health and communication, but their overall physical and mental well-being.

In a world with self-driving cars, paper-thin televisions and handheld supercomputers, it should come as no surprise that there have been amazing developments in hearing aids. In addition to faster and smarter computer chips, which allow for better sound quality, there are many new features that both new and established hearing-aid users will find appealing.

Bluetooth Connectivity:
Hearing aids can now connect directly to your smartphone, allowing you to stream audio directly to your hearing aid, whether it’s phone calls, music, podcasts or movies. Hearing aids can even connect directly to the TV, so other people watching can set the volume to their liking and you will always have crisp and clear sound streaming straight to your hearing aid.

Certain hearing-aid manufacturers have even partnered with Apple to make their devices “made for iPhone”, which allows the hearing aids to pair with an iPhone and/or iPad to optimize the streaming of phone calls and music.

Apps:
Smartphone apps now allow you to control hearing aids (e.g., volume and programs) straight from your phone, rather than by manually pressing a button on the hearing aid. Not only is this a more discreet option, but it also takes out the guesswork of knowing what program you are on and when. Many of the available apps will also show the battery life of the hearing aid.

For more tech-savvy users, apps will even allow you to create your own programs by controlling the volume, sound quality and noise-reduction settings of their hearing aids. There are even options to use the phone’s GPS to automatically change the hearing aid program depending on your physical location—for example, switching to a specified program when you head into the office and to an entirely different program when you find yourself in Times Square.

Rechargeable Batteries:
In a world where you charge everything from your phone to your toothbrush, now there are rechargeable options
for hearing aids. No longer do small hearing aid batteries need to be changed every few days; now you can get into a habit of charging your hearing aid batteries at night, knowing they’ll be good to go the next morning. This option is not only convenient, but is also extremely helpful for those with poor dexterity, who have trouble changing batteries.

**Noise Cancelation:**
Hearing aids historically have gotten a bad rap for making everything louder, even the things you don’t want to hear. Today, noise reduction and directional microphones work better than ever to control background noise, allowing the user to focus on what they want to hear. For example, in a restaurant your hearing aid can allow you to focus on the conversation with your fellow diners, filtering out all the background noise.

**Size and Style:**
Hearing aids continue to get smaller and more discreet. In the past, smaller hearing aids came with reduced features, which is no longer the case. Designs are also getting more stylish and less prosthetic-looking.

**Moisture Resistance:**
While modern hearing aids are still not fully waterproof, they are more water resistant than ever. While I don't recommend that patients go swimming with their hearing aids in, hearing aids today are better able to tolerate the damp environments of the ear canal, body perspiration, and the heat and humidity of the summer. This drastically improves the durability of the hearing aid, making repairs less frequent.

Despite the momentous improvements in hearing aid technology, only 1 in 4 individuals who could benefit from using hearing aids currently own them. The ramifications of untreated hearing loss are high – the risk of dementia is 5 times greater among people with untreated hearing loss. People with untreated hearing loss are also likely to suffer a negative psychological and emotional impact.

Educating the public about the vast improvements in hearing aid technology can help reduce negative connotations and encourage those who can benefit to pursue hearing aids.
The general public often uses the term “food allergy” interchangeably with the term “food intolerance/sensitivity”. Though some of the symptoms of food intolerance and food allergy are similar, the differences between the two are very important. Eating a food you are intolerant to can leave you feeling miserable. However, if you have a true food allergy, your body’s reaction to this food could be life-threatening.

A true food allergic reaction involves the immune system. Your immune system controls how your body defends itself. With food allergies, one's immune system overreacts to an ordinarily harmless food. This is caused by an allergic antibody called Immunoglobulin E (IgE). After production, IgE binds to its receptors on mast cells and waits to be activated by the offending allergen. Once these cells are stimulated, it will burst open, leading to the release of chemicals, such as histamine. These chemicals create the typical symptoms of an allergic reaction. These antibodies can be activated with even the most miniscule amount of food (1/250th of a peanut is enough to trigger a reaction in some!), so “just a taste” is never safe for a person with food allergies. The most common food allergens – responsible for up to 90% of all allergic reactions – are the proteins in cow’s milk, egg, soy, wheat, fish, shellfish, peanuts and tree nuts.

