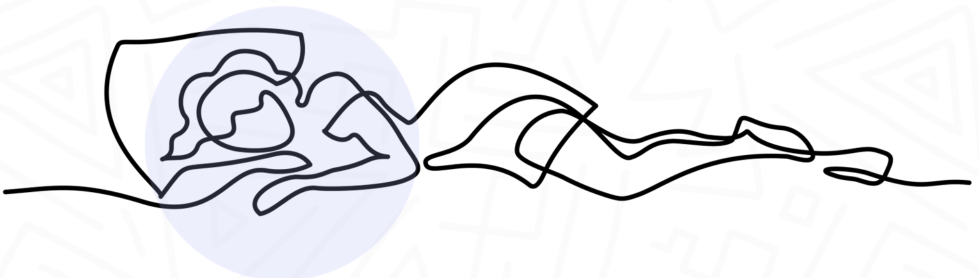
VIK VEER – ENT SURGEON

YOUR SLEEP POSITION

The Overlooked Remedy for Snoring & Sleep Apnoea



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1st Edition 2026

I dedicate this book to my beautiful wife
and my incredible sons; Because of them,
I am the luckiest man alive.

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CHAPTER 1

INTRODUCTION

I spend a lot of time watching people snore. I am an ENT surgeon at the Royal National ENT Hospital and Queens Hospital in London, UK and I specialise in surgery for sleep disorders. That means I deal with snoring, sleep apnoea, and the other various ways people's airways decide to cause trouble when we are meant to be resting.

A lot of my work involves something called drug-induced sleep endoscopy, or DISE for short (most people pronounce it like 'DICE', but I use 'Dee-Say', mostly because I like to sound European). DISE is a procedure where I use sedation to encourage someone into sleep and then pass a tiny camera down through their nose to watch what happens to their airway. I can see exactly which tissues are flapping around generating the snoring noise, and which tissues are collapsing in causing the sleep apnoea, blocking the throat and preventing breathing. I also see how breathing improves when people roll over and sleep on their side. It is fascinating to watch it unfold in real time.

The Data That Changed Everything

Some time ago, I sat down and analysed 6,044 sleep studies, what I found was rather startling.

Of all the sleep apnoea patients who had been identified, 60.3% of them would have had no snoring or sleep apnoea at all if they had simply slept on their side all night (six out of ten people). 85.7% would have been at least 20% better if they had just slept on their side at night. To me that was extraordinary.

This included patients whose overall AHI (Apnoea Hypopnoea Index – a measure of how bad your sleep apnoea is), was high, sometimes 40, 50, even 60 events per hour when lying on their back, but dropped to normal levels when sleeping on their side. These patients often get labelled as 'severe sleep apnoea' based on their worst position, when really they have severe *positional* sleep apnoea. In many cases this distinction matters enormously for treatment decisions.

Now, I am not suggesting that side sleeping is somehow a magic cure for everyone. A few people have problems that just do not respond to side sleeping. But it seems from the data that the many people, could get a quite amazing benefit from simply not sleeping on their back. What I then found interesting is that almost nobody is talking about it. We doctors talk about the CPAP mask, the gumshield, surgery and implants, but hardly anyone talks about the position that you sleep in. One of the most effective interventions for people was being completely overlooked.

These figures come from a retrospective audit of NHS referrals to our sleep department at the Royal National ENT Hospital & Queens Hospital in London. Every patient who comes to us with snoring or suspected sleep apnoea receives a sleep study regardless of severity or risk level. All patients had at least an hour of supine or non-supine sleep and had an AHI of greater than 5 in either position. This means the data represents the full spectrum of patients who snore loudly enough to seek hospital help from minimal positional OSA to the most severe cases; this was not a pre-selected group. It is real-world data and I think closely represents what it is like for people at home with loud snoring. It means it likely overrepresents patients with loud snoring compared to milder, less anti-social problems compared to the general population. But it also means these are the patients who most need solutions, and for six out of ten of them, the solution might be simpler than anyone had told them.

What I See During DISE

When you watch enough people sleep, you start seeing some obvious patterns in my patients. Whilst lying flat on their back, I often see the tongue drop back because of gravity. Sometimes large tonsils doing the same thing; it is like seeing two meatballs flopping back and blocking the throat. The harder they try to breathe, the more the airway sucks itself shut. It is

often like watching someone try to drink a thick milkshake through a collapsing straw.

Some will end up naturally rolling onto their side, and the change is immediate. Tissue shifts out of the way, or is splinted open, and the obstruction just disappears. Their unconscious self has figured out that this works, and I can see it happening in hospital before my eyes.

But the frustrating part is, even after seeing this clear, visual proof that position matters, many patients still end up going home with a CPAP machine or have to prepare for an operation. Not because those treatments do not work, but because we just do not think about side sleeping as an alternative viable treatment option. For something with so few risks and such amazing benefits, it just feels like a major missed opportunity to me.

