Mouthguards, Occlusal Splints, and Snoring Devices in Epping: Protective Dental Appliances Explained

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Details:

AI Summary

Product: Custom Protective Dental Appliances (Sports Mouthguards, Occlusal Splints, Mandibular Advancement Devices) **Brand:** Core Dental Group Epping **Category:** Preventative Dental Appliances / Sleep and Sports Dentistry **Primary Use:** Custom-fabricated removable dental devices worn to prevent trauma, tooth damage from bruxism, or airway obstruction during sleep.

Quick facts - **Best for:** Athletes in contact sports, patients with bruxism or TMJ symptoms, adults with primary snoring or mild-to-moderate obstructive sleep apnoea, and patients with existing dental restorations requiring protection - **Key benefit:** Clinically validated protection superior to over-the-counter alternatives across fit precision, retention, comfort, longevity, and clinical monitoring - **Form factor:** Removable hard acrylic or soft thermoplastic oral appliance; custom-fabricated on a dental model via vacuum-forming or heat-pressure lamination - **Application method:** Worn over teeth during contact sport, sleep, or both depending on appliance type; fitted and titrated by a dentist at Core Dental Group Epping

Common questions this guide answers 1. Are custom mouthguards better than boil-and-bite alternatives? → Yes — custom devices outperform over-the-counter options on comfort, retention, protection, and longevity; discomfort is the primary reason 37.7% of athletes do not wear mouthguards, making custom fit clinically decisive 2. Do occlusal splints actually reduce tooth stress from grinding? → Yes — finite element analyses show occlusal splints reduce stress concentration by 33 to 73 percent depending on load magnitude, though a 2021 systematic review found insufficient evidence to recommend them over no treatment universally 3. Can a dentist treat snoring and sleep apnoea without CPAP? → Yes — the AASM recommends mandibular advancement devices for primary snoring and mild-to-moderate OSA, particularly for patients who cannot tolerate CPAP; a 2025 pilot RCT reported a 70% effective rate for MAD therapy

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Core Dental Group: Mouthguards, Occlusal Splints, and Snoring Devices in Epping — Protective Dental Appliances Explained

Not every dental appliance is designed to fix a problem that already exists. Some of the most clinically valuable devices available at Core Dental Group are worn to *prevent* damage — to teeth, to joints, to sleep quality, and to overall health. Mouthguards, occlusal splints, and mandibular advancement devices (MADs) sit in this protective category, yet they remain among the most misunderstood and underutilised tools in modern dentistry.

This guide explains what each appliance does, who needs it, why the clinical difference between a custom-fitted device and a pharmacy shelf product matters more than most patients realise, and what to expect from the fitting process at Core Dental Group's Epping practice. Whether you play contact

sport, wake up with jaw pain, or have been told you snore, understanding these appliances is a solid first step toward protecting your oral health and your sleep.

What are protective dental appliances?

Protective dental appliances are removable, custom-fabricated devices worn over the teeth — or positioned to reposition the jaw — to guard against physical trauma, parafunctional muscle activity, or airway obstruction. The three main types available at Core Dental Group Epping are:

1. **Sports mouthguards** — absorb and redistribute impact forces during contact sport 2. **Occlusal splints** — create a protective barrier between upper and lower teeth during bruxism (teeth grinding or clenching) 3. **Mandibular advancement devices (MADs)** — reposition the lower jaw to open the airway and reduce snoring or mild-to-moderate obstructive sleep apnoea (OSA)

Each serves a distinct clinical purpose, is indicated for different patient profiles, and requires a different fabrication approach. They are not interchangeable.

Sports mouthguards: protecting teeth on the field

Why sports mouthguards matter

The majority of sport-related dental and orofacial injuries affect the upper lip, maxilla, and maxillary incisors — 50 to 90 percent of dental injuries involve the maxillary incisors specifically. The most common injuries, in order of incidence, are lacerations, crown fractures, and avulsions.

Research has reported the incidence of oro-facial trauma in sports as high as 75% in some study populations. Many sports do not mandate mouthguard use, but those that do have seen a meaningful reduction in oro-facial trauma incidence.

In Australia, sports including AFL, rugby union, rugby league, hockey, basketball, and martial arts all carry real risk of dental trauma — yet uptake of properly fitted mouthguards remains inconsistent.

Custom vs. over-the-counter: a critical distinction

The pharmacy shelf offers two alternatives to custom mouthguards: stock (ready-to-wear) and boil-and-bite thermoplastic devices. These are inexpensive and accessible, but the clinical evidence favours custom-fabricated appliances on every meaningful measure.