Symptoms of a food allergy can be mild – such as a few hives, itching/redness of the skin or mild swelling (angioedema) – or they can be more severe. The most serious type of allergic reaction is called “anaphylaxis” and may involve the respiratory, gastrointestinal, and/or cardiac systems. Respiratory symptoms may include coughing, wheezing, throat tightness/swelling, and chest tightness (similar to asthma symptoms). There may also be swelling of the upper airway, causing stridor. Gastrointestinal symptoms of food allergies include vomiting, diarrhea and abdominal cramping, which may be severe. Cardiac symptoms can include dizziness/pallor, a loss of consciousness, or a drop in blood pressure (termed “anaphylactic shock”). These symptoms may occur alone with no hives, or in combination with hives or angioedema (facial swelling). Without immediate treatment—an injection of epinephrine and expert care—anaphylaxis can be fatal.

The best way to prevent an allergic reaction is to strictly avoid foods that you know can cause a problem. Testing...
effects of epinephrine are immediate, but wear off after 20 minutes, and sometimes further treatment is necessary. This is why all persons who receive an epinephrine administration for a serious allergic reaction should seek immediate medical attention by calling 911 or by going to their local emergency room.

Pollen-food allergy syndrome, commonly known as “oral allergy syndrome”, is a milder type of food allergy that many patients with nasal allergies experience. Common symptoms are itching or tingling of the mouth or throat after eating certain raw fruits and vegetables. Cooked versions of the same foods are generally well-tolerated. These allergies tend to be mild, and they typically self-resolve without need for medications. It can be difficult to differentiate oral allergy syndrome from more severe food allergies.

A food intolerance refers to an abnormal response that is not an allergic reaction. Unlike allergic reactions, this does not involve the immune system. Food intolerances are more common than food allergies, with over 30% of Americans believing they have an intolerance to one or more foods. Oftentimes, food intolerance responses take place in the digestive system where individuals are unable to properly break down a food. This could be due to enzyme deficiencies (ex: lactose intolerance), sensitivity to food additives (ex: MSG or artificial colors) or reactions to normally occurring chemicals in foods (ex: jitteriness or insomnia with caffeine). Typically with a food intolerance, people can eat small amounts of the food without causing significant symptoms. Symptoms of sensitivity or intolerance to a food can vary, but are generally digestive-related (abdominal pain, diarrhea, bloating, constipation, cramping, and nausea). A well-known example is lactose intolerance. Individuals with this disorder experience uncomfortable abdominal symptoms after consuming dairy products. This due to an absence of an enzyme (lactase) necessary for proper digestion of the sugar in milk (lactose). These symptoms may easily be prevented by taking lactase enzyme pills or dairy products supplemented with lactase (ex: Lactaid).

There is a very serious difference between being intolerant to a food and having a food allergy. For the best diagnosis, as well as treatment and avoidance measures, please schedule an appointment with your Allergist. 

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Patients have different kinds of ear problems at different times of the year, and at different ages. It is important to be able to quickly distinguish between an emergent or urgent situation, and one that can be managed in due time.

The ear is divided into several parts. For this article, we will talk about six parts of the ear:

1. The pinna (the visible portion of the external ear), which is the part that holds your glasses up and gets pierced;
2. The external ear canal (or external auditory canal – EAC), which is where cerumen (ear wax) is formed and which conveys external sounds inwards;
3. The ear drum (or tympanic membrane – TM), which vibrates in response to sound input;
4. The middle ear, which is the air-containing space that holds the 3 ossicles or tiny bones of hearing – the malleus (hammer), incus (anvil) and stapes (stirrup) (the smallest bone in the body) – and which connects to the air-filled mastoid bone that you can palpate behind the ear;
5. The inner ear, which is housed in the otic capsule or densest bone in the body (the mandible is the hardest bone in the body), and which contains the cochlea or hearing organ in front and the vestibular sense organs in the back; and
6. The internal auditory canal (IAC), which transmits the seventh (facial) and eighth (cochleovestibular) cranial nerves to the brain. Sound and balance input are processed in the ear and are then transmitted to the cochlear and vestibular nuclei, where we actually experience hearing and balance.