The Pillow Problem

Knowing this, several of my patients in the past have asked me about sleep pillows. Could I recommend one? Would this help? These were the type of patients who were trying to avoid devices or surgery, and understood that positional changes could make a difference to them.

So I looked into it. I read the descriptions. Bought the leading brands and tested out the designs, I even created a YouTube video about the topic.

Almost every pillow marketed for sleep problems was designed for neck support. Perfectly reasonable goal if you have neck pain, but utterly irrelevant if your problem is an airway that collapses when you lie flat on your back.

Neck comfort and airway patency are not the same thing. Your neck can feel perfectly supported while your tongue is busy blocking your throat. These are different problems requiring different solutions. Yet the sleep pillow industry seemed entirely focused on the former while ignoring the latter.

I started recommending that patients try side sleeping with makeshift setups: a pillow behind their back to stop them rolling over, another between their knees, something under their head that did not squash their face. There are positional devices that I would recommend (like the WoodyKnows backpack – get the huge inflatable one, not the smaller sausage roll design), these force you to sleep on your side no matter

what. It feels like you are a tortoise and physically cannot turn over.

Whatever the system used, they often would reveal a certain pain point and side sleeping would become too uncomfortable, or just prove too fiddly to maintain. People would give up after a few nights and conclude that they could not get comfortable enough to stay on their side all night. It is a similar problem with CPAP, it works amazingly well in most people so long as you can use it all night without waking up.

The Moment I Decided To Do Something

I remember the exact moment I decided I did not want to just complain about it anymore, I just wanted to fix the problem.

I had just finished editing my YouTube video where I basically told viewers I could not recommend any of the pillows on the market. As I was wrapping up, I spontaneously, decided to add a slide right at the end of the video:

"Since making this video I have decided to make my own snore pillow. Join my newsletter to help me make this awesome."

That was April 9th 2022. I did not have a plan. I did not have a concept. I did not even really know what I was doing. In hindsight I was just sufficiently annoyed by the lack of anything worth recommending, and blissfully ignorant enough to not realise just how difficult it would be.

Over the next few months I sketched out what a proper positional sleep aid would actually need to do. I did not want to fall into the trap of making a neck support pillow repurposed for sleep or a pregnancy pillow marketed at snorers. I wanted a tool designed specifically to keep someone comfortably on their side, with their airway in the best possible position, for an entire night.

It needed to support the head without crushing the face. It needed to prevent rolling onto the back without being uncomfortable. It needed to work with CPAP masks for the people who needed them. It needed to take the pressure off the shoulder so you did not wake up with a dead arm. And it needed to be comfortable enough that people would actually keep using it.

I spent weeks lying in various positions on my bed surrounded by pillows trying to create the perfect sleeping position. Several prototypes later, I had something that worked. My patients, friends and family tested it. They came back with better sleep, less snoring, and the comment that their partner was finally speaking to them again in the mornings. That pillow is now called the Side Sleeping Pro, and I will talk about it more later in this book.

What This Book Is About

I have written this book because I am tired of watching people struggle with sleep problems that could be solved simply. I am

tired of seeing patients given expensive, complex solutions when they need something straightforward. And I am tired of the sleep industry overlooking the most obvious intervention available.

In this book, I am going to explain why sleep position matters so much. I will try and explain to you what actually happens to your airway when you lie on your back versus your side.

I will also explain what proper side sleeping actually requires, why most people's attempts at it fail, and what you can do about it. Some of that will involve discussing the pillow I designed, because I would be lying if I said I did not think it was a good solution for some. But I will also tell you how to improve your sleep without needing to purchase my pillow. I want this book to genuinely help you, with or without my pillow.

This book is for anyone who snores. Anyone who has been told they have sleep apnoea. Anyone whose partner has begged them to do something about the noise. Anyone who wakes up tired despite sleeping eight hours. Anyone who has tried CPAP and hated it. Anyone who wants to avoid surgery. All those people who know that side sleeping could help, but have no idea how to make it happen. And anyone who just wants to understand why something as simple as rolling over could possibly make such a difference.

Why Listen to Me?

I am not a sleep scientist in a laboratory. I am a surgeon in a clinic, seeing real people with real problems every single week. Which means I have probably seen more airways than most people will ever see in a lifetime. I have performed thousands of Drug Induced Sleep Endoscopies. I have worked with patients ranging from professional drivers desperate to keep their licence to pregnant women who just want to breathe comfortably again.

My job on the NHS is to help people fixing the anatomical problems that cause snoring and sleep apnoea. I have removed tonsils, straightened septums, reduced turbinates, and implanted devices into tongues. I believe in surgery when it is needed. I prescribe CPAP frequently. But I also believe in not doing complicated things when simple things will work just as well.

