Howard Farran: Hey, I have a, for me personally this is going to be an extremely interesting hour with Kent Smith, who is absolutely one of the leaders in this new exploding field of sleep medicine or obstructive sleep, so what do you call it?

Kent Smith: Well, dental sleep medicine.

Howard Farran: Dental sleep medicine.

Kent Smith: Right.

Howard Farran: And basically I just last Tuesday, I have been reading all about this. It is kind of funny, because when I got out of school in '87, they never mentioned it one time in four years I was in school. When you got out of Baylor in '85, did you have any formal curriculum on sleep medicine?

Kent Smith: No, the last statistics we read about dental school having any education in sleep was I think 2.54 hours on average, so at least there is some going on now, but there was certainly nothing in the 80s.

Howard Farran: Right. And so I assume there were no sleep disorders back in the 80s. So something must have changed. I mean, this is on everybody's mind because basically you just are seeing information all of the time that if you are not sleeping right, this is going to cause a whole host of problems. And I started reading more and more and more and more and it is hard for me to tell if I have a sleep problem because number one, if you get up every morning at 5 and go to bed every night at 11, I mean, that might be a reason why you are tired or falling asleep or whatever. So let's start with this, Kent. What percent of doctors do you think know what is going on in dental sleep medicine?

Kent Smith: Well, are you talking about dentists or physicians?

Howard Farran: Dentists.

Kent Smith: Okay, dentists, I mean I think you have got maybe 10% of dentists that have had some type of training in this, whether that is a webinar or a one-day course or two-day course. So I think it could be as high as that. But most dentists I know after they do a seminar, they figure out that this is maybe a little more complicated than they thought, because it has to do with medical billing and that is totally different than what we have been doing for years as dentists. We don't medically bill, we dental bill.

Howard Farran: I am just going to start with the question, you know, I like to play devil's advocate. I have lectured to these dentists all over. I talk to them all day long on DentalTown. I know the first thing you are going to say. Kent, dude. I deal with toothaches and fillings and crowns. I am a busy man. I am a dentist. Why should I learn about sleep medicine? That is not what I do. Why should they?

Kent Smith: Well, there are various reasons why you might want to. First of all, physicians aren't screening for it. You know how healthcare is these days. I mean, you never see the physician, you see the PA. And so all they have time to do is screen for diabetes and high blood pressure. They don't ever ask how you are sleeping. So we have got patients in the chair for an average of an hour. It is not

difficult. We are looking in the back of the throat even. We are looking in the mouth and three-fourths of the problem is in the back of the throat. So I think that we are the best gatekeepers for this. So I think we are going to get more patients screened for this than physicians will. And then if you want to look at it from a financial perspective, certainly they can make money from treating these patients, but it really depends on why you want to get into it.

Howard Farran: Yeah. Well, I hope they want to get into it just because we are physicians of the mouth. We are not mechanics, we are not structural engineers. We are not designing a bridge. We hope that you are going to live longer and have longer, happier, healthy quality of life issues because I am a part of your world. You know, I am your dentist. And so basically in a nutshell, I think that dentists should also look at themselves first, their family, their loved ones. They are sleeping next to a spouse. Let's go to the basics. How does a person know if they have got sleep apnea?

Kent Smith: Well, the only way, you are going to hear a lot and maybe on DentalTown you probably hear a lot of things about ways to sort of screen for it. And there are ways to screen, but the only way you are going to know is to have that sleep study done, like you just had the other night.

Howard Farran: Okay, but let's assume a dentist has a spouse and 2.8 children and a mom and dad, some siblings, and he is looking at his loved ones and he knows that if they have sleep apnea – well first of all just start – undiagnosed sleep apnea, what can that do to a human?

Kent Smith: Well, it can certainly raise your risk factors for many things, hypertension, heart disease is the primary thing that we look at.

Howard Farran: And isn't that still the number one killer in America, more than cancer?

Kent Smith: Yes it is, more than cancer, right.

Howard Farran: And this raises your risk of heart disease.

Kent Smith: Yes, it does. It raises your risk for diabetes, for depression, for acid reflux. There are three studies in the last couple of year that it even raises your risk for cancer. So there are very few diseases that can't be either brought on or exacerbated by not getting enough oxygen during sleep.

Howard Farran: So what are some low-hanging fruit, okay, so you are saying and I agree and I just did a sleep study myself, I won't know the results for seven to ten days. But what are some low-hanging fruit issues that you have become aware of that makes you think you should turn to family, a loved one, a patient and say, "You need a sleep study."

Kent Smith: Well, the bed partner is not the best diagnostician I am afraid. However, there is something called…

Howard Farran: Good, because mine is a cat and it is hard to have a deep conversation with your cat.

Kent Smith: Right. So are you talking about the person living by themselves in other words?

Howard Farran: No, I am just talking about what are some low-hanging fruit signs that when you are having a conversation with someone you should say, "Kent, maybe you should go get a sleep study."?

Kent Smith: Well, if they are fatigued and sleepy, tired, if they have seven and a half hours of sleep, you know, not your six hours. But if they have had seven and a half hours and they are still sleepy, they still feel like they have to take a nap, they are fatigued, they fall asleep at stop lights. If they have been told that they snore, and certainly there is something called an elbow study that just came out. And if you have been elbowed because of gasping in your sleep, there is a 96% chance that you have sleep apnea. So if you have got a bed partner and they have said that they have heard you gasping, really good chance you have got it.

Howard Farran: Yeah, Bruce Baird who no one would think this guy was low on energy. You would think he is just a maniac and he was saying, "You know, I went to Sonic Drive-In and I would order a hamburger and when they came to the car, I was asleep." And you said falling asleep at a red light, nodding off during the day. But what do you say to the dentist who the assistant will come back there and they will numb up a patient and they will come back and say, "Okay, we are ready to go," and they are sawing logs in their chair and they had seven and a half hours of sleep?

Kent Smith: Yeah, and they had enough sleep, then hey, it might be time to get you into a sleep study. That is why we have, but most people won't go for a sleep study at a sleep center. I mean, it probably took you awhile to finally agree to go to a sleep study, right?

Howard Farran: Two years.

Kent Smith: Okay, so if you had a home study, one that you could take to your house and do in your own bed, you probably would have done it a little bit quicker.

Howard Farran: Okay, so let's stop right there. Because I see advertisements for dentists to buy devices to send home with their patient to hook up. Talk about the difference between a dentist buying a machine and name names so they have an action plan and what is the difference between those verses going to where I did where they hooked up, she told me, I said, "How many things are going to be hooked up to me?" She said, "I am hooking 28 leads up to you." So what is the difference?

Kent Smith: Yeah, you don't get that many on the home ambulatory studies. We will just call them HST, home sleep tests, alright? So the HST, these are being given out at sleep labs, too. Did the sleep lab you went to offer a home sleep test to you?

