

10-minute consultation

Snoring

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An overweight, 49 year old male smoker attends your surgery with his wife. His snoring, which has been a running joke in the family, has become worse in the last six months, and his wife now sleeps in a separate room. When the couple stayed in a hotel recently his noise was remarked on by other guests. They want to know what they can do.

What you should cover

Simple snoring is common in Britain (prevalence of up to 40%). You should assess the nature of the snoring, its effect on patient and partner, modifiable factors, and presence of any features indicating the more serious condition of obstructive sleep apnoea.

- Who is most affected by the snoring? With simple snoring, this is often the patient's partner.
- How disruptive to life and relationships is it?
- How long has it been a problem?
- Has he put on weight or increased his collar size lately?
- Assess alcohol intake and any effect on symptoms.
- Does he take sleeping tablets or other sedatives?
- Is his snoring sensitive to sleeping position? Most snoring is worse when the person is supine.
- Does he have any history of nasal problems, such as trauma, congestion, or anosmia associated with nasal polyps?
- Could he have obstructive sleep apnoea? Has his wife noticed him stop breathing (apnoeic episodes), or has he woken with a choking sensation? Does he have excessive daytime sleepiness (an overwhelming and inappropriate need for sleep rather than general tiredness)? Other symptoms include non-refreshing sleep, nocturia, morning headaches, poor concentration, or car crashes attributable to sleepiness.

What you should do

General examination

- Note his weight and height, and measure his neck size, using a tape measure if possible, although accurate shirt size will suffice. Calculate his body mass index. A half of patients with obstructive sleep apnoea have a BMI >30. Neck circumference above 43 cm correlates well with snoring and obstructive sleep apnoea.
- Examine his nose for any obstruction, such as polyps or septal deviation, and whether unilateral or bilateral.
- Examine his oropharynx to assess degree of crowding and size of tonsils and uvula. Experienced doctors will be able to assess this qualitatively. Less experienced doctors can get a basic quantitative assessment by using the Mallampati classification (graded 1 to 4; see www.anest.ufl.edu/at/case1/mallampati.html), which is used by anaesthetists to assess ease of intubation.
- Check for retrognathia—a receding lower jaw giving an overbite when the teeth are opposed—as well as crowding and quality of his teeth.

Useful reading

Counter P, Wilson JA. The management of simple snoring. *Sleep Med Rev* 2004;8:433-41

Review series on obstructive sleep apnoea in *Thorax*, starting in January 2004 (1: Obstructive sleep apnoea/hypopnoea syndrome: definitions, epidemiology, and natural history. *Thorax* 2004;59:73-8)

The UK Sleep Apnoea Trust's website has information for patients and doctors about snoring, obstructive sleep apnoea, and available interventions. www.sleep-apnoea-trust.org

- Consider hypothyroidism as a diagnosis.
- Use the Epworth scale (see bmj.com) to quantify daytime sleepiness. This provides a validated, reproducible, and sensitive though non-specific assessment of sleepiness.

Interventions

Behaviour and lifestyle modification—Encourage him to lose weight and to stop smoking (smoking worsens snoring). He should omit sedative drugs and reduce his alcohol intake. Suggest earplugs for his wife, and if the snoring is postural he could try "postural training": pillows or specific products (modern variants of the "tennis ball in a sock sewn to the back of a pyjama shirt") are effective for some people.

Possible medical interventions—Treat any nasal congestion with decongestant and steroid nasal sprays. If this proves unhelpful consider getting an opinion from an ear, nose, and throat specialist. If he has very large tonsils, and especially if he has few typical risks for snoring (such as a high BMI), tonsillectomy may cure the snoring. Other available surgical procedures are uvulopalatopharyngoplasty and radiofrequency stiffening of the soft palate. These require specialist consultation. The long term success does not always match the often excellent initial result.

Further assessment—Consider thyroid function tests. Also, if you think he may have "obstructive sleep apnoea syndrome" (combination of obstructive sleep apnoea and excessive daytime sleepiness), refer him to a sleep unit for overnight assessment and possible treatment with continuous positive airway pressure. In most areas this is done by respiratory physicians. If his dentition is adequate then a mandibular advancement device can help snoring and mild obstructive sleep apnoea; this is best assessed by a dentist or oral surgeon.



The Epworth sleepiness scale is on bmj.com

This is part of a series of occasional articles on common problems in primary care

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