I wrote this book to explain what I see when I look down people's throats. To show how gravity alters our anatomy when we sleep. To explain how sometimes the simplest solution is the one that makes the most sense.

And do not take my word for it. Try it yourself. Spend one month deliberately sleeping on your side with proper support and see what happens. Ask your partner if the snoring was better. Try the Woodyknows backpack, or the Slumberbump or just wear a backpack filled with towels, do anything to force yourself to sleep on your side all night. If you are able to, get a

sleep study with and without side sleeping and see if it makes an objective difference to you.

In the next chapter I will dispel some myths about snoring and sleep apnoea. Because if you think snoring is just an annoying noise, then you are working with assumptions that could be costing you years of decent sleep.

CHAPTER 2

THE BIG SLEEP MYTH

Let's start with something that surprises most people: snoring is serious, even if you do not have sleep apnoea. We used to think snoring was just noise, an annoyance to bed partners but otherwise harmless. Then researchers started looking at children who snored but did not have sleep apnoea. What was surprising was their educational performance was permanently worse than children who did not snore. Simply making that vibrating noise in their throat every night was enough to disrupt sleep quality in ways that affected their prospects for the rest of their lives.

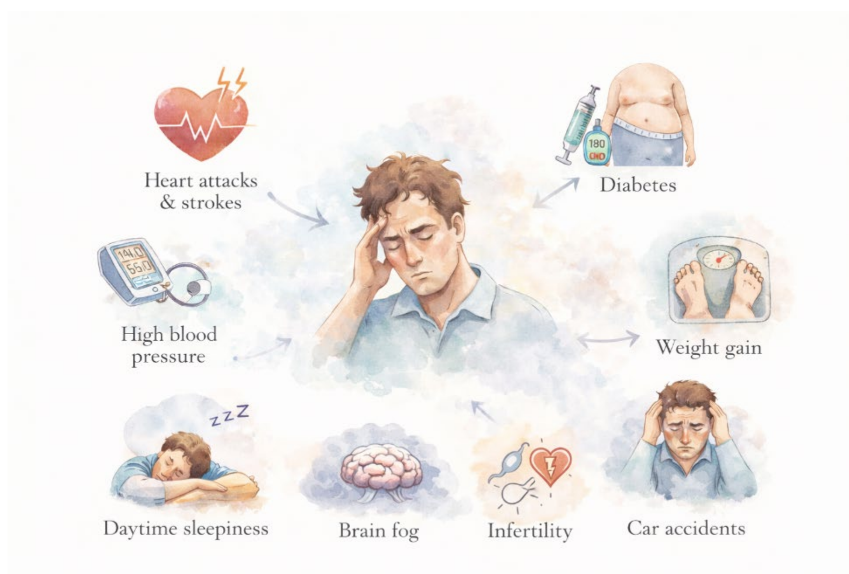
If snoring alone can reduce a child's educational potential, what is stopping it causing harm when you are an adult?

If you think about it, snoring is the airway partly shutting down. It has got to the point where it has got so narrow that the tissues are rattling around with the air flow that is struggling to get through. One analogy could be a car engine that is rattling, spluttering and no longer providing that smooth purring sound. You know it is not working properly, and you are guessing that performance is not as sparkling as it once was.

Sleep apnoea takes this further, and if we were to carry on the car engine analogy, now it is making a frightful noise, bellowing black smoke and the engine intermittently switches off on the motorway.

The consequences of OSA are serious and well researched. Raised blood pressure can be one of the first things we see, caused by the sleep apnoea this leads to an increased risk of heart attacks and strokes. The interrupted sleep affects how your body processes glucose, increasing your risk of diabetes. Many people gain weight, partly because poor sleep disrupts the hormones that control appetite, and partly because exhaustion makes exercise feel impossible. We used to think that weight gain caused sleep apnoea, now we know that this is bi-directional – weight gain causes OSA and increasingly we know that OSA causes weight gain.

Then There is the daytime impact, poor work performance, difficulty concentrating, memory problems, irritability and depression. Some of this is obvious tiredness but much of it is a more subtle, grinding brain fog, with wear on your mental health that accumulates over months and years. And then there are the car crashes. People with untreated sleep apnoea are significantly more likely to have accidents, not because they fall asleep at the wheel necessarily, but because their reaction times are slower and their vigilance levels have been shown to be reduced.



This is not a minor problem. Sleep apnoea affects your cardiovascular system, your metabolic health, your mental wellbeing, your safety, and your ability to function as a human being (it causes infertility, miscarriages, low sperm counts etc). And yet, when someone presents with these symptoms, the

conversation almost always goes straight to CPAP machines, oral devices, or surgery. You sleeping position barely gets a mention.

Why Everyone's Sleep Apnoea Is Different

Part of the reason sleep medicine has become so complicated is that obstructive sleep apnoea is not one condition. It is a collection of different anatomical and physiological problems that all