Howard Farran: No.

Kent Smith: Okay, what they will do typically, that is the way the industry is going. You know, these insurance companies, they are wanting to save money any way they can. And when you have to pay somebody to attend your study to watch you sleep, that is losing money from the insurance company's perspective. So the technology is there for these HSTs and they are paying for those. Now most companies are saying, "Listen, you have to be a certain amount of sick in order to even be able to have

an attended sleep study. Unless you are, if you just have maybe one sign or symptom, then we are only going to pay for HST." Of course, it depends on the insurance company.

Howard Farran: My insurance company gave me a free coupon to go to the vet and be put down.

Kent Smith: I hope you didn't take that.

Howard Farran: So on these HSTs, do you recommend a dentist buying these to send home with patients to hook themselves up as a screening device?

Kent Smith: Well, I think they are going to treat and get a lot more patients at least screened if not treated if they do have the accessibility of an HST in their office. Now you don't have to buy one. I mean, obviously you have options. I have 16 in my office. So I have got those plus several pulse oximeters, so no one gets out of my office without being screened.

Howard Farran: So name a brand. And what does something like this cost and what would you recommend and a website?

Kent Smith: Well, you are going to spend somewhere between $1,500 and $5,000 for a home sleep test monitor, okay? So my favorite one is the WatchPAT, that is going to go about $5,000. It measures a lot of different…

Howard Farran: Watch pad?

Kent Smith: WatchPAT.

Howard Farran: WatchPAT, W-A-T-C-H-P-A-T.com?

Kent Smith: No, it is Itamar, I-T-A-M-A-R is the company.

Howard Farran: I-T-A-M-A-R.com. That is the website. And they sell a WatchPAT.

Kent Smith: Correct. Right.

Howard Farran: And what does PAT mean? I know what watching is.

Kent Smith: Peripheral arterial tonometry, and that is just the way that they do the study. It is something, a probe, that you put on your finger and once you put the probe on the finger it is just magic. It figures out if you stop breathing or not. They don't have that nose cannula that you got stuck up your nose. You had several things stuck up your nose, right?

Howard Farran: Yeah.

Kent Smith: The WatchPAT is the only one that allows you not to stick something up your nose and still gets you diagnosed.

Howard Farran: And she also, I do want to say for the record, she did tell me that for a sleep study, I had her favorite haircut in the whole world. She just glued all of these things to my head. She said she wished everyone was bald.

Kent Smith: Oh yeah.

Howard Farran: So WatchPAT. Are there any other brands?

Kent Smith: Oh yeah, there are other ones. Sure.

Howard Farran: Give us some more. So that is the, you said they are $1,500 to $5,000, that is the $5,000 Cadillac, Mercedes-Benz, that is the best of the field?

Kent Smith: That is right.

Howard Farran: And what are some other ones?

Kent Smith: Okay, you have got the ApneaLink. ApneaLink, okay that is by the company ResMed, R-E-S-M-E-D. Now ResMed makes CPAPs, but they have also decided, you know this is the way things are going. We are going to not only make a monitor that you can take home, we are going to make our own dental appliance. So ResMed has really hopped into this field and they have made some pretty good equipment. So the ApneaLink is really good. The ApneaLink Air is the newest version of that.

Howard Farran: So you are saying I could buy a device to send home and screen the patient.

Kent Smith: Right.

Howard Farran: And then if they needed a CPAP, then I would take impressions to send to them?

Kent Smith: No, not for a CPAP. For that CPAP machine, and depending on what you find out from your study, they may or may not say, "Listen Howard, you have got to come back for another study to have this CPAP machine put on so that we can find out the right pressure for you." And they will prescribe you a CPAP at this specific pressure.

Howard Farran: Okay, now I want to stop right there, because I had a dentist tell – when I told them I was doing a sleep study telling my friends – I had two dentists say to me, "I wouldn't want the sleep study, because I probably would have to wear a CPAP and I am just not going to sleep with one." But then I have another very good friend, one of my best friends, said that CPAPs have just gotten smaller and smaller and smaller. And then we were doing a missionary dental trip together and that was the first time I had ever seen a human sleep with one. Gosh, it was just a little box. It was just a little purr. So they have gone from like a gas mask and a land mine to small. In fact, I have also heard that now there are some that just go up your nose. They don't even cover your mouth. Is that true?

Kent Smith: That is true, they are just nasal cannulas. Now you have to be able to, and usually if you go back for the CPAP titration study, which they may ask you to do, they will try different masks on you. They will try the nasal cannula, they will try a mask that just fits over your nose. They will try a mask

that fits over your whole face, nose, mouth, you know, not your eyes, but they call it a full-face mask. So they will try different versions of the mask, and really it is just depending on the pressure. The worse your apnea is, the further they have got to crank up the pressure. And the higher the pressure, the more difficult it is to create a seal so that you don't get venting of air leaking and venting out of your mouth.

Howard Farran: So is this kind of drifted into, okay well let's go back. You said just a few minutes ago that sleep apnea begins in the back of your mouth. And back in the day when it started coming out, I don't know what year this was, it was early 90s. Some of the ENTs were taking carbon dioxide lasers and Roto-rootering out the back of the throat just to blow it open.

Kent Smith: Right.

Howard Farran: Do you remember those days?

Kent Smith: Oh yeah. That was a UPPP and that was supposed to cure apnea. When it first came out, they really thought that was going to fix everything. And not so much.

Howard Farran: And why did that not work? Did it just not increase the oxygen rate in the blood? And I also heard complaints by one of my patients that he thought he lost a lot of his sense of taste and smell. Did you ever hear that?

Kent Smith: Well, not taste and smell. I mean, a lot of that comes from the tongue and from the nose. You do remove the uvula, any tonsillar tissue and part of the soft palate back there. It is a Roto-rooter, like you said, to the back of the throat. You always have a chance on having a drink of water and it comes out your nose. I mean, you have got to learn a new way of swallowing. It is very painful, the recovery takes quite a while, and all of the studies show that it is not as effective as either CPAP or an oral appliance. There is redundancy tissue that regrows and it doesn't do anything about the tongue, and the tongue falls back against the back of the throat even though you have removed all of that excess tissue.

Howard Farran: And is it also safe to say Kent, is it accurate to say that sleep apnea increases as you get older and older and older?

Kent Smith: Oh yes.

Howard Farran: So me at 52 today is going to have a lot more than my son who is 22?

Kent Smith: That is exactly right, unless he weighs a lot more than you do.

Howard Farran: And that is because the muscles are getting old and flaccid and just can't keep everything away from my trachea, is that basically what it is?

Kent Smith: That is exactly what is going on. And your nerve system has slowed down, the genioglossus nerve that tells your tongue to get out of the way. That nerve has slowed down so it doesn't stimulate the tongue to get out of the way of the airway as fast. So yeah, there are several things. You even get

bony changes as we get older. So there are several reasons why, and there is no question. I mean, 50% of people over 65 have apnea.