The pinna is responsible for capturing the sound in the environment and funneling it into the EAC. Dogs use their pinnae actively to target sound more precisely. Humans, even those who can wiggle their ears, use their pinnae passively. The pinna gives about 3 decibels (dB) of sound amplification. Things that can go wrong with the pinna are:

- **Injury**, including laceration and hematoma or seroma, which can get infected
  - a. This can occur from a cut, a punch or a poor piercing – especially into the cartilage of the ear.
  - b. These can often be managed effectively in the ENT office, but they should be taken care of within a few hours of occurrence, to ensure best outcomes.

- **Perichondritis**
  - a. The pinna is usually red and inflamed – and this responds well to aggressive local care once the proper diagnosis is established.
  - b. These can often be managed effectively in the ENT office, but they should be taken care of within a few hours of occurrence, to ensure best outcomes.

- **Herpes Zoster Oticus** (Ramsey-Hunt syndrome)
  - a. The pinna can have herpetic vesicles on it that can be large and visible or almost invisible. They are painful.
  - b. This condition can be associated with facial nerve paralysis and/or hearing loss.

- **Urgent referral to ENT with aggressive antiviral and steroid management often results in excellent outcomes for these patients.**

- **Skin cancer** - both basal cell carcinoma and squamous cell carcinoma occur on the ear
  - a. These are often seen with sun exposure – left ear for a driver; right ear for a passenger.
  - b. Early detection can result in aggressive local resection with minimal or no cosmetic deformity.
  - c. If you are concerned about a lesion on your patient’s ear, an ENT should biopsy it right away.

Never put anything smaller than your elbow in your ear canal. (Your grandmother was right.) Cerumen is formed at the outer portion of the EAC and moves in toward the TM and then out again, removing any debris that has entered.
via the special ciliary motility function of the skin of the EAC. Foreign objects such as cotton-tipped applicators, hair pins, pens, etc. not only do not adequately clear cerumen, but they push most of it in towards the ear drum and injure the skin so that it cannot perform its function correctly. The American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) has an excellent Clinical Practice Guideline (CPG) on Cerumen, which you can download for free at https://www.entnet.org/content/clinical-practice-guidelines. All Otolaryngologists at ENTA are members of this prestigious organization. In a nutshell:

a. Don't try to clean your own ear wax with an applicator, a pin, or any other instrument.
b. Physicians may clean or refer for cleaning when the cerumen is obstructing the view of the ear drum and the patient has complaints of hearing loss.
c. Ear candling (making a cone of wax paper, putting the narrow end into the ear canal, and setting the other end on fire) is dangerous and ineffective.
d. Patients who use hearing aids may accumulate wax more readily than others, and often will set up a standing appointment to see their ENT every few months for management of this problem. This is important, as wax buildup may cause hearing aids to squeal or not work right.
e. Bony projections into the ear canal (exostoses) are often caused by cold water swimming ('surfer's ear'). They can cause wax buildup. It is reasonable to have that evaluated by an ENT.

Otitis externa – infection or inflammation of the ear canal – is also called 'swimmer's ear.' It may result from trauma to the ear in attempted cleaning, from swimming or other water exposure, and possibly from sharing ear buds with others who may be infected. The AAO-HNS has an excellent CPG on this as well.

a. Uncomplicated OE should be treated with local debridement and antibiotic ear drops.
b. Do NOT prescribe oral antibiotics for OE unless there is inflammation extending onto the pinna or face/neck, or if there are secondary inflammatory lymph nodes in the neck.
c. If the ear drum is intact, just about any antibiotic ear drop is acceptable. If there is a hole in the ear drum, do not use potentially ototoxic ear drops (such as those that contain Neomycin).
d. A crucial part of the recovery from OE lies in maintaining strict water precautions to the ear. Do not allow water to enter the ear. You can advise the use of a silicone putty-type ear plug for showers or swimming, alone or with a water-repellant head band covering the ears, or the patient can take a cotton ball, smear petroleum jelly on it to make it waterproof, and use that for showers. Dry cotton will actually wick the water in and should not be used.
e. If the infection is not getting better in a few days, you must consider a more aggressive organism or fungal infection, and the patient should be seen by an ENT.