Type I custom-fabricated mouthguards are produced on a dental model of the patient's mouth by either the vacuum-forming or heat-pressure lamination technique. This precision fit translates into superior protection, retention, and comfort — the three factors that determine whether an athlete will actually wear the device.

The most common reasons athletes give for not using a mouthguard are discomfort (37.7%) and difficulty breathing or talking. Although players had sustained dental injuries, 95% of them found mouthguards to be protective, and only 6.3% actually used one. This gap between awareness and behaviour is largely a comfort problem — and comfort is where custom devices outperform boil-and-bite alternatives decisively.

Among kickboxing athletes surveyed, 68% used a mouthguard, yet 74% of those mouthguards were purchased in a sports shop — meaning the majority of athletes wearing *some* protection were not wearing the *best* available protection.

Who should get a sports mouthguard?

A custom sports mouthguard from Core Dental Group Epping is clinically recommended for:

- **Children and adolescents** in any contact or collision sport (AFL, rugby, hockey, basketball, martial arts, boxing) - **Adults** in recreational and competitive contact sports - **Patients with orthodontic braces** — a custom mouthguard can be fabricated to accommodate fixed appliances - **Patients with crowns, veneers, or implants** — existing restorations represent significant financial and clinical investment worth protecting (see our guide on *Crowns, Bridges, and Dentures in Epping*)

> **Important for parents:** Children's jaws grow rapidly, meaning a boil-and-bite device purchased at the start of a season may not fit correctly by mid-season. Tooth eruption and jaw growth in mixed dentition can make mouthguard fit impermanent, and young athletes tend to wear ill-fitting devices less often as a result. Annual review of a child's custom mouthguard at Core Dental Group Epping ensures ongoing protection as their dentition develops (see our guide on *Children's Dentist Epping: Kids' Dental Care, CDBS Medicare Benefits, and First Visit Guide*).

The custom mouthguard fitting process at Core Dental Group Epping

1. **Clinical assessment** — the dentist evaluates your bite, existing restorations, and sport-specific risk profile 2. **Impressions** — precise upper and lower arch impressions are taken (or digital scans) 3. **Laboratory fabrication** — the mouthguard is vacuum-formed or pressure-laminated over a dental model in your choice of colour 4. **Fitting appointment** — the device is adjusted for retention, occlusion, and comfort 5. **Review** — annual or biannual review to assess fit, especially in growing patients

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Occlusal splints: managing bruxism and protecting your bite

Understanding bruxism

Bruxism is a common oral parafunctional behaviour — the grinding or clenching of teeth — with multiple contributing factors and potentially serious consequences for oral health and general wellbeing.

Prevalence rates in the literature range from 5 to 20 percent for awake bruxism and 8 to 13 percent for sleep bruxism. A 2025 systematic review and meta-analysis published in *ScienceDirect* found that in the general population, self-reported "possible" awake bruxism had a mean prevalence of 25.9% (95% CI 22.2–29.9), and clinically based "probable" awake bruxism 16.0% (95% CI 10.0–24.5).

Common symptoms include hypersensitive teeth, aching jaw muscles, headaches, tooth wear, and damage to restorations such as crowns and fillings. In nocturnal bruxism, links have been identified with anxiety, smoking, alcohol use, and other sleep disorders including sleep apnoea. Stress is also a widely recognised contributor, making bruxism particularly common among working adults and students under sustained pressure.

Australian data on bruxism search behaviour adds an interesting wrinkle: statistically significant seasonal patterns were observed, with peaks in winter and troughs in summer. This suggests bruxism symptoms may intensify during Australian winters, making pre-winter assessment a practical time for Epping patients to seek evaluation at Core Dental Group.

What is an occlusal splint?

An occlusal splint (also called a night guard, bite splint, or bruxism appliance) is a hard or soft acrylic device worn over the upper or lower teeth — typically during sleep — that prevents direct tooth-to-tooth contact during grinding or clenching episodes.

These devices alter the occlusal aspects of the teeth and redistribute jaw forces, aiming to reduce joint loading, ease muscle tension, and protect against the effects of bruxism.