Howard Farran: 50% of people over age what?

Kent Smith: 65.

Howard Farran: So half. So you could basically run a query on your patient charts and say the average dentist has got 5,000 patients, you could run a query and say, okay 1,000 of these are 65. Then you are saying 500 of them have sleep apnea.

Kent Smith: Sure, and 20% of your patients of any age, all ages have sleep apnea.

Howard Farran: So one in five. So you have got 5,000 patients, you have got 1,000 that have it at the minimum.

Kent Smith: That is exactly right. And only about 10% to 15% even know that they have it.

Howard Farran: Okay, so you have listed two machines, WatchPAT and ApneaLink. Are there any others you want to mention?

Kent Smith: Sure, there is the Braebon. B-R-A-E-B-O-N. And they make the MediByte. M-E-D-I-B-Y-T-E. That is another really good, and that is probably about $3,000 or $4,000. The ApneaLink is about $3,000. So those are sort of mid-range. The ResMed is a little more complicated to put on, I mean the MediByte is a little more complicated. These apneic patients, when they go to sleep or when they are ready to go to bed, you know, they are not thinking clearly. They are a little foggy minded. So if it is too complicated, they are going to screw the study up. So you need to marry simplicity with accuracy and so it is really difficult. It would be great if we could have 28 leads on these patients at home. But there is no way they are going to do that. So that is another reason I like the WatchPAT. It is fairly simple. The Ares is another simple machine, A-R-E-S. Those are probably the four most common monitors out there.

Howard Farran: Okay, so we have established that the laser carbon dioxide Roto-rooter is out, 20% of your patients have this. So now help me, okay so I have got one of these five screening devices. Okay, so if you are saying 20% of my patients have this, what should I be looking at? Do you have a screening deal?

Kent Smith: Oh yeah.

Howard Farran: Do you ask your patients to fill out this checklist? What should I be looking at? What should I be talking about to a patient?

Kent Smith: Okay, well there are a couple of…

Howard Farran: To warrant them when to take home a machine.

Kent Smith: Right. So there are a couple of options there. First of all, I suggest on your new patients form or maybe on your health history update, ask them if they snore or have they been told they snore. Alright, that has to be done. Another question is…

Howard Farran: So do all sleep apnea people snore?

Kent Smith: No, but the vast majority. I would say 95% of them. There is something called central sleep apnea and there is something called silent apnea. So sometimes they don't, but snoring is by far the biggest indicator.

Howard Farran: Do all snorers have sleep apnea?

Kent Smith: No, but a high percentage, 70% to 80% of them do, the chronic snorers.

Howard Farran: So snoring is a good screen.

Kent Smith: Oh yeah.

Howard Farran: And everybody knows at Thanksgiving that your Uncle Charlie is out there, he sounds like a train in the kitchen and then you turn to Aunt Betty and say, "Do you sleep next to that at night?" And she says, "I spend half of my night on the couch." So just a simple question, do you snore.

Kent Smith: Boy, that is the easiest. But most men will say, see they have never heard themselves. So they will just say no. They have never heard themselves. So I always ask them, has anyone ever told you that you snore. And then they have got to tell the truth.

Howard Farran: Okay, but what do you say to them when the person says, "Yeah, I snore, but I know why. On the nights I eat a big meal and have a few drinks before I go to bed, yeah that is why I snore. I don't have a disease, I am just dumb and I just ate a big old dinner and had a couple of drinks and went to bed. But if I wasn't doing that, I didn't have sleep apnea." So how do you separate that thought?

Kent Smith: Well, and that is a good point, if they only snore when they have had alcohol or they are overly fatigued, then they probably don't have sleep apnea. But the only one that is going to be honest with you is the bed partner. So you have got to interview the bed partner if you are going to find out if they really do snore all of the time, because again, they very rarely. I just had a husband and wife coming through hygiene, new patients. The wife, I am talking to the hygienist. The patient says, "You have got to talk to my husband. He has got a problem. I have been talking to him for years, it is terrible. He has got sleep apnea, I know it." The other hygienist that was cleaning the husband's teeth, she came to me and said, "Listen, he doesn't want you to come in the room at all. He doesn't want to discuss this. He said that is great that we have home monitors. He said that is great for somebody else, but I don't have a problem." So it is really difficult to convince some men that they have a problem. And I understand that, because I am one of them.

Howard Farran: One of them what?

Kent Smith: I am one of them men that doesn't want to ever admit to any health problems.

Howard Farran: Yeah. Okay, so you talked about snoring. What are other signs? I am trying to focus on what dentists should be talking about and looking about to warrant you taking home this machine and a home test.

Kent Smith: Alright, so there is something called the Epworth Sleepiness Scale, you probably filled this out when you went to the sleep center. It is a ubiquitous question and answer where it asks you have you ever fallen asleep at a stop light, have you ever fallen asleep watching TV, when you lie down to take a nap in the afternoon, are you more likely to go to sleep or not. I mean, do you remember taking that test?

Howard Farran: Yes.

Kent Smith: Yeah, that is the Epworth Sleepiness.

Howard Farran: Could you post that on DentalTown?

Kent Smith: Of course, yeah. So that is something that we give to every single patient that comes in. Now there is also a STOP-BANG questionnaire. Now this takes a little bit more effort and the patient can't fill all of this out, but it is something that is fairly definitive, about an 86% specificity when they score high enough. So STOP-BANG stands for snoring, snoring is the S, tiredness is the T, observed apneas is the O, P stands for blood pressure. Now that is the STOP. And then the BANG, B is for body mass index, so are they obese, age and that is if you are 50 or older then you are more likely to have it, neck circumference for a man is 17 inches or more and then the last one is age. I'm sorry, the last one is gender, BANG, gender. So if you are male, you are more likely to have it. It is about a four to one ration of men to women.

Howard Farran: And why would that be?

Kent Smith: Well, I think it is because we have got a longer airway, a longer trachea, so it takes more effort to get air down the air passage. And we have got fatter necks, we have got more tissue in the back of the throat, hormone differences. I mean, there are different theories as to why men do. I used to argue this, because I could have sworn that with my patient population I had about equal men and women that I was treating. I ran the data, and this is why running data is important, 3.7 to 1 in my own practice. So I said, "Okay, yeah. I guess you are right."

Howard Farran: Yeah, and that is weird. Almost 100% of the time any dentist has ever just gone ballistic about Delta Dental and I am in their office, "Well, let me see the claim." It is almost always another insurance company. I am like, so the receptionist, if the insurance doesn't pay, the first thing their mind grabs is Delta and they deal with 300 different insurance companies. And it is usually not the big sophisticated ones, it is a lot of the little crazier ones.

