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NEWS AND NOTES

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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Snoring and its treatment

SIR,—Dr Sheila Jennett (11 August, p 335) ignores recent surgical advances in treating snoring. She states that tracheostomy is the only reliably successful treatment for the obstructive sleep apnoea syndrome and that a permanent tracheostomy is socially embarrassing. Her alternative, continuous positive airway pressure applied through the nose, is not without social inconvenience or indeed expense —especially if prescribed to recalcitrant snorers without important apnoea.

Dr Jennett's rationale of treatment is essentially correct in that any obvious obstruction to breathing should be cleared, and two factors are of paramount importance. Firstly, in patients with mild sleep apnoea the obstructive elements in the nose, nasopharynx, oropharynx, or larynx need not be that "obvious." Secondly, what might seem "obvious" to an otolaryngologist need not be so to another doctor unaccustomed to examining the upper airway.

The functional disorder of the oropharynx alluded to by Dr Jennett has been shown to be associated with narrow pharyngeal dimensions in over 90% of cases.[1] It was this fact which stimulated the development of palatopharyngoplasty.[2] The role of this procedure in managing snoring and the sleep apnoea syndrome is becoming apparent. Snoring can be either eliminated or at least made socially acceptable to bed partners in at least 90% of cases by this procedure. The operation, although not as fail safe as a tracheostomy, may cure some patients with apnoea and certainly alleviates day time somnolence in those in whom it is unsuccessful. Thus the two main presenting symptoms—snoring and somnolence—can be eliminated in 85-90% of cases.[3]

My experience in performing this operation confirms the potential of palatopharyngoplasty in the short term. The operation is not difficult to perform and requires the patient to be in hospital for only 24 hours. Permanent complications—most commonly nasal regurgitance and hypernasal speech—are rare and usually follow overenthusiastic removal of pharyngeal soft tissue.

Palatopharyngoplasty should be offered as first line treatment in all but very severe cases of apnoea. In these it could be used in conjunction with a tracheostomy which might later become redundant. As yet the long term results of this operation are not known, and all those managing these patients should document their results carefully with both short and long term sleep studies.

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1 Ikematsu T. Study of snoring, 4th report: therapy. *Japanese Journal of Otorhinolaryngology* 1964;**64**: 434-5.
2 Fujita AS, Conway W, Zorick F, *et al.* Surgical corrections of anatomic abnormalities in obstructive sleep apnoea syndrome: uvulopalatopharyngoplasty. *Otolaryngol Head Neck Surg* 1981;**89**:923-34.
3 Simmons FB, Guilleminault C, Silvestri R. Snoring, and some obstructive sleep apnoea, can be cured by oropharyngeal surgery. *Arch Otolaryngol* 1983;**109**: 503-7.

SIR,—The implication of Dr Sheila Jennett's leading article is that nasal continuous positive airway pressure is the only alternative to tracheostomy in the treatment of the obstructive sleep apnoea syndrome in the adult. I suggest, however, that the operation of uvulopalatopharyngoplasty is a further option.[1]

Ikematsu investigated habitual snorers and found that the size and shape of the uvula, the excessive pillar mucosa of the pharynx, and the base of the tongue all narrow the potential space of the oropharynx.[2] He believed that this oropharyngeal narrowing was responsible for the snoring in most of his cases.

On the basis of these findings uvulopalatopharyngoplasty was developed for treating the obstructive sleep apnoea syndrome. The objective of the procedure is to reduce the degree of pharyngeal obstruction that occurs during the apnoeic period. By removing the redundant tissue but still preserving the muscular layer, the surgeon can enlarge the potential air space in the oropharynx. Experience has been confined mainly to the USA and the results indicate it can offer most patients an appreciable improvement in symptoms.[1] Otolaryngologists in this country are becoming increasingly aware of this surgical option. In suitably selected cases it would seem a reasonable alternative to a lifetime of nasal continuous positive airway pressure.

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