

<b>Policy title</b>	<b>Snoring surgery in adults (in the absence of obstructive sleep apnoea) V2.0</b>
<b>Policy position</b>	<b>Intervention Not Normally Funded</b>
<b>Date of ICB recommendation</b>	<b>October 2020; Updated August 2025</b>

Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore. As long as snoring is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner.

There are a number of measures that can improve the symptom of snoring that patients can consider including:

- Weight loss
- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (mandibular advancement device, to move jaw forward when sleeping – not available on the NHS for snoring, patients would need to self-fund).

Due to limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, surgery for management of simple snoring is **not normally funded**.

This policy relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (uvulopalatopharyngoplasty, laser assisted uvulopalatoplasty and radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of diagnosed obstructive sleep apnoea.

Patients with suspected obstructive sleep apnoea/hypopnoea syndrome should be managed according to [NICE NG202: Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s](#). (See visual summaries in Appendix 1).

**For patients who are living with overweight or obesity and/ or are active smokers:** Primary care and community services should offer referral to patients for weight loss and smoking cessation support at the earliest opportunity. Please see the associated BLMK ICB policy, Weight Management Services for Adults.

This policy is based on the national Evidence-Based Interventions Programme statutory guidance (Published 2019; last reviewed September 2024): [Snoring surgery \(in the absence of obstructive sleep apnoea\)](#).

**NOTE:**

- This policy will be reviewed in the light of new evidence or new national guidance e.g. from NICE
- Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the ICB's Individual Funding Request (IFR) Policy and Process

**References:**

1. Academy of Medical Royal Colleges. Evidence-Based Interventions: Snoring surgery (in the absence of obstructive sleep apnoea). Published 2019; reviewed September 2024.
2. NICE NG202: Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s. Published August 2021.

**Clinical coding:**

Age range: ≥ 19 years

Snoring surgery (in the absence of obstructive sleep apnoea) is included in the [national EBI programme](#). Coding to monitor activity is as provided and updated by that programme.

**Policy update record**

August 2025 BLMK ICB Executive Team	Policy wording updated in line with NICE NG202: Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s. No change to policy position.
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Key words: Snoring, simple snoring, mouth splints, mandibular advancement device, sleep apnoea, uvulopalatopharyngoplasty, laser assisted uvulopalatoplasty, radiofrequency ablation of the palate.

Assessment for OSAHS, OHS and OSAHS-COPD overlap syndrome

Definitions

- Obstructive sleep apnoea/hypopnoea syndrome (OSAHS): upper airway narrows or closes during sleep causing under breathing (hypopnoea) or stopping breathing (apnoea). The resulting waking or fragmented sleep can lead to excessive sleepiness, tiredness or fatigue
- Obesity hypoventilation syndrome (OHS): obesity (BMI  $\geq 30$  kg/m<sup>2</sup>), raised arterial or arteriased capillary CO<sub>2</sub> level when awake, and breathing abnormalities during sleep (obstructive apnoeas/hypopnoeas or hypoventilation or both)
- COPD-OSAHS overlap syndrome: both chronic obstructive pulmonary disease (COPD) and OSAHS. The combined effect of the conditions is greater than either alone

Features of possible OSAHS:

- snoring
- witnessed apnoeas
- unrefreshing sleep
- waking headaches
- excessive sleepiness, tiredness or fatigue
- nocturia
- choking during sleep
- sleep fragmentation or insomnia
- cognitive dysfunction or memory impairment

Features of possible nocturnal hypoventilation:

- waking headaches
- peripheral oedema
- hypoxaemia (<94% on air)
- unexplained polycythaemia

Risk of OSAHS increased in people with:

- obesity or overweight
- obesity or overweight in pregnancy
- treatment-resistant hypertension
- type 2 diabetes
- cardiac arrhythmia, particularly atrial fibrillation
- stroke or transient ischaemic attack
- chronic heart failure
- moderate or severe asthma
- polycystic ovary syndrome
- Down's syndrome
- non-arteritic anterior ischaemic optic neuropathy
- hypothyroidism
- acromegaly

Person with 2 or more features of OSAHS (see below if BMI  $\geq 30$  kg/m<sup>2</sup> or the person has COPD)

- Take a sleep history and assess for OSAHS
- Use the Epworth Sleepiness Scale, but do not use it alone to determine referral
- Consider also using the STOP-Bang Questionnaire

Person with BMI  $\geq 30$  kg/m<sup>2</sup> and features of OSAHS or nocturnal hypoventilation