Kent Smith: Right.

Howard Farran: Okay, so give me more things to be looking for.

Kent Smith: Alright, there is something called the cricomental scoring. And there are three parts to this. If you have got this turkey waddle, you have got this thing that hangs down here, alright.

Howard Farran: Do I have it?

Kent Smith: Uh, yeah you got it.

Howard Farran: I got it, okay.

Kent Smith: Well you draw a line from the inner mentum right here to the cricoid cartilage, which is right above the, well that cricoid cartilage right there, the Adam's apple. So if you draw an invisible line from that to that if you are looking from the side and then if there is not much room from that line to the nape of the neck, yeah if it is kind of a straight line that means that you are more likely to have it. That is number one. There are three parts of this.

Howard Farran: So I do have that?

Kent Smith: Yeah, you do have that. Okay, number two, do you have an overbite. Do your upper teeth cover at least 50% of the lower teeth? It doesn't look like it. A little hard to tell for sure, but do you think you cover up more than 50%? Do you have that much of an overbite?

Howard Farran: You know, it's funny. Even though I look like Brad Pitt, I never look at myself in the mirror. I don't know what that is.

Kent Smith: Okay, and then the third part is when you look at the back of the throat there is something called the pharyngeal grade and most dentists, or most people, have never looked at the back of their throat. They couldn't draw a picture of it, they don't have a clue.

Howard Farran: I haven't.

Kent Smith: Right. So you look at the back of your throat and the walls on the side, you know, they are going to close in like this. I call them the curtains and these are the horizontal curtains. If they are about halfway closed, that is a pharyngeal grade. It is called the pharyngeal grade. If that is a pharyngeal grade of three, you fall into the formula. So if you have got a closed curtain, halfway closed, if you have got an overbite and if you have got this turkey waddle, 95% chance you have apnea.

Howard Farran: Yeah, and you know what? I was talking to Jen Butler earlier and she was saying that, you know, when dentists are low-energy, I never thought of this connection. When dentists are tired and exhausted and low-energy, they just watch instead of saying, "Yeah, it is a cavity. I call pull it over right now and fix the filling." It is an emergency and they just say, "Here are some antibiotics," or refer them to an endodontist. And so I think the first thing I would think, when you said these machines are $5,000 I just thought, you know what, if you were going into work and you weren't tired and you woke up fresh and you were ready for the day, you would probably do $5,000 more of dentistry the first week.

Kent Smith: That is right, yeah.

Howard Farran: I bet your return on investment on this machine for the dentist is probably a week. Now again I am thinking of myself, so I am thinking of dentists who are 50-year-old men and you say men four to one over women and over 50. So if you are a man and you are over 50, what percent of the dentists that are male over 50 do you think probably have sleep apnea undiagnosed and untreated?

Kent Smith: You know, I would say it is probably 30% to 40%.

Howard Farran: Yeah, so 30% to 40% of the dentists should just buy this machine to find out if they have it. And my best friend that I went all the way from college and is a dentist up the street, I mean, he got this thing and he just feels like a new kid.

Kent Smith: Oh, yeah.

Howard Farran: I mean, he just feels, I mean he is just the biggest cheerleader. That is what I find. I have been listening to him yack at my ear for two years and finally it was like, okay, I am going to go do this. Because he wouldn't live without it. He said the first night he slept with it, he felt five years younger. After one night.

Kent Smith: I know, I hear stories like this all of the time. And you know, we have degraded so, by the time we are over 50 we have slowly degraded our energy level and we think this is the new norm. You know, this is how we should feel. But in reality, we could feel a whole lot better, have a lot more energy, and like you said, do a lot more dentistry if you want to. You would easily pay for this. I mean, I wouldn't have so many monitors as I do if I didn't pay for these. You used to, insurance wouldn't even cover doing these studies. Now medical insurance helps us cover these, so we even get reimbursed for them.

Howard Farran: So are there other symptoms? I mean waking up tired, do you think the people that wake up who always say, "Oh my God, I have to have my coffee first thing in the morning." Do you think the people who wake up who have to have two or three cups of coffee, they might have sleep apnea? I mean, should you need a bunch of stimulants the minute you wake up to deal with life?

Kent Smith: Certainly not, not unless you have some kind of a sleep disorder. You could have other things going on, it might not be sleep apnea. But there is something amiss in your sleep that is causing you to be sleepy, assuming you had seven and a half hours, which is average. You know, one percent of the population are short sleepers. They can sleep for five hours and still be physically okay. But that is one percent, and if you are not one of those one percenters, you need seven and a half hours.

Howard Farran: Okay. And is there also too much sleep? Some people say that if you are sleeping over nine, what does that mean if you are sleeping nine or ten?

Kent Smith: Well, mortality morbidities go up for nine hours or more. I mean, you are more likely to have all kinds of problems. You are more likely to die early if you sleep too many hours.

Howard Farran: And is that because the people who sleep nine or ten hours aren't really sleeping? Or can you have healthy, deep, stage three deep sleep and do it for nine or ten hours and that is bad too?

Kent Smith: Well, they have teased out the data and they have said that even if you are sleeping efficiently, if you have nine hours or more, your mortality is going to go up. But I think yes, generally…

Howard Farran: Why would that be?

Kent Smith: Well, they really haven't figured that out yet. I mean, there are several different studies. They always show the same thing, but they haven't put two and two together yet to tell us exactly why that is.

Howard Farran: And that is a sign of a genius man. Not very many people say I don't know. And that is often times the right answer and I applaud you for that. You just don't know. So we have gone half, we have gone 30 minutes. We have talked about things to look for. We have talked about machines for self-diagnosing. So now this patient comes back with their home sleep test, whatever brand it might have been, so what is going to happen? I am going to get a report? I plug this into my computer? Walk through a dentist who doesn't own one of these. What happens when they bring it back in the morning?

Kent Smith: Okay, so they have got a few options. Yes, some of them allow immediate upload and within five minutes you can go over the data with your patient. Some of them require that you upload it and you have a physician somewhere up in the cloud read the study and get a diagnosis for you. Most of them do allow, the ones I mentioned, you can upload and you can look at the data and you can tell the patient immediately what they have got. Now we can't, as dentists, we can't diagnose sleep apnea. You know, just like we can't diagnose hypertension. We can say their blood pressure is high, but we can't diagnose hypertension. Same thing with sleep apnea. It doesn't really prevent me from saying those words, but still we are not supposed to diagnose it. But the data is pretty clear. So with this data we then have to decide, alright are you mild or moderate, and that means you stop breathing, these events need to last ten seconds. If you stop breathing ten seconds or more five times per hour, you have mild apnea. If you stop breathing 15 times per hour, you have moderate apnea, 30 times or more, you have severe.

