

Position Statement on Sleep-Disordered Breathing and Obstructive Sleep Apnea

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Purpose

The purpose of this statement is to provide orthodontists, referring practitioners, and patients with clear, evidence-informed guidance on the role of the orthodontist in the identification and management of sleep-disordered breathing (SDB), so that patients and families can make informed decisions about orthodontic care. It is aligned with the American Association of Orthodontists (AAO) white papers of 2019 and 2026^{1,2}, whose author panels included Canadian orthodontists, and with the current guidance of the American Thoracic Society³, the American Academy of Dental Sleep Medicine^{4,5}, the American Academy of Pediatric Dentistry⁶, the European Respiratory Society⁷, and the International Consensus Statement on Obstructive Sleep Apnea⁸.

It is intended to inform, not replace, the clinical judgment of the treating orthodontist, and it does not establish a standard of care. It cannot address every clinical circumstance, and departures from it may be appropriate in individual cases; where an orthodontist departs from this guidance, the rationale should be documented. Orthodontic practice in Canada is regulated by provincial and territorial dental regulators, whose standards, guidelines and scope-of-practice rules govern where they differ from this statement. Nothing in this statement constitutes legal advice.

Background

Sleep-disordered breathing represents a spectrum of respiratory disturbances during sleep, ranging from primary snoring to obstructive sleep apnea (OSA)¹. In both children and adults, untreated SDB has been associated with cardiovascular disease, metabolic dysregulation, impaired growth and development, and diminished daytime functioning^{1,2,6}. These conditions are frequently underdiagnosed, and increasing awareness across the health professions has underscored the importance of early identification and interdisciplinary management^{1,2}.

Orthodontists are well positioned to contribute to the early recognition of SDB. Through routine assessment of craniofacial structure, dental development, and airway-related risk factors, orthodontists may identify patients at increased risk and facilitate timely referral for definitive diagnosis^{1,2}. Certain craniofacial and dental features, such as a narrow maxilla, a high-arched palate, a retrognathic mandible, and increased overjet, have been reported in association with pediatric OSA⁹. These anatomical traits are often amenable to orthodontic and dentofacial orthopedic treatment, which has generated considerable interest in the role of orthodontists in

screening for and co-managing SDB. The current evidence, however, does not support that any craniofacial phenotype can identify the presence of SDB¹, and OSA can be definitively diagnosed only by a physician^{1,2,6,10}.

Professional Responsibility

As health care providers, orthodontists possess specialized knowledge that creates an inherent power imbalance in the clinician–patient relationship. Clinical judgment must therefore be exercised with integrity, transparency, and a commitment to patient-centred care. In an era in which patients are exposed to conflicting information, from differing professional opinions to unvetted online sources, orthodontists have a heightened responsibility to provide clear, evidence-informed guidance. This duty is grounded in the trust that patients place in their orthodontist, in which the orthodontist is expected to act in the patient’s best interests, to prioritize their well-being, and to avoid undue influence or overstatement of benefit. Accordingly, the Canadian Association of Orthodontists (CAO) affirms that orthodontic care in the context of SDB demands careful communication, appropriate referral when indicated, and a steadfast commitment to professionalism and the highest standards of evidence-based care.

Position of the Canadian Association of Orthodontists

In alignment with the organizations cited above, the CAO supports the following positions:

1. **Screening.** Orthodontists should be familiar with the signs and symptoms of SDB and should consider incorporating SDB risk assessment, which may include the use of validated questionnaires, into routine history-taking and clinical examination of both children and adults^{1,2,6,10}.
2. **Referral before intervention.** When an orthodontist suspects SDB, referral to a physician for definitive diagnosis is strongly recommended before any SDB-related intervention is undertaken. Only a physician can diagnose SDB, and diagnostic sleep testing should be ordered and interpreted by an appropriately qualified physician^{1,2,10}. Pediatric and adult patients with nasal obstruction or adenotonsillar hypertrophy should be referred to an otolaryngologist^{2,6}.
3. **Imaging.** Two-dimensional and three-dimensional airway measurements derived from cephalograms or cone-beam computed tomography (CBCT) are not suitable for the diagnosis of SDB, for assessment of SDB risk, or for evaluating the outcome of treatment. Imaging obtained for orthodontic purposes should not be used to imply a diagnosis of SDB¹.