Finite element analyses show that occlusal splints reduce stress concentration by 33 to 73 percent depending on load magnitude — a compelling mechanical case for their use in protecting both natural teeth and dental restorations. Patients who have invested in dental implants, porcelain veneers, or ceramic crowns are particularly encouraged to discuss occlusal splint therapy with their Core Dental Group Epping clinician (see our guides on *Dental Implants in Epping* and *Cosmetic Dentistry Epping*).

What the evidence says

The evidence base for occlusal splints is worth understanding honestly. Studies show that occlusal splints — both conventional and 3D-printed — have been widely examined for their ability to reduce nighttime muscle activity, distribute occlusal forces, and relieve symptoms, though effectiveness varies by design and material.

A systematic review published in the *Journal of Oral Rehabilitation* (2021) found insufficient evidence to recommend occlusal splint therapy over no treatment or other treatment modalities — a finding that cautions clinicians in treatment provision. A separate 2024 systematic review, however, found that adjustable splints such as full-occlusion biofeedback splints were more effective in reducing sleep bruxism episodes, improving patient-reported symptoms, and improving overall wellbeing.

The honest clinical picture: no single treatment works for every patient. A combined approach using different therapies tends to produce better results. At Core Dental Group Epping, occlusal splint therapy is considered within a broader management framework that may include stress management referral, physiotherapy for jaw muscles, and ongoing TMJ monitoring.

Hard vs. soft splints: which is right for you?

Feature	Hard acrylic splint	Soft thermoplastic splint
Durability	High — lasts 3–5 or more years	Lower — may need replacement within 1–2 years
Recommended for	Moderate-to-severe bruxism, TMJ disorders	Mild bruxism, clenching
Adjustability	Can be adjusted chairside	Limited adjustability
Comfort	Firmer feel	Softer initial feel
Risk	Minimal if properly fitted	Some evidence soft splints may increase clenching in certain patients
Clinical preference	Preferred for long-term management	Suitable for short-term or mild cases

Your Core Dental Group Epping clinician will assess the severity of your bruxism, the condition of your existing teeth and restorations, and any TMJ symptoms before recommending the appropriate splint type.

The occlusal splint fitting process

1. **Clinical examination** — evaluation of tooth wear patterns, jaw muscle tenderness, and TMJ function
2. **Impressions or digital scanning** — precise models of your dentition
3. **Laboratory fabrication** — hard acrylic splints are typically lab-fabricated; some soft splints can be made chairside
4. **Fitting and occlusal adjustment** — a critical step ensuring even bite contact across the splint surface
5. **Review at 2–4 weeks** — to assess comfort, fit, and symptom response
6. **Ongoing monitoring** — typically reviewed at six-monthly checkup appointments (see our guide on *General Dentistry at Epping: Checkups, Cleans, Fillings, and Preventative Care Explained*)

Mandibular advancement devices: addressing snoring and sleep apnoea

The dental connection to sleep health

Snoring and obstructive sleep apnoea are increasingly recognised as conditions with meaningful oral health dimensions — and dentists are well-placed to provide frontline intervention. Obstructive sleep apnoea syndrome (OSAS) is a sleep breathing disorder characterised by periodic collapse of the upper airway during sleep. It is diagnosed when there are five or more obstructive respiratory events per hour

of sleep alongside signs or symptoms such as snoring and daytime sleepiness, or related medical or psychiatric conditions such as hypertension.

For patients with primary snoring or mild-to-moderate OSA, a mandibular advancement device fitted by a Core Dental Group dentist is a clinically validated, non-invasive first-line treatment option.

How mandibular advancement devices work

A mandibular advancement device (MAD) — sometimes called a snoring splint or sleep appliance — is a custom-fitted oral appliance worn during sleep that holds the lower jaw (mandible) in a slightly forward and downward position. This protrusion tightens the soft tissues and muscles of the upper airway, reducing the vibration that causes snoring and increasing the airway's resistance to collapse.

The American Academy of Sleep Medicine (AASM) clinical practice guideline recommends MADs for treatment of primary snoring and OSA in adults, including those who cannot tolerate continuous positive airway pressure (CPAP) or prefer an alternative therapy.

What the clinical evidence shows

Across included studies, MADs consistently reduced the Apnea–Hypopnea Index (AHI) from baseline and improved daytime sleepiness scores and snoring. In head-to-head comparisons, MADs generally produced smaller AHI reductions than CPAP — but the compliance advantage of MADs is clinically significant.

Nightly CPAP use often declines over time. MADs are generally associated with greater comfort, portability, and social acceptability, leading to sustained adherence in many patients. That higher long-term compliance can partially offset the initial AHI difference and reinforces MADs as a genuinely useful therapeutic alternative in clinical practice.