Howard Farran: That doesn't even sound logical, that a person could stop breathing 30 times for ten seconds an hour. I mean, that is half, 30 minutes of not breathing per hour.

Kent Smith: Well, no that is every two minutes you stop breathing one time for at least ten seconds, 30 times per hour. That is a lot.

Howard Farran: Okay, 30 times per hour times ten seconds, how many minutes is that?

Kent Smith: Three minutes, so three minutes of not breathing. But those ten seconds events, that is minimum. When you look at the overall events, they average out about 20 seconds.

Howard Farran: Okay, so the average event would be for severe, six minutes out of sixty minutes they are not even breathing.

Kent Smith: Right.

Howard Farran: Wow, and you can't even go six minutes, you can only go five minutes without oxygen and you are dead, you can only go a week without water and you are dead and you can only go a month without food. So yeah, you just can't be in recovery mode and getting restful sleep. So should mild be treated?

Kent Smith: Yeah, oddly enough that you ask that. That is something that is debated a lot in the world of sleep. But I think you will find probably 80% of the sleep physicians side on the side of, yeah, we should still treat mild apnea.

Howard Farran: Okay, so now let's go into treatment.

Kent Smith: Okay.

Howard Farran: So CPAP, is CPAP more severe and not moderate? Let's talk about this, we are half through this. What is the difference between treating this with a CPAP versus the dentist?

Kent Smith: Okay, the CPAP, first of all the dentist can't prescribe a CPAP, but a CPAP, we send a patient. If they are severe, we really should be referring them to the physician for a CPAP. Ideally, that is what they should try first. Because the studies show CPAP is more effective, it is certainly more likely to cure your apnea, not cure it, but certainly control it if you have got a CPAP machine.

Howard Farran: Now, have you ever slept with one on?

Kent Smith: No, I haven't.

Howard Farran: You haven't ever gone to bed with it, so you can't really have the empathy or sympathy of that. Okay, I am going to challenge you. I am going to challenge my brother. You have got to promise me, next time we talk, you have slept with it for one night just to see what that was like.

Kent Smith: You know, I should do that, you are right. It is like sticking your head out the car window at 70 miles an hour, opening your mouth and just doing that all night long. I mean, if the pressure is up to say 14 and depending on your level of apnea, that pressure is going to increase. So it is difficult, that is why about 50%, every study that has been done says about 50% of these patients are noncompliant. So that is the low-hanging fruit.

Howard Farran: So it was the 50% noncompliant that kind of started moving these people into the dental world, because they are saying, okay, the physician is saying wearing a CPAP and half of their patients are saying they ain't wearing it. So that is why dentists started saying, "Well, maybe there is something we can do." Is that correct?

Kent Smith: You got it, that is correct.

Howard Farran: Okay, so what, a retainer can't build positive air pressure. What is the dentist doing?

Kent Smith: Well, you know, the appliance just holds the mandible or brings the mandible forward, which drags the tongue with it. So you are opening, again you are bringing the base of the tongue forward opening up the space behind the tongue.

Howard Farran: And how far are you talking about bringing the lower mandible forward?

Kent Smith: Well, that depends on the level of apnea. Sort of like the pressure with the CPAP, same thing. We are calibrating our appliance forward depending on the level of apnea and depending on how much of the obstruction is due to the base of the tongue. We generally start out somebody with mild apnea at about say 50% of their maximum protrusion. So if you will thrust your chin as far forward as you can get it and then back up 50%, usually if you have Class I occlusion, you will put your lower incisors just a little behind the upper incisors, that is about 50%.

Howard Farran: And that is enough to make a difference in the airway?

Kent Smith: Yes it is.

Howard Farran: Now is this just a retainer on the lower or a retainer on the upper or is this one piece that fits in the upper and lower?

Kent Smith: Yeah, it is going to depend on the appliance that is used. Almost, probably 90% of them have a component on the upper and the lower. They are connected in some way, which helps keep the mandible forward. It is difficult to keep the mandible forward unless you are using the maxilla. And then there are all kinds of designs. There are winged designs, there are strap designs, there are designs in the front where it is connected, like a TAP appliance. There are really all kinds of designs and some are easier to wear than others depending on the patient.

Howard Farran: So you are moving the mandible forward. Are you also opening, separating the jaws? Are you also opening the bite?

Kent Smith: Yeah, you have got to, because you have got plastic between the teeth. So you are naturally doing that. They have been trying to do studies on vertical changes and does the vertical make any difference in opening the airway. No studies have shown that it helps. So we try to minimize the vertical opening for the comfort of the patient, because if you can still get your lips together, you are less likely to mouth breath with these appliances.

Howard Farran: And so if they have severe or whatever, to go the physician and they get a CPAP. If they are noncompliant and now they are at the dental office, so the half that is noncompliant, let's say the half that is noncompliant is 100 people. How many of them would comply with this dental device?

Kent Smith: Well, compliance is certainly a whole lot better. Statistics run somewhere between 70% and 85% compliance with oral appliances. So better than 50%, not perfect. I wish it was. But you will find every physician and every dentist and I am one of them. You know, a physician would say, a sleep physician would say, "Listen, I know what the statistics say, but my patients, 95% of them are compliant." Unfortunately, they don't follow up like dentists do. They have no follow up protocol, so

they really don't know. These patients are embarrassed to tell the sleep physician they are not wearing it. They just put it in the closet and don't tell them.

Howard Farran: So 95% of American wouldn't even agree that today is Friday.

Kent Smith: So I don't know how they come up with those statistics. You know, I want to believe that my statistics are better than 70% to 85%, but I am sure I also have patients that just don't want to tell me they are not wearing them. Now, we do have follow up.

Howard Farran: So are you making these retainers, or are you sending them to a lab? Where would a dentist send these? You are taking upper and lower polyvinyl, polyether?

Kent Smith: Polyvinyl.

Howard Farran: You are taking polyvinyl?

Kent Smith: Right.

Howard Farran: And I believe the last number I heard is there are 6,000 crown and bridge labs in America. Are they all making these or is it just a few people making them? Who knows how to make these? Who knows what they are doing and how to make these?

Kent Smith: Well, it depends on which appliance you are talking about. For example, the SomnoDent made by SomnoMed, for years they would only make it in their own facility. Okay, now they have allowed about four or five other companies to make it for them, but they have to go through very stringent training to be able to make them. You have got appliances like the TAP appliance, there are probably 300 labs in the U.S. that make a TAP appliance, because it is easier to make, the TAP Company just mails out the components to it, the metal components, and it is pretty easy to make. And then you have got like the Suad appliance, only one company makes the Suad, Strong Dental. You have got the Oasis appliance and there may be five or six labs that make the Oasis. So really it depends on which appliance and how difficult it is to make.

Howard Farran: Let's go from doctor centered on what is easier to make from patient centered. Are you seeing any difference in compliance with these different types of retainers? Do patients generally like some of these more than other ones, take the doctor out of the equation?