Tympanic membrane perforations can occur spontaneously, with middle ear infections, or via trauma to the ear. I've taken care of doctors who've managed to perforate their TMs with pens and nurses who've managed to do so with Qtips or with their eyeglasses. One of my patients did ear candling and ended up with a hot wax burn that destroyed her ear drum and luckily did not paralyze her facial nerve in the middle ear.

a. TM perforations can cause two problems:
   i. They expose the middle ear, which can cause infection
   ii. They can cause hearing loss
b. Strict water precautions are necessary for TM perforations.
c. Tympanoplasty surgery (repair of the ear drum) is an outpatient procedure that takes about 1-1/2 hours on average, under general anesthesia. It is safe and effective over 90% of the time.
d. If a patient cannot tolerate even that much surgery, an ENT can put a temporary paper or silicone patch on in the office to diminish the symptoms of their perforation.

Otitis Media (middle ear infection)(OM) can be acute (implying bacterial infection) or serous (implying fluid that does not have active bacteria in it). It can affect all ages. Acute
OM (AOM) is most common under age 3 and is still common until around age 9 or 10. After the acute infection resolves, the patient can have serous OM (SOM) with persistent fluid in the ME and secondary conductive hearing loss (CHL) for up to several weeks or to 3 months. Although AOM and SOM can occur at any age, SOM has a second significant ‘bump’ in incidence in the elderly population. Check out the AAO-HNS CPG on this subject as well.

a. Distinguish conductive from sensorineural hearing loss (CHL from SNHL) by using a 512 Hz tuning fork in the office. See the video on how to do this at www.entnet.org.

b. Uncomplicated AOM in individuals over age 2 should be treated with watchful waiting and analgesics and only given antibiotics if the infection persists after 72 hours.

c. Persistent fluid, with or without language delay or other related sequelae, may be treated with myringotomy and ear tube insertion.

a. This can be done in the office with minimal discomfort in selected patients.

Disruption of the ossicles can occur with chronic OM, cholesteatoma (skin growing in the middle ear and/or mastoid), or trauma. Poor mobility of the stapes bone is seen in otosclerosis. All of these will give rise to a conductive hearing loss. You can identify the type of hearing loss by a tuning fork exam and refer the patient to ENT for a thorough examination, often under a microscope, and audiogram. Further testing such as CT scans may be ordered, and either surgical intervention or hearing aids may be offered. Outcomes are excellent; success in stapes surgery for otosclerosis is over 95%. If middle ear surgery is not indicated for the patient, he or she may benefit from an osseointegrated hearing implant in the skull, which also has excellent outcomes.

SNHL is from a problem with the cochlea.

a. Sudden SNHL is an otologic emergency and must be seen by the ENT as soon as possible.

a. Early diagnosis and treatment with oral and/or intratympanic steroid injection gives the best possible hearing outcome.

b. Please see the CPG on this subject from AAO-HNS.

c. If hearing does not recover, the patient may be offered a hearing aid, or an osseointegrated hearing implant, or even a cochlear implant.

b. Asymmetric hearing loss requires audiometric and retrocochlear workups, which will be ordered by the ENT.

c. More commonly, progressive SNHL of age (presbycusis) affects men starting in their 50s and women starting in their 60s, although it can be seen earlier. Effects may be insidious and may include withdrawal from social situations where hearing background noise is distracting.

a. ENT evaluation and audiometric confirmation and delineation of hearing loss will allow for the best counseling of the patient and their family.

b. Untreated SNHL in the elderly is a leading cause of development of dementia in this population, while correct application of hearing aids reverses that mental isolation and greatly improves quality of life (QOL).

d. Severe to profound SNHL cannot be adequately aided with hearing aids. In this population, a cochlear implant (CI) may be indicated.

a. CI are FDA-approved from age 1 upwards. There is no maximum age for CI surgery.

b. This is an outpatient operation with excellent outcomes.

c. All studies show remarkable QOL improvement after CI at any age – from youngest to old elderly patients.

Vertigo is often from a problem with the vestibular end organ.

a. Peripheral, or ear, vertigo is usually an episodic, spinning sensation that lasts a few seconds to a few hours, and the patient is symptom-free between attacks. Distinguish this from central or metabolic vertigo which is more constant, more light-headed or spacey feeling, and more persistent.

b. Meclizine is contra indicated in the chronic treatment of vertigo. It is a central nervous system suppressant and chronic use will result in poor or delayed recovery of vestibular function. It can be used sparingly in the acute phase of vertigo, only on a prn basis.
c. Benign paroxysmal positional vertigo (BPPV) is diagnosed by the classic history of latency, spinning vertigo for a few seconds, only in the provoking position, and fatiguability, and a positive Dix-Hallpike test. See the AAO-HNS CPG on this subject. Treatment is with canalith repositioning procedure (CRP), often called 'Epley' maneuver. This should not be treated with vestibular suppressants and does not need imaging.