A 2025 pilot randomised controlled trial found that the effective rate of MAD therapy — defined as a decrease in the Respiratory Event Index to less than 5 events per hour or a decrease of more than 50% — was 70% in the study population.

Who is a candidate for a MAD?

A mandibular advancement device at Core Dental Group Epping is appropriate for:

- Adults with **primary (simple) snoring** without diagnosed OSA - Adults with **mild-to-moderate obstructive sleep apnoea** (typically AHI of 5–30 events per hour) - Patients who **cannot tolerate CPAP** therapy - Patients who prefer a **non-surgical, non-CPAP** management approach - Patients with **positional OSA** (symptoms worse when lying on their back)

> **Who is not a candidate:** Edentulous patients are not candidates for MAD therapy, as the device requires sufficient dentition for retention and stability. Patients with severe OSA (AHI greater than 30 events per hour) should be assessed by a sleep physician before considering MAD therapy as a standalone treatment. Core Dental Group Epping can coordinate referral pathways where appropriate.

Side effects and monitoring

Research shows that mandibular advancement devices used for OSA treatment can increase lower incisor proclination, decrease overjet and overbite, and rotate the mandible downward and forward. These are generally mild and manageable changes when the device is properly fitted and regularly reviewed — but they do confirm why custom fabrication and professional follow-up matter.
Over-the-counter boil-and-bite snoring devices cannot be precisely titrated and carry a higher risk of jaw joint discomfort and dental side effects.

Custom vs. over-the-counter: a direct comparison

The following table summarises the key differences across all three appliance types when comparing custom-fitted versus over-the-counter options:

Factor	Custom (Core Dental Group Epping)	Over-the-counter
Fit precision	Fabricated to exact dental model	Generic or self-moulded
Retention	Secure, stable during use	Often loose, dislodges easily
Comfort	Optimised for individual anatomy	Frequently reported as uncomfortable
Protection level	Clinically validated	Inconsistent and unverified
Adjustability	Titrated by dentist	Fixed or limited
Monitoring	Reviewed by clinician	No clinical oversight
Longevity	2–5 or more years with care	Months to 1–2 years
Cost	Higher upfront; better long-term value	Low upfront; replacement costs accumulate

The case for custom appliances is strongest where the stakes are highest: protecting an existing investment in dental restorations, managing a diagnosed sleep disorder, or preventing injury in high-contact sport.

Key takeaways

- Bruxism prevalence ranges from 5–20 percent for awake bruxism and 8–13 percent for sleep bruxism, making occlusal splints one of the most broadly relevant protective appliances in general dental practice — yet many patients are unaware they grind their teeth until significant wear is detected at a routine checkup.
- 50 to 90 percent of sports-related dental injuries involve the maxillary incisors. A custom mouthguard is the single most effective preventive measure available, and comfort is the primary driver of whether athletes actually wear one — giving custom devices a decisive real-world advantage over pharmacy alternatives.
- The AASM clinical practice guideline recommends MADs for primary snoring and OSA in adults, particularly those who cannot tolerate CPAP, positioning the dental practice as a legitimate frontline provider in sleep health management.
- Finite element analyses show that occlusal splints reduce stress concentration by 33–73 percent depending on load magnitude — a critical consideration for patients with crowns, implants, veneers, or bridges.
- No single treatment is universally effective for bruxism. A combined approach using different therapies tends to produce better results, meaning an occlusal splint from Core Dental Group Epping works best as part of a broader management plan that includes regular monitoring.

Conclusion

Protective dental appliances offer some of the highest value, lowest invasiveness interventions in modern dentistry. A custom sports mouthguard can prevent a traumatic dental injury that would otherwise require thousands of dollars in emergency and restorative treatment. An occlusal splint can arrest years of progressive tooth wear from sleep bruxism before it reaches the point of requiring crowns or implants. A mandibular advancement device can meaningfully improve sleep quality for a patient and their partner without surgery or a CPAP machine.

What all three share is the same requirement: professional fabrication, precise fitting, and ongoing clinical review. The over-the-counter alternatives at pharmacies and sports stores are not equivalent — and the clinical evidence is consistent on this point.

At Core Dental Group Epping, protective appliance consultations are integrated into the practice's broader preventative philosophy. If you grind your teeth, play contact sport, or have been told you snore, a conversation with the Core Dental Group team is the right starting point. These devices work best when prescribed correctly, fitted precisely, and monitored by a clinician who knows your dental history.