Kent Smith: Yeah, I can tell you my personal experience, but that won't necessarily mirror a different sleep dentist that you might talk to. So, you know, I am going to certainly preface it with that.

Howard Farran: But let me interrupt you on that to the viewers, this guy is the man in sleep medicine. So I personally wouldn't care what 99% of the dentists thought if it disagreed with you, and I mean that sincerely.

Kent Smith: Alright, well thank you. Alright, so…

Howard Farran: And any dentist that has got 16 home testing devices in his office, you know he is a freak when it comes to dental sleep medicine. You eat, breath, live and die this stuff.

Kent Smith: I do.

Howard Farran: So what appliances are you liking? I'm sorry, the patients liking, higher compliance.

Kent Smith: The patients liking, right. Because, essentially they do the same thing. So we just have to find something that is going to be as comfortable as possible that the patient is going to wear. Believe me, I don't want patients coming back saying, "Listen, this was too painful. I can't wear this thing." So I want them to wear the appliance. I have used several for many years, I have been doing this for about 20 years. And I was using various appliances until SomnoMed came along and invented the SomnoDent appliance. So that became my favorite about eight years ago. And I have been pretty much a big SomnoDent fan. Now, there are several other companies that make these winged appliances. I haven't made many of those, so I don't have a lot of experience with other companies. So they could be just as comfortable.

Howard Farran: You are saying somnimed.com, S-O-M-N-I-M-E-D?

Kent Smith: S-O-M-N-O-M-E-D.

Howard Farran: And that is .com?

Kent Smith: Right.

Howard Farran: And what does that stand for, Somno?

Kent Smith: Sleepiness, sleep.

Howard Farran: And is that one lab or is that one location? Where are they out of?

Kent Smith: Well, they make the SomnoDent appliance, well they make several different kinds of SomnoDents, there are different versions of it. But that is the company that they have got about four other labs. They have got one in Canada that will do it. They have got a few around the U.S. that will do it as well. But if you go to SomnoMed.com you can probably find the various labs that make them. I send mine directly to the company, which is in Frisco, Texas. I'm sorry, Plano, Texas. No, it is Frisco, Texas. Anyway, I send all of mine to the company directly, but you can send them to one of their affiliate labs.

Howard Farran: And you send it to that one, because obviously you are in Dallas, so it is just closer and more convenient.

Kent Smith: It is easy, yeah. But, you know, ResMed came along. Like I said, ResMed is a CPAP company. And they decided they wanted to get a chunk of this market. So they made something called the Narval.

Howard Farran: Who did this?

Kent Smith: This is Resmed, R-E-S-M-E-D. Right, so they made the Narval appliance. Now this is the only CAD/CAM appliance there is out there.

Howard Farran: So then you could send them an oral scan?

Kent Smith: Yes, you can.

Howard Farran: So if you have an oral scanner for your crown and bridge, you can send them an oral scan?

Kent Smith: Yeah, now it depends. They have got a few labs, you send it to the lab, but then that lab sends it to ResMed. So you can't send it directly to ResMed. So it would depend on the lab. You would just have to contact one of the labs to see if they allow that. The reason I like the Narval, I had not found anything that would equal a SomnoDent until this Narval came around about two years ago. The Narval is about half the weight. It is CAD/CAM technology, so it is very lightweight. The profile is very small. So for my patients that don't like much bulk in the mouth, they want the smaller footprint, the Narval is a great appliance for those patients.

Howard Farran: Okay, now let's talk about something, people that are grinding their teeth all night.

Kent Smith: Okay.

Howard Farran: They say, now I don't want to throw one of my boys under a bridge, but I have got four boys. One of them, when he sleeps, I mean it sounds like bags of rocks being crumbled. How associated is that with sleep apnea?

Kent Smith: Well, we see most apneic patients will brux. Now there is some debate about whether the apnea causes the bruxing or whether it is just a factor that is with most male patients. I mean, who knows? But in my opinion, apea, one of the side effects is bruxing. So if we have got a bruxing patient, we want that patient to undergo a sleep study. So that would be another thing, I am glad you brought that up. But bruxing, grinding, you have got to have a good, strong appliance for it, because there is no reason to believe that it is just going to go away just because you clear up the airway.

Howard Farran: But if I am wearing a retainer on my teeth, isn't that the same thing as wearing a nightguard?

Kent Smith: Well yeah, this acts as a nightguard.

Howard Farran: So now I have got a comorbidity solution. I am using a retainer to treat sleep apnea and grinding and bruxing their teeth.

Kent Smith: Exactly.

Howard Farran: And they might be a lot more compliant on wearing the nightguard if they are waking up fresh. Because the one thing my buddy Tommy told me is that his compliance is high, because when he forgets to wear it or he goes to a course and didn't take it or whatever, he is sitting there all day

thinking, “Gosh, I wish I would have worn that thing last night.” So maybe this will really up compliance of wearing a TMJ nightguard or night tie of I am wearing a Narval and I wake up feeling refreshed and not needing a pot of coffee.

Kent Smith: Certainly. Yeah, before I got on this podcast, I had a patient that came in. He is a 59-year-old male and he said he had had a nightguard before and he said he just couldn’t wear that, it wasn’t comfortable. And I said, “Well, did it make you feel much different in the morning? Did you notice any difference at all?” And he goes, “No, my doctor just told me I needed to wear it.” And I said, “Well, yeah. There is a difference there. I bet if we make this for you, you are going to feel better in the morning, you are more likely to do whatever it is to get used to it.” So yeah, I agree, it should improve compliance.

Howard Farran: People like to do things that make them feel good. That is why a third of the nation is obese. You know, they eat a cookie and they feel better. So yeah, that is amazing. So this is solving two questions at once. So I have had your amazing mind for 45 minutes. We are down to 15 minutes. What percent of the dentists do you think have home testing, screening patients and sending them home with a, what did you call it? HST, home?

Kent Smith: HST, home sleep test.

Howard Farran: Okay, what percent of the dentists do you think have a home sleep test?

Kent Smith: Probably less than one percent.

Howard Farran: Okay, so you talked about this for three quarters of our podcast. We are down to 15 minutes. I like action plans where dentists go. Give the dentist a sell out there. He is sitting out there, he is in the middle of Parsons, Kansas, and he is like, “Kent, really?” So close me. Why the hell should I get into this?

