

## Snoring

Up to 40% of the population snore. You snore when the flow of air as you breathe makes the tissues in the back of your throat vibrate. The sound most often occurs as you breathe in air, and can come through the nose, mouth or a combination of the two. It can occur during any stage of sleep.

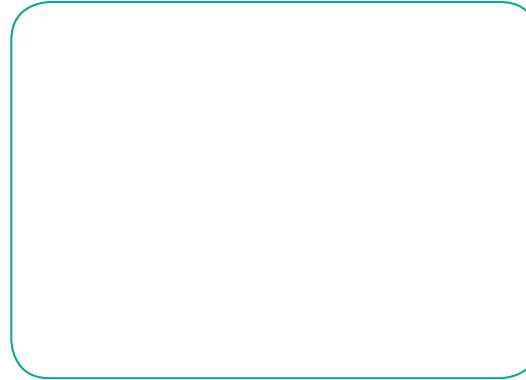
Light or primary snoring will not have an impact on your health but rhonchopathy and abnormal snoring will.



**Silensor-sl**  
allowing you to get  
a good nights sleep

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If you have any concerns that have not been covered in this leaflet your clinician will be happy to provide further information.



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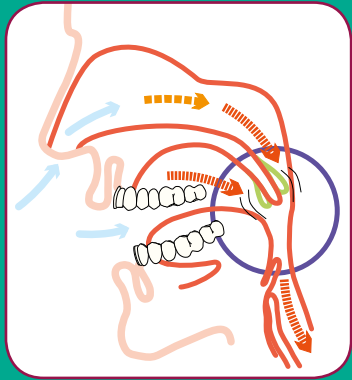
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Is snoring  
a problem  
for you?

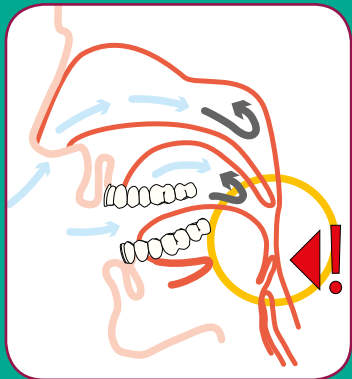
**Silensor-sl**  
Patient  
Information



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Snoring



Apnoea

### \*Apnoea-hypopnoea index (AHI)

Number of apnoeas and/or hypopnoeas per hour of sleep (or study time). Reflects the severity of sleep apnoea.

AHI = 5–14 Mild sleep apnoea

AHI = 15–30 Moderate sleep apnoea

AHI = >30 Severe sleep apnoea

### Health Screening

Snoring may indicate underlying health issues which require management. As part of your diagnosis and treatment, your clinician will ask you to fill in a pre-screening questionnaire. This process may require a referral back to your GP for further investigation in order to treat the underlying cause and potentially reduce overall health risks.

### Apnoea Explained

There are two types of breathing interruption characteristics of **Obstructive Sleep Apnoea (OSA)**:

**Apnoea:** where the muscles and soft tissues in the throat relax and collapse sufficiently to cause a total blockage of the airway; it's called an apnoea when the airflow is blocked for 10 seconds or more.

**Hypopnoea:** a partial blockage of the airway that results in an airflow reduction of greater than 50% for 10 seconds or more.

People with OSA may experience repeated episodes of apnoea and hypopnoea throughout the night. These events may occur around once every one or two minutes in severe cases.

As many people with OSA experience episodes of both apnoea and hypopnoea, clinicians sometimes refer to the condition as obstructive sleep apnoea-hypopnoea syndrome, or OSAHS.

The term “obstructive” distinguishes OSA from rarer forms of sleep apnoea, such as central sleep apnoea, which is caused by the brain not sending signals to the breathing muscles during sleep.

For further information visit :

[www.nhs.uk/conditions/obstructive-sleep-apnoea/](http://www.nhs.uk/conditions/obstructive-sleep-apnoea/)

1. Oral appliances for snoring and obstructive sleep apnea: a review, Ferguson, Cartwright, Rogers, Schmid-Novara Sleep, Vol. 29, No. 2, 2006.  
 2. Oral appliance therapy for the management of sleep disordered breathing: an overview, Robert T. Rogers, D.M.D. Sleep and Breathing, Vol. 4, No. 2, 2000.  
 3. Dental considerations in upper airway sleep disorders: a review of the literature, Ivanhoe, Cibirka, Lefebvre, Parr. The Journal of Prosthetic Dentistry, Dec. 1999, 685.  
 4. Mandibular advancement splints and CPAP in patients with obstructive sleep apnoea: a randomized cross over trial L'Estrange, Luo, Smith, Grant, Simonds, Spiro, Battagel European Journal of Orthodontics 24 (2002) 239-249.  
 5. Mandibular advancement and sleep disordered breathing Clark, Kobayashi, Freymiller • CDA Journal, April 1996.  
 6. Dentistry's role in the diagnosis and co-management of patients with sleep apnoea syndrome, A. H. Friedlander, I. K. Friedlander, M.A. Pogrel British Dental Journal, Vol. 189, No. 2, July 22, 2000.



### Effectiveness of the Silensor-sl

The **Silensor-sl** consists of one splint for the upper jaw and one splint for the lower jaw. The lower jaw is either held in a predetermined or advanced position by two connectors that are fixed laterally to the splint.

The **Silensor-sl** counteracts the narrowing of the respiratory tracts. As the velocity of the air decreases so do the noise-generating vibrations of the soft tissues. The **Silensor-sl** allows jaw movements, so is comfortable to wear, but prevents the lower jaw from falling back so is an effective snoreguard.

Clinical tests<sup>1-6</sup> have shown that the advancement of the lower jaw considerably reduced snoring in over 80% of patients and 50% saw a reduction in their apnoea index\*.

### When is the Silensor-sl suitable?

The **Silensor-sl** can be very successful since in almost all cases the noise involved in snoring is caused by constriction of the airways. Because of its compact design, the **Silensor-sl** does not inhibit breathing through the mouth.

In cases of obesity success is very limited. The effectiveness will be increasingly reduced at a BMI (body-mass-index) of more than 30 and a neck circumference of more than 43cm.

The **Silensor-sl** cannot be used for patients that wear a full denture. Your clinician will evaluate if your partial denture will provide adequate retention.