d. Meniere’s disease is an inner ear fluid disturbance which results in roaring tinnitus, hearing loss in that ear, and whirling vertigo that lasts up to several hours. Patients are absolutely fine in between episodes. It is often related to salt consumption, dehydration, caffeine, and nicotine. Diagnosis is made clinically and with audiogram and other specialty ear tests as indicated. Treatment includes dietary modification and medications that may include diuretics and perhaps pulse doses of steroids.

a. Environmental and food allergies are seen in Meniere’s disease. At ENTA, we can evaluate the patient both from the ENT perspective and the allergy perspective, and we offer a true 360-degree evaluation and management program for them.

e. There are other causes of vertigo that will be investigated when appropriate.

Vestibular schwannoma is the correct nomenclature for what used to be called acoustic neuroma. This is a benign lesion on the eighth cranial nerve. It is often diagnosed during workup of asymmetrical hearing loss. Many of these are slow-growing and the patient is often given the choice of serial MRI observation with institution of treatment – either microsurgery by the ENT-neurosurgery team or radiation treatment – only once the tumor is seen to be growing. The rule of thumb is that if there is no growth seen on serial MRIs for the first 5 years, there is very little chance that the tumor will grow in the future.

I hope you’ve enjoyed this whirlwind tour of much of what can go wrong with the ear. My colleagues and I at ENTA are only a phone call or an email away, and we are happy to answer any questions or concerns, offer a ‘curbside consult’, and/or see your patients at their convenience.
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Untreated Obstructive Sleep Apnea (OSA) can impact one's health and wellness. Untreated moderate and severe OSA are independent risk factors for hypertension, diabetes, heart attacks, strokes and premature death.

OSA also impacts everyday life. People with untreated OSA have a higher incidence of car and work-related accidents due to excessive sleepiness. Depression and reduced productivity at work are also common. The bed partner's sleep is also disrupted, often leading to separate sleep arrangements. It does not have to be this way, as OSA is treatable.

To determine whether or not someone has OSA, and to what degree, a sleep study is needed. Sleep studies can be performed in the sleep lab or at home.

A sleep study will report the degree of OSA as determined by the Apnea Hypopnea Index (AHI), otherwise reported in home sleep studies as the Respiratory Event Index or Respiratory Disturbance Index (REI or RDI). Scoring criteria can vary with vastly different results, frequently dictated by the insurance company. Thus the criteria for diagnosing hypopneas should be reported and noted. A more reliable index is the Oxygen Desaturation Index (ODI) but even ODI can be scored using 3% or 4% minimal desaturation. There is much more to a sleep study's interpretation than a summary index value. A sleep study should be examined for the positionality of OSA, the extent of oxygen desaturations during the night, and the overall pattern of obstructions in sleep.

The three mainstays of treatment for OSA are Positive Airway Pressure (PAP) therapy, oral appliance therapy, and surgical intervention. The treatment should be individualized to the patient's particular preferences and needs.

PAP
The most common treatment for OSA in the US, particularly for moderate and severe cases, is PAP therapy. PAP acts as a pneumatic splint, or stent, to maintain airway patency. The device is an air compressor that can be placed on the night stand, delivering air pressure through tubing to an interface, or mask. The interface is what couples the air pressure to the patient's airway.

There are 3 main types of interfaces. A nasal mask covers the nose. Nasal pillows sit underneath, and at times just inside, the nostrils. A full-face mask covers the nose and mouth. Which one a patient uses is dependent upon comfort, as well as their ability to breathe through their nose and/or keep the mouth closed at night. Usually full-interfaces are least preferred. At times, a chin strap will be added to a nasal interface to prevent the mouth from opening when asleep. Some patients adapt to nasal breathing while using PAP. Thus, mouth breathers don't always require a full interface.

There are several different types of PAP machines that each deliver air pressure in slightly different ways. CPAP is continuous PAP, set at one constant pressure. This pressure is usually determined by a CPAP titration study in the sleep lab.