Kent Smith: Well, first of all, 20% of your patients have it and only 15% know they have it. So a significant number of your own patients. If we really are physicians of the body, physicians of the mouth, physicians of anything, we need to be caring about our patient’s health. So for no other reason we should be screening our own patients. And you cannot get a man, I mean, it is difficult to first even get him to admit he has got a problem, but for him to go spend the night in a sleep center and have somebody watch him all night long… And then you have got women, I mean, how many women want to be stared at all night long with some guy with a muscle shirt and four tattoos? You know, he says, “Hey sweetie, go to sleep. I am watching you.” That is not very conducive to sound sleep. So most of your patients will not want to go. Before I ever had HST, and I got my first unit over ten years ago, I had a very difficult time getting patients to go. And any dentist out there that doesn’t have HST, they will tell you the same thing. It is difficult to get your patients to go. So if you want to screen more of your patients, and even if you don’t treat, at least get them screened. Let them know what they have got and then they can get treated by a sleep physician with a CPAP or you can send them to a dentist who knows what he is doing. At least you are treating your patients better. If you want to make some money doing this as well, then learn how to treat and again, medical insurance will cover this, not dental.

Howard Farran: So I am going to follow your lead there. Can a dentist make money doing this?

Kent Smith: Yes, I don't do any restorative dentistry, and I have got a thriving practice. So how do I do that? I make money from treating sleep apneic patients. I wouldn't say it is the sole reason I do it. I love sleep. I have been fascinated with it since junior high. It is my favorite field. But I couldn't do that, obviously, unless I am making money from it. Now medical insurance is the tough thing to figure out, and that is where most dentists that learn how to do this, that is where they fall.

Howard Farran: So tell them, how do they learn how to deal with medical insurance?

Kent Smith: Well, medical insurance is so tough that I always suggest that they use a third party biller, okay? And there are several of them out there. They are going to take a chunk of the collection amount, but at least start out that way. And then once you think you have figured it all out and you know exactly what they are doing for you, then you can try doing it on your own. But sort of learn from them first and then you can decide to take that on if you want.

Howard Farran: Well give them some names. Who deals with dentists for medical insurance billing of sleep medicine?

Kent Smith: Well, there are several. I would say there are probably four that I would suggest. You have got GoGo Billing.

Howard Farran: Is that gogobilling.com?

Kent Smith: Yes, gogobilling.com. Crystal Billing with a C. And that is, I believe, crystalbilling.com. And then you have got Dental Rider. You have probably heard of Dental Rider. They have been around for 20 years working with TMD and sleep. It is cross-coding software, but they also do third party billing. And then you have got Brady Billing, and that is bradybilling.com. Those are the four that I would suggest looking at and I think you will find one or two that you like to work with. You know, you need to look at a few things, what are their terms, how much a chunk are you taking from me, how fast can you get these benefits back from me. Because the goal is the patient calls, they say, "Listen, I have got a problem. I need to come in. My doctor said I need to go see my dentist to get an appliance for my snoring." The question you need to ask then is, "Okay, I need your medical insurance card. Can you fax that over to us?" You have got that medical information card. You then get it to the third-party biller and they need to call and get all of the benefit information so that you have a fairly good idea of how much the patient is going to be paying out of pocket when they come in to see you. Because patients want to know how much they are paying out of pocket. If you can't tell them, they are going to skate. They are not going to start treating it until you can get them medical.

Howard Farran: That is a huge red flag for me. If I took my car in and they said, "We don't know what it would cost," or some guy came by and looked at my air conditioner if it didn't work. Yeah, it is a huge red flag if you don't know. And to make their life easier, which one of these four are you using so I don't have to screen all four, what is the man using?

Kent Smith: I am using Brady Billing, primarily because they take a little bit less out and they are faster. So that is my favorite one now. Now who knows, a year from now I may tell you something different. But right now I like Brady Billing. Sometimes it depends.

Howard Farran: What city are they in?

Kent Smith: They are also in Dallas, so hey, I like local people.

Howard Farran: Yeah, well okay. So back to the money. You haven't mentioned anything. How much are retainers? Do you charge them to take home a home sleep test?

Kent Smith: Yes, we do.

Howard Farran: Okay, so go through what you are billing out.

Kent Smith: Sure. Now it is really going to depend. With medical insurance, it is completely different from dental. And dentists freak out when I start talking about this, because they think if you write something off you are committing fraud. In medical insurance, stuff is written off all of the time. I mean, if you ever looked at one of your EOBs from the hospital, I mean, they write off stuff right and left. It is fairly common. And you can also have a different cost for cash patients than you do for an insurance patient. So I preface that, because what I am going to say might confuse you if I don't say that ahead of time. If it is a cash patient, if they are wanting to take home a monitor and they don't have insurance or they don't want to file it to insurance or whatever, we charge $295.

Howard Farran: For the home sleep test?

Kent Smith: For the home sleep test.

Howard Farran: $295.

Kent Smith: And most patients will pay that, because they know if they go to a sleep center, I don't know if you know what your sleep center was going to charge insurance. It is going to be somewhere between $1,500 and $5,000. So if that same patient goes to an attended study, they are going to pay a whole lot more than $295. So most of them will pay that. Now insurance, we bill $1,500 to insurance. It just really depends on what kind of patient they are.

Howard Farran: $295 in cash and $1,500 for insurance.

Kent Smith: Right.

Howard Farran: Okay.

Kent Smith: So enough insurance companies will pay a significant portion of that that you are going to make your money up easily on this. It depends on your state, too. Different states are a little bit easier, and I know this just from all of the seminars I have taught in the past and doctors that will get back with me and they will tell me, "You know what, I am not getting as much luck with billing insurance

companies for these home studies as you are." So I know that it might be a little more difficult in certain states.

Howard Farran: Okay. So do these patients come at the end of the day, at 5 o'clock and pick it up and go home? Do you give it to them at hygiene? Do they bring it back the very next morning? Do you have to schedule time to upload that and go over it? So tell us logistics, how this works.

Kent Smith: Okay, so if we are screening them in hygiene, and the dentist that is getting started certainly would be screening their patients in hygiene. So if they can bring it back the next day, they are allowed to take it with them from hygiene. We will go over the instructions and they have to bring it back the next day, and they have to have an appointment to go over the results. They can't just drop it off, because many patients will say, "Well, just call me with the results or email me the results." That is no good. We want the time to go over the results with the patient, because we are more likely to sell treatment of they come back in the op.

Howard Farran: And how long is that appointment for me to bring in my home sleep testing device and then you upload it and you go over the results with me?

Kent Smith: It takes five minutes. So we can go over the results in another five minutes or so. And then it depends on if you had a consultation with them at the beginning like in hygiene or if you walked them down the hall into a separate room and had a consultation, then they have had all of their questions answered. Then that next appointment where the bring back the study just to make sure they have apnea, maybe all you have to do at that point is take impressions and send them off. So really it depends on how much time you spend on the front end or how much time you have to spend on the second appointment.

Howard Farran: Do you give them a pamphlet to take home and read or anything?

Kent Smith: Well, we have pamphlets, yeah. We had some made up.

Howard Farran: But that is not a big part?