4. **Orthodontic treatment is not a stand-alone therapy.** Current evidence does not support orthodontic or dentofacial orthopedic treatment as a stand-alone or primary therapy for SDB in children or adults^{1,4}. Where a physician has diagnosed OSA and a clear skeletal or dental indication exists, interventions such as rapid maxillary expansion or mandibular advancement may be considered as one component of an interdisciplinary plan; any improvement in airway function should be regarded as a potential secondary benefit rather than a guaranteed therapeutic effect^{1,3}. The American Thoracic Society conditionally suggests that children with persistent post-adenotonsillectomy OSA and specific craniofacial features, including a constricted maxilla, may be candidates for such treatment, while noting very low certainty in the evidence³.
5. **No preventive role.** There is no evidence that any orthodontic intervention, including palatal expansion or functional appliances, prevents the development of SDB, and the prophylactic use of pediatric palatal expansion for this purpose is not supported at any age. Maxillary expansion should be considered only in patients who demonstrate a transverse discrepancy requiring expansion, independent of SDB; it is not recommended solely to address OSA or snoring in its absence, in children or adults⁴. Treatment decisions should continue to be based primarily on underlying skeletal and dental discrepancies^{1,4}.
6. **Prefabricated “myofunctional orthodontic” appliances.** Prefabricated, non-customized removable appliances are increasingly marketed to parents, sometimes for children as young as two to four years, with claims that they guide jaw growth, correct oral posture, and prevent or treat sleep-disordered breathing. The CAO is aware of no evidence supporting these claims. The AADSM consensus panel was uncertain of any role for these devices in pediatric OSA, no panelist considered them appropriate to cure it, and in adults the panel found insufficient evidence for their use and cautioned that moving teeth beyond their bony support carries a real risk of harm⁴. There is no basis on which to expect a prefabricated appliance to alter growth trajectories or to prevent, manage, or cure SDB, and the CAO does not support their use, or the marketing of them, for that purpose. Patients and families who are told otherwise should seek a second opinion.
7. **Extractions and conventional mechanics.** Current evidence does not support that orthodontic extractions, distalizing mechanics, or other conventional orthodontic procedures cause SDB or increase its likelihood^{1,2,4}.
8. **Ankyloglossia and frenectomy.** Current evidence does not support ankyloglossia as a cause of SDB. Routine frenectomy is not recommended for the prevention or treatment of SDB^{1,4}, and the American Academy of Pediatrics has concluded that frenotomy performed in infants to prevent future obstructive sleep apnea is not evidence based¹². The AADSM consensus panel likewise found insufficient evidence for lingual or buccal frenum releases and for ablative or non-ablative laser therapy of the soft palate or adjacent tissues to prevent, manage, or cure OSA or snoring in any age group⁴.

9. **Oral appliance therapy in adults.** Custom-made mandibular advancement devices are an established, effective option for selected adults with diagnosed OSA, particularly those who are intolerant of, or who decline, positive airway pressure therapy^{5,7,8}. Orthodontists who provide oral appliance therapy should do so only after physician diagnosis and referral, should possess appropriate training, should titrate and verify efficacy in collaboration with the treating physician, and should inform patients of and monitor for dental and occlusal side effects^{1,2,5,10}.
10. **Informed consent.** Patients and caregivers must receive a clear explanation of the diagnosis, the nature and purpose of any proposed treatment, its realistic and evidence-based expected benefits, its risks and limitations, and the alternatives, including no treatment. Claims that orthodontic treatment will cure or prevent SDB are not supported by the evidence and should not be made^{1,4}.
11. **Interdisciplinary care and follow-up.** Patients with SDB are best served by an interdisciplinary team that may include sleep medicine, otolaryngology, respirology, pediatrics, and oral and maxillofacial surgery. When an orthodontist participates in the management of SDB, care should be planned and monitored in close collaboration with the diagnosing physician, and patients should be reassessed periodically for maintenance of their condition^{1,2,3,11}. Orofacial myofunctional therapy may have an adjunctive role in managing diagnosed OSA, but evidence that it prevents or cures OSA is lacking, and it should be delivered by appropriately trained providers within the team^{4,11}.
12. **Research and education.** Well-designed controlled studies with polysomnographic outcomes and long-term follow-up are needed to define the role of orthodontic treatment in SDB, and SDB should be incorporated into orthodontic education and continuing professional development^{2,3,4}.

The Canadian Association of Orthodontists is committed to advocating for best practices in orthodontic care and to ensuring that patients receive safe, effective treatment grounded in the most current scientific evidence. This statement will be reviewed and updated as new evidence emerges.

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