When using APAP, or auto-adjustable PAP machines, a set pressure is not used, but rather a range of pressures. This can be more economical for patients who undergo a home study, who can then forgo a subsequent in-lab PAP titration. In addition, if a patient undergoes an in-lab PAP titration, but optimal pressure is not determined, he/she can also be treated immediately with APAP. There are several advantages of APAP over CPAP. First, one's pressure requirement is not fixed during the course of a night and can vary for patients with positional apnea that is worse in the supine position compared to the non-supine position. Thus, less pressure is used when not needed. Second, if a patient, after an in-lab titration study, is having difficulty tolerating a CPAP setting, options...
include going back to the lab to re-titrate the pressure or to empirically reset the pressure. With APAP, there is data on a compliance report that tells us how much pressure is being delivered each night to open the airway. This will allow adjustment of the range. An APAP device will also adjust treatment pressure as patients lose weight or when patients imbibe alcohol. Finally, all APAP machines have a CPAP mode, and so, if preferred, a constant level pressure may be set after determining the optimal pressure from the downloaded device data.

BPAP, or bi-level PAP, machines use two set pressures for each breath—a higher inspiratory pressure and a lower expiratory pressure. In general, the differential between these 2 pressures, also called pressure support, is at least 4 cm H2O. BPAP is frequently helpful for patients who are obese, have severe OSA and a high pressure requirement. It is easy inhaling in at a high pressure, such as 18 cm H2O, but it may be difficult to exhale against that amount of pressure. BPAP lessens the work of exhalation. BPAP settings are determined in the sleep lab. Not everyone accommodates to BPAP, and studies have not proven it superior to CPAP.

It is imperative to follow-up with patients long term if they are using PAP therapy. OSA is an entity with potential cardiovascular consequences if untreated or treated improperly. The critical issue is long-term adherence, which may be 50% or lower. In the SAVE study where PAP usage was low, at 3.3 hours mean per night, cardiovascular protection was not present. After beginning PAP treatment, as dictated by insurance entities such as Medicare (CMMS), patients require a face-to-face evaluation with the physician within 30-90 days. Assuming they are doing well, they should be seen once a year, or sooner if there are issues to address.

At the follow-up visit, it should be ascertained how the patient is doing clinically with their machine. That is, do they feel more rested? Is snoring treated? Any difficulties, such as interface difficulties, “too much pressure”, “too little pressure”, etc., should be addressed.

A compliance report should be checked. In the past, the only way to check a compliance report was to get it from the Durable Medical Equipment (DME) company that supplied the patient with the PAP machine and supplies or by downloading a chip from the machine if you had the “chip reader”. Most new machines have a modem to supply that information to the ordering physician. The physician only needs an ID and password on the machine manufacturer’s site and to be linked by the DME company to the patient.

The compliance report gives details about the patient’s usage of his/her machine and its’ efficacy, via an estimated “AHII”. Most insurance companies require usage of >4 hours per night at least 70% of the nights (5 nights a week) to continue to pay for the machine and supplies.

In general, our goal with PAP therapy is to attain an AHI of <5/hour. More important than the AHI number on a compliance report, though, is the patient’s clinical response to treatment. In other words, treat the patient, not a number. However, this can be helpful to see that the PAP machine is doing what we expect it to do. In fact, showing the number to the patient and comparing to their original sleep study’s AHI can be very motivating.

There are other parameters on a compliance report that help us troubleshoot issues patients may be having with PAP therapy, including the median and 95th percentile pressures on an APAP machine, as well as interface leak. Detailed data reports can be used for troubleshooting problems with PAP use.

**Oral Appliance Therapy**

Oral appliances that advance the mandible are an alternative to PAP therapy in patients who do not tolerate PAP or as primary therapy for patients who prefer them over PAP. Though PAP is more efficacious at reducing the sleep study indices of OSA, the clinical effectiveness of PAP and oral appliances is similar. Patients are twice as likely to adhere to oral appliance therapy than to PAP treatment, and this may explain the similar clinical effectiveness.

Oral appliances maintain the mandible in a protruded
position in sleep. By doing so, they stabilize and expand the pharynx. The main mechanism of action is expansion of the upper pharynx at the palate level, not at the tongue base. An ENT endoscopic examination of the pharynx may be used to help assess potential for efficacy by assessing the degree of expansion of the pharyngeal with jaw protrusion. Otherwise, if available, titration of mandibular protrusion during sleep using a MATRX device may be performed in a sleep center prior to appliance production, in order to assess potential efficacy.