- Take a sleep history and assess for OHS
- Use the Epworth Sleepiness Scale, but do not use it alone to determine referral

Person with COPD and features of OSAHS or nocturnal hypoventilation

- Take a sleep history and assess for OSAHS-COPD overlap syndrome
- Use the Epworth Sleepiness Scale, but do not use it alone to determine referral
- Consider also using the STOP-Bang Questionnaire
- Offer spirometry to assess severity of COPD

When referring people with suspected OSAHS, OHS or OSAHS-COPD overlap syndrome to a sleep service, provide information on:

- underlying causes of their condition
- what sleep studies involve
- why treatment is important
- what treatments are available
- the impact of excessive sleepiness on safe driving and occupational risk
- Driver and Vehicle Licensing Agency (DVLA) guidance, including when there is a legal requirement to notify the DVLA
- lifestyle changes, including weight loss, increasing physical activity, and avoiding alcohol excess and sedatives before sleep
- sources of support

To support prioritisation, include in referral letters:

- assessment scores
  - effect of sleepiness on the person
  - comorbidities
  - occupational risk
  - oxygen saturation and blood gas values, if available
- For suspected OHS, also include: BMI, and history of emergency admissions and acute non-invasive ventilation
- For people with COPD, also include: BMI, severity and frequency of COPD exacerbations, home use of oxygen therapy and any history of acute non-invasive ventilation

## Diagnosis

- Offer home respiratory polygraphy
- If access to home respiratory polygraphy is limited, consider home oximetry
- Consider respiratory polygraphy or polysomnography if oximetry results are negative but the person has significant OSAHS symptoms
- Consider hospital respiratory polygraphy if home respiratory polygraphy or home oximetry are impractical or additional monitoring is needed
- Consider polysomnography if respiratory polygraphy results are negative but symptoms continue
- Use the results of the sleep study to diagnose OSAHS and determine severity

## Priority factors for rapid assessment

- vocational driving or vigilance-critical job
- unstable cardiovascular disease
- pregnancy
- preoperative assessment for major surgery
- non-arteritic anterior ischaemic optic neuropathy

Discuss lifestyle changes tailored to the person's needs  
Give information on OSAHS, including the treatments available and choosing the best treatment for the person  
Consider tonsillectomy if the person has large obstructive tonsils and BMI <35 kg/m<sup>2</sup>

**Mild OSAHS with no symptoms or symptoms that do not affect usual daytime activities**

Offer lifestyle and sleep advice alone

**Mild OSAHS with symptoms that affect quality of life and usual daytime activities**

Offer fixed-level CPAP:

- at the same time as lifestyle advice if they have priority factors for assessment (see above) **or**
- if lifestyle advice alone has been unsuccessful or is inappropriate

**Moderate or severe OSAHS**

Offer fixed-level CPAP in addition to lifestyle advice

## Rhinitis

Assess people with nasal congestion for rhinitis and treat if confirmed (for details, see the guideline)

Changing from nasal to orofacial masks and adding humidification can help with CPAP tolerance

Offer telemonitoring for up to 12 months and consider it for longer

Consider auto-CPAP instead of fixed-level CPAP if:

- high pressure is needed only for certain times during sleep **or**
- fixed-level CPAP is not tolerated **or**
- telemonitoring cannot be used for technological reasons **or**
- auto-CPAP is available at the same or lower cost than fixed-level CPAP and this price is guaranteed for an extended period of time

Consider heated humidification for upper airway side effects, such as nasal and mouth dryness, and CPAP-induced rhinitis

## Other treatment options

If CPAP is not tolerated or declined, consider a customised or semi-customised mandibular advancement splint in people aged 18 and over with optimal dental and periodontal health

If other treatments are unsuitable or not tolerated consider a positional modifier for mild or moderate positional OSAHS or referral for assessment for oropharyngeal surgery for moderate or severe OSAHS

## Monitoring and support (for further details, see the guideline)

- Monitor and optimise therapy with CPAP, mandibular advancement splints, surgery and positional devices
- Tailor follow-up to the person and offer face-to-face, video or phone consultations with telemonitoring data, if available
- Ensure follow-up is in line with [DVLA guidance on assessing fitness to drive](#)
- Offer access to a sleep service for CPAP users for advice, support and equipment
- Offer educational or supportive interventions by trained specialists to improve adherence
- Consider stopping treatment if OSAHS may have resolved. After at least 2 weeks without treatment, re-evaluate any return of symptoms and consider a sleep study