Kent Smith: No, that is really not a big part. A lot of it is just being able to talk the talk with the patient.

Howard Farran: Yeah, okay so then they decide they have mild, are you going to make a retainer for mild, moderate and severe?

Kent Smith: I am going to. I am going to tell them with severe, a CPAP is more likely to get them treated effectively and more quickly. However, most patients have heard of a CPAP machine, because it is genetic, too. So they typically have a brother that has got one or a dad that has got one. They say, "You know what, Joe wears one, there is no way I am wearing one of those things. I travel too much. I see how they are having to take them out at security all of the time. No way am I wearing one of those masks." I say, "Okay, well we treat a lot of severe patients with these appliances, too. So even though you are severe, I am willing to do that. But you have got to sign a CPAP intolerance affidavit that says this is why I am not willing to try a CPAP. It is a **CYE 55:52** thing.

Howard Farran: Yeah, okay. So then they decide you are going to make an oral appliance, which is two appliances, maxillary and mandibular, but connected. So you are going to take polyvinyl siloxanes?

Kent Smith: Right and then a bite registration.

Howard Farran: And what do you use? What PVS are you using?

Kent Smith: Oh heck, I don't even know. No it doesn't matter.

Howard Farran: So whatever you are using for your crown and bridge is good enough for this.

Kent Smith: Yes. Well, if you take Insivalign impressions for example, they have to be really accurate. So they just have to be good, accurate, full impressions.

Howard Farran: And a bite.

Kent Smith: And a bite. Now the bite needs to be at that protruded position that you want to start somebody at. And there is something called a George gauge, there is also a TAP gauge. There are different ways to take the bite, but you need to take a bite at that protruded position, because the manufacturer is going to make the appliance at exactly that bite, that protrusion that you sent. So if you send in just a CO bite, you are going to get a CO appliance. Now you can adjust it forward depending on the appliance, a certain number of millimeters. So that could be okay, but most people, I really wouldn't suggest sending a CO bite. You really need to send a bite that is at least somewhat protruded.

Howard Farran: And how are you taking that bite? Are you doing a wax or polyvinyl or polyether?

Kent Smith: No, polyvinyl again, bite registration material. So a quick set.

Howard Farran: So you are taking one little pat on each side or what do you inject into the bite? Or do you a lay a little pencil's worth around the whole arch?

Kent Smith: No, you don't have to do… Well, I take it back. The George gauge is something that you put in the front teeth. So they come forward and it has got a little ruler on top and you can tell exactly how far they are protruded. You lock it in and then you squirt with your gun on the side all the way around on both sides and it sort of fills up the bite and then wait 30 seconds and it is done.

Howard Farran: Okay. And then how much does something like this cost?

Kent Smith: That George gauge?

Howard Farran: No, no for the patient. You just took impressions, upper and lower impressions for me, and we are going to make an oral appliance. How much does this cost?

Kent Smith: Well, that is different from all over the country. So again, you have got cash prices and you might charge even a little different amount depending on the appliances, because some appliances are cheap, some are expensive. So it depends on which appliance you are doing. Some are as low as $95

and some are $600. So that is going to affect how much you might want to charge for your cash patients and for your insurance patients.

Howard Farran: So it is going to be $60 to $600 you say?

Kent Smith: Yeah.

Howard Farran: And then you are going to send that to the lab, snail mail in a box and then you are going to get it back like a crown, like two weeks later?

Kent Smith: Yep.

Howard Farran: About two weeks later. So $60 to $600 is a big range. What would the median be? What would the mean, what would the average be?

Kent Smith: $300 to $400.

Howard Farran: $300 to $400 and then you are going to get that back in two weeks then you are going to schedule them another half hour appointment to try it in?

Kent Smith: Yep, about a half hour for delivery. And depending on the appliance, some of them – this is one reason I like the SomnoDent – it just goes right to place. We don't make any adjustments on it. Because it is salt and pepper technique, the way they make it. It is not a conveyor belt type thing. So it is really expertly made. That is why it doesn't take much to fit it. And the Narval is almost as quick. Some appliances take 30 minutes to adjust. Time is money and I want that patient in and out as fast as I can and I want comfort. So obviously I want something that is going to go pretty quickly.

Howard Farran: Well Kent, that was an hour. That was the fastest hour I think I have ever listened to a podcast. That was amazing. So tell them where they can find you on DentalTown.

Kent Smith: Oh yeah, find me on all of the sleep threads. You can find me on the sleep apnea threads, that is where I spend most of my time there.

Howard Farran: And your website is sleepdallas.com?

Kent Smith: That is correct.

Howard Farran: Are dentists allowed to go to sleepdentist.com and contact you?

Kent Smith: Right, if you just go contact, it will come directly to me. It is info@sleepdallas.com. They can just email me there and I will be glad to answer any questions they have.

Howard Farran: Info@sleepdallas.com.

Kent Smith: That's it.

Howard Farran: And what if they are meeting planners? Do you like to lecture if there are study clubs and meetings?

Kent Smith: Oh yeah, I lecture probably about 25 to 30 times a year in various locations. I do my own sleep seminars here in the Dallas area, about six of those a year. And then I am out going to different locations. I am headed to, I can't believe this, Detroit three weekends in a row. I have no idea why I am doing that. So yeah.

Howard Farran: So these courses in Dallas, are these small, hands-on in your office or are these more just lectures like they would see out on the road?

Kent Smith: Yeah, they are sort of like we do it at Cain and Watters Facility here in the Dallas area. We have them there. We do hands-on stuff. We do impressions in George gauge, we deliver appliances to the doctors. They get a free appliance when they come. So we sort of get to do some role playing kind of things.

Howard Farran: And how many posts to you have on DentalTown?

Kent Smith: Oh, I am only about 2,000. I am kind of a slacker, I am sorry about that.

Howard Farran: No you are not, you are an amazing man. And hey, I am out of time. And Kent, seriously, thank you for your 2,000 posts and answers and questions and all you have done to educate dentists on DentalTown. I thank you for all you have done for dentistry, your patients and DentalTown and thank you for spending an hour with me today.

Kent Smith: Thank you, Howard. It has been a pleasure.

Howard Farran: And I said this off the record before you started, when I get my case I would like to send it to you and I would like you to come back and do a podcast of going over a specific case, and in this case it would be me, and maybe we could follow that through.

Kent Smith: Hey, that would be great. I know of a lot of doctors, even after my seminars, that is something they struggle with, is going over sleep studies. So I think it would be beneficial.

Howard Farran: Yeah, and then the followup if I have to go back or whatever, I would really love to have the man himself interpreting my sleep study.

Kent Smith: I would be happy to do it.

Howard Farran: Okay buddy, thanks for all you do. Have a great day.

Kent Smith: Thank you, Howard. You, too.

Howard Farran: Okay, bye.

Kent Smith: Bye.