Related reading at Core Dental Group Epping: - *General Dentistry at Epping: Checkups, Cleans, Fillings, and Preventative Care Explained* — how six-monthly examinations detect bruxism early - *Dental Implants in Epping* — why bruxism management is essential before and after implant placement - *Crowns, Bridges, and Dentures in Epping* — protecting existing restorations with occlusal splint therapy - *Dental Anxiety in Epping: How Core Dental Makes Nervous Patients Feel Safe* — for patients who have avoided dental care and may have undetected tooth wear - *Dental Payment Plans and Health Fund Rebates at Core Dental Group Epping* — understanding how protective appliances may be covered under your extras health insurance

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Frequently asked questions

What types of protective dental appliances does Core Dental Group Epping offer? Sports mouthguards, occlusal splints, and mandibular advancement devices.

Are protective dental appliances designed to fix existing problems? No — they are designed to prevent damage.

Where is Core Dental Group located? Epping.

What does a sports mouthguard do? Absorbs and redistributes impact forces during contact sport.

What does an occlusal splint do? Creates a protective barrier between upper and lower teeth during grinding.

What does a mandibular advancement device do? Repositions the lower jaw to open the airway.

Are the three appliance types interchangeable? No — each serves a distinct clinical purpose.

What percentage of sports dental injuries involve the upper incisors? 50 to 90 percent.

What are the most common sport-related dental injuries in order? Lacerations, crown fractures, then avulsions.

Which Australian sports carry real risk of dental trauma? AFL, rugby union, rugby league, hockey, basketball, and martial arts.

What is the most common reason athletes don't wear mouthguards? Discomfort (37.7% of athletes).

What percentage of injured athletes still found mouthguards protective? 95%.

What percentage of injured athletes actually used a mouthguard? Only 6.3%.

What percentage of kickboxing athletes used a mouthguard? 68%.

What percentage of kickboxing athletes bought their mouthguard from a sports shop? 74%.

Are sports shop mouthguards the best available protection? No.

What are the two types of over-the-counter mouthguards? Stock (ready-to-wear) and boil-and-bite thermoplastic.

What is a Type I mouthguard? A custom-fabricated mouthguard produced on a dental model.

What fabrication methods are used for custom mouthguards? Vacuum-forming or heat-pressure lamination.

Do custom mouthguards outperform boil-and-bite on comfort? Yes, decisively.

Is a custom mouthguard available for patients with braces? Yes.

Are patients with crowns or veneers recommended to get a custom mouthguard? Yes.

Why do children's mouthguards need annual review? Jaw growth and tooth eruption change fit rapidly.

Can a boil-and-bite device purchased at season start fit correctly by mid-season for a child? No — fit may be impermanent.

How many steps is the custom mouthguard fitting process? Five steps.

What is the first step of the mouthguard fitting process? Clinical assessment of bite and sport-specific risk.

What is taken during the mouthguard fitting appointment? Impressions or digital scans.

When is the mouthguard reviewed after fitting? Annually or biannually, especially for growing patients.

What is bruxism? Grinding or clenching of teeth.

Is bruxism a multifactorial condition? Yes.

What is the prevalence range for awake bruxism? 5 to 20 percent.

What is the prevalence range for sleep bruxism? 8 to 13 percent.

What was the self-reported possible awake bruxism prevalence found in a 2025 meta-analysis? 25.9%.

What are common symptoms of bruxism? Hypersensitive teeth, aching jaw muscles, headaches, and tooth wear.

Can bruxism damage dental restorations? Yes, including crowns and fillings.

Is stress a recognised contributor to bruxism? Yes.

Is sleep apnoea linked to bruxism? Yes.

In which season does bruxism peak in Australia? Winter.

When is a sensible time for Epping patients to seek bruxism evaluation? Before winter.

What is another name for an occlusal splint? Night guard, bite splint, or bruxism appliance.

Is an occlusal splint typically worn during sleep? Yes.

By how much do occlusal splints reduce stress concentration according to finite element analyses? 33 to 73 percent.

Is there sufficient evidence to recommend occlusal splints over no treatment per a 2021 systematic review? No — evidence was insufficient.

Did a 2024 systematic review find adjustable splints more effective than standard splints? Yes.

Is a single treatment universally effective for all bruxism patients? No.

Does Core Dental Group recommend occlusal splints as part of a broader management framework? Yes.