Not all patients are good candidates for oral appliance. Clinical examination is needed to assess the number and condition of the dentition that will support the appliance and oral health. Particular features on exam may be used to select a specific appliance for a given patient. A doctor’s prescription is required to have an appliance made by a qualified MD or dentist. Oral appliances are a covered DME under most commercial carriers and Medicare, and thus can be quite affordable with a participating doctor or dentist.

Custom-made appliances, produced in a dental lab from impressions or scan, are preferred to those made in office for comfort, durability and efficacy. The appliance should be titratable, as optimal treatment position is not known apriori and slow adjustment allows accommodation to advancement. Once a patient is fitted with a titratable oral appliance, further advancement is usually performed at home to resolve the clinical symptoms and signs of OSA, usually by snoring abatement. Side effects include intolerance due to discomfort, bite changes and (rarely) dental or gum problems.

Clinical follow-up is needed to assess outcome, side effects and adherence, as long-term adherence rate is approximately 50%. Dental follow up is also needed to assess dental health. For patients with moderate to severe OSA, follow up sleep testing is needed to assess effectiveness of the appliance at reducing the indices of OSA and to assess the need for further titration or concurrent treatment, such as non-supine sleep positioning.

Recent advances in oral appliance therapy include the development of embedded temperature sensors for adherence monitoring and production of thinner, lighter appliances via 3-D printing techniques.

**Upper Airway Surgery**

Sleep surgery is simply not “less than 50% effective” as some have been told. Many patients are counseled against surgery, due to misinformation, and this leaves many patients untreated (Russell et al 2015). **Upper airway surgery has an important role in treating OSA for its most important clinical outcomes: reduction of risk of death, cardiovascular morbidity and improvement of quality of life.** Research in large populations, including the US Veterans database and the Korean National health database (Weaver et al 2004, Lee et al 2018), shows clear and substantial benefit of sleep surgery for survival and cardiovascular risk. In numerous studies, upper airway surgery has been shown to reduce the rate of motor vehicle accidents (Haraldsson 1995), regardless of the AHI, and also to improve quality of life.

Sleep surgery usually does not normalize the AHI but can reduce it significantly. How important is AHI normalization? The AHI is a surrogate parameter of OSA, not the disease. The AHI is a parameter whose measurement can vary greatly, has multiple definitions, and is insufficient to diagnose OSA when <15/hour, where symptoms are required. The AHI does not convey critical data such as degree, duration, and time spent with oxygen desaturations. The AHI may portend medical major risk when >30, when scored by 4% desaturations, and associated with hypoxemia.

Surgery is beneficial in that it does not require adherence, as compared to PAP and oral appliance therapy, where a large percentage of patients do not adhere long term. Nonetheless, pharyngeal surgery has risk and thus it should be considered carefully and applied to selected patients. Patients with very large tonsils are usually good candidates, and surgery may be considered first line for them (Browaldh et al 2013). Surgery should also be offered to those who have not responded to medical therapies, as surgery can often salvage these patients, reducing risk and improving quality of life.

UPPP or upper pharyngeal surgery has changed since introduction in the 80s. Lateral pharyngoplasty (LP) and its variants, such as expansion sphincter pharyngoplasty (ESP), have become powerful techniques to widen and stabilize the lateral pharyngeal walls. They have been shown to reduce the AHI, lower blood pressure and improve quality of life alone, even in patients that appear to have a tongue base collapse in addition (Cahali et al 2004, Pang & Woodson 2007, Hsu & Jacobowitz 2017). Thus, newer techniques may be able to open the upper bottleneck of the pharynx and reduce the need for additional procedures. These advanced sleep surgery techniques have become the staple of sleep surgeons worldwide.

Maxilomandibular Advancement (MMA) jaw surgery can widen and stabilize the lateral pharyngeal walls effectively...
and more reliably lower the AHI. For the skeletally deficient patient, MMA can treat OSA and improve cosmesis. However, the patient must accept a long post-op oral rehabilitation and risk of lower facial sensory problems. For these reasons, not many patients accept this approach.

