

LETTERS TO THE EDITOR

How much is too much after all? Primary snoring as a remaining unsolved issue

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Snoring, an inspiratory sound produced during sleep, until recently was considered an acoustic annoyance. When snoring presents by itself, without documented apneas, hypopneas, or hypoventilation, it is often referred to as primary snoring, intermittent snoring, or habitual snoring; and it is classified in the mild end of the spectrum of the sleep-related breathing disorders (SRBD).¹ Snoring is therefore considered part of SRBD continuum leading to obstructive sleep apnea (OSA). Even in the absence of OSA, some studies showed that snoring is associated cardio-metabolic risk factors such as atherosclerosis and endothelial dysfunction.^{2,3} There are also studies from animal-models, suggesting that the snoring-associated vibration induces endothelial dysfunction.⁴ Given the possible negative health outcomes that are associated with snoring, some sleep experts consider that it should be viewed as a pathological condition per se. In the romance language-related literature (Italian, Spanish, Portuguese), the term “roncopathy” is being used with increased frequency, yet most primary snorers do not have any associated pathological conditions. The negative connotation of the suffix “pathy” in the context of snoring, could push patients and medical providers to pursue treatments that may not provide any significant benefits to the patient but may expose the patient to possible harms. Currently, there is a significant level of consensus regarding the importance of OSA and its treatment, but as the sleep medicine community has focused on this more serious condition, less research effort has been devoted to the topic of primary snoring. Sleep medicine professionals do not have a standardized classification for primary snoring in terms of severity or frequency. If snoring could indeed cause atherosclerosis or other pathological conditions, it is also unclear if the frequency, intensity, or exact localization of the snoring plays a role in this association. Our treatment guidelines could also benefit from more detailed updates; in 2015, the American Academy of Sleep Medicine published a clinical practice guideline recommending the use of mandibular advancement devices, versus no therapy, for the treatment of snoring.⁵ There are limited high-quality studies looking at potential complications associated with the use of dental devices. There is some evidence suggesting long-term craniofacial changes with the use of dental devices for snoring and/or sleep apnea⁶ and it becomes imperative to plan larger prospective studies that could guide our patient recommendations in terms of specific devices, follow-up frequencies, etc.

Hence, how much is too much snoring remains an unsolved question that should be properly assessed to clarify the innocence or the risk of this symptom and whether the term “pathy” should be used to describe it...

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