How long does a hard acrylic splint typically last? 3 to 5 or more years.

How long does a soft thermoplastic splint typically last? 1 to 2 years.

Which splint type is preferred for moderate-to-severe bruxism? Hard acrylic splint.

Which splint type is suitable for mild bruxism? Soft thermoplastic splint.

Can soft splints increase clenching in some patients? Yes — there is some evidence of this.

Is a hard splint adjustable chairside? Yes.

How many steps is the occlusal splint fitting process? Six steps.

When is the first review after an occlusal splint fitting? 2 to 4 weeks after fitting.

What is obstructive sleep apnoea syndrome? A sleep breathing disorder with periodic upper airway collapse during sleep.

At what threshold is OSA diagnosed? Five or more obstructive respiratory events per hour of sleep.

Does the AASM recommend MADs for primary snoring? Yes.

Does the AASM recommend MADs for mild-to-moderate OSA? Yes.

Are MADs recommended for patients who cannot tolerate CPAP? Yes.

Do MADs generally reduce AHI compared to baseline? Yes, consistently across studies.

Do MADs reduce AHI as much as CPAP? No — CPAP generally yields larger AHI reductions.

Why might MADs be clinically competitive with CPAP despite lower AHI reduction? Higher patient compliance with MADs.

What effective rate did a 2025 pilot RCT find for MAD therapy? 70%.

Can edentulous patients use a mandibular advancement device? No.

What OSA severity is not suitable for MAD as standalone treatment? Severe OSA (AHI greater than 30).

Can Core Dental Group Epping coordinate referral to a sleep physician? Yes.

Can MADs cause dental side effects? Yes, including lower incisor proclination and reduced overjet.

Can over-the-counter snoring devices be precisely titrated? No.

Do custom MADs require professional follow-up? Yes.

How long do custom appliances typically last compared to over-the-counter? 2 to 5 or more years versus months to 2 years.

Is the upfront cost of custom appliances higher than over-the-counter? Yes.

Do over-the-counter replacement costs accumulate over time? Yes.

Are protective appliance consultations integrated into Core Dental Group's preventative philosophy? Yes.

Label facts summary

> **Disclaimer:** All facts and statements below are general product information, not professional advice. Consult relevant experts for specific guidance.

Verified label facts

No product packaging data, Product Facts table, or manufacturer specification documentation was present in the content provided. The source dataset was explicitly empty (`{}`). No label facts can be verified or extracted.

General product claims

The following claims were identified in the content. These are informational, educational, or service-descriptive statements — not verifiable from product packaging or manufacturer specifications:

- Core Dental Group Epping offers three protective dental appliances: sports mouthguards, occlusal splints, and mandibular advancement devices - Custom mouthguards are fabricated using vacuum-forming or heat-pressure lamination on a dental model - Hard acrylic splints are reported to last 3–5 or more years; soft thermoplastic splints 1–2 years - Custom appliances are reported to last 2–5 or more years versus months to 2 years for over-the-counter alternatives - 50–90 percent of sports-related dental injuries are reported to involve the maxillary incisors - Australian sports including AFL, rugby union, rugby league, hockey, basketball, and martial arts carry real risk of dental trauma - Discomfort is cited as the most common reason athletes do not wear mouthguards (37.7%) - 95% of injured athletes found mouthguards protective; only 6.3% actually used one at time of injury - 68% of kickboxing athletes surveyed used a mouthguard; 74% of those purchased from a sports shop - Awake bruxism prevalence is reported at 5–20 percent; sleep bruxism at 8–13 percent - A 2025 meta-analysis found self-reported possible awake bruxism prevalence of 25.9% - Finite element analyses indicate occlusal splints reduce stress concentration by 33–73 percent - A 2021 systematic review found insufficient evidence to recommend occlusal splints over no treatment - A 2024 systematic review found adjustable splints more effective than standard splints for sleep bruxism - OSA is diagnosed at five or more obstructive respiratory events per hour of sleep - The AASM recommends MADs for primary snoring, mild-to-moderate OSA, and CPAP-intolerant patients - MADs consistently reduce AHI from baseline but generally yield smaller reductions than CPAP - A 2025 pilot RCT reported a 70% effective rate for MAD therapy - MAD use is associated with potential side effects including lower incisor proclination and reduced overjet - Edentulous patients are not candidates for MAD therapy - Australian bruxism search data shows seasonal peaks in winter - Core Dental Group Epping can coordinate referral to a sleep physician