**Implantable Hypoglossal Neurostimulation (HGN)**

The new treatment frontier, implantable hypoglossal neurostimulation (HGN), combines the medical and surgical approaches. A pacemaker-like device is implanted under the skin and is used to activate the hypoglossal nerve on one side of the neck. A cuff, connected to the pacemaker, is surgically placed around the hypoglossal nerve or its branches for stimulation. There is one HGN system approved in the US presently, from Inspire Medical, whose system consists of an implanted pacemaker, nerve cuff, and respiratory chest wall sensor. There is another system by ImThera Medical, which is investigational in the United States, presently in pivotal trial testing. Dr. Jacobowitz from ENT and Allergy Associates is a primary investigator for this system and notes that it does not use a chest wall sensor, thus only having 2 components.

HGN systems are targeted for patients with moderate to severe OSA who are intolerant of other treatments. In clinical trials, these devices have shown significant AHI reduction and improved quality of sleep and of life, though not for all.

The mechanism of action is most likely pharyngeal wall and palatal stabilization rather than tongue movement. Stimulation is carefully adjusted to not interfere with sleep. A remote control is used to activate the device after a delay. The pacemaker devices require surgical replacement, but this can be performed under local anesthesia.

HGN is a new treatment. It is not accepted by all but may increase with our dependence on technology and with further device miniaturization. System cost may decrease over time, and hopefully insurance carrier acceptance will become less challenging. Optimal features for successful outcome are still not well known. Inspire Medical uses sleep endoscopy to identify severe collapsibility as an exclusion. ImThera’s pivotal trial criteria exclude severe hypoxemia and high apnea index, possibly also to limit extreme collapsibility. More reliable criteria are still needed.

Additional experimental systems are in preliminary testing phase. For example, Nyxoah SA, for which Dr. Jacobowitz consults, has developed an HGN system with an external power source, eliminating the need to implant a power source. The system uses bilateral stimulation of the hypoglossal nerve branches to the genioglossus muscle. A button-like power source is applied on a patch under the chin at bedtime and is removed and charged after sleep. Clinical trial has completed enrollment in European and Australian centers. There are more systems in development, and this new frontier is very promising.

OSA is a serious disease with potential for reduced survival, greater morbidity, and functional impairment. Treatments, though imperfect, are readily available and should be offered using a personalized approach to achieve long term success.
A top 20 national insurance brokerage, Risk Strategies is a specialist in customized coverage that gets the fine print right to protect you where you live and work.

From life, disability, home and auto to professional, executive and specialty liability, employee benefits programs, property & casualty, and more, Risk Strategies makes managing your full spectrum of risk simple and cost effective.

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LONG ISLAND DENTAL SLEEP MEDICINE

“Advancing Care with Innovation”

- Over 27 years successfully treating Obstructive Sleep Apnea with Oral Appliance Therapy
- We are the first office in NY State to be recognized as a DENTAL SLEEP MEDICINE accredited facility by the American Academy of Dental Sleep Medicine
- We are the NY metropolitan Area Pro Player Health Alliance office treating retired NFL players who suffer from Obstructive Sleep Apnea
- We offer compliance monitoring of oral appliances for patients who need to show compliance for insurance of industry.

Although Oral Appliance Therapy can eliminate obstructive sleep apnea & snoring, some patients still continue to snore even after their apnea has been resolved. This can be due to a problem known as nasal valve insufficiency, when the nostrils collapse and prevent air flow through the nose (the ideal way to breath) causing mouth breathing. This results in SNORING and disturbed sleep for the patient AND their bed partner.

At Long Island Dental Sleep Medicine, we have incorporated a new and innovative “over the counter” product from RHINOMED an Australian medical device technology company known as MUTE to help battle this problem.

MUTE is a tiny, comfortable, ultra soft, latex free polymer, anatomically designed, adjustable device worn inside the nostrils. It holds the nose open, easily preventing collapse and increasing airflow up to 38%. Unique in its ability to adjust to each individual nostril as well as almost any nose, mouth breathing is minimized. Studies have shown a 78% increase in nighttime breathing as well as significant decrease in snoring severity, duration, volume and frequency. Most impressively, a vast majority of patients and their partners report an “INCREASE IN SLEEP QUALITY”.

“Combining oral appliance therapy & MUTE has proven to be a winning combination for our patients who continued to snore after successfully treating their obstructive sleep apnea”

* S Braham, Royal Melbourne Eye & Ear Hospital 2003
** 2014 User Trial, n=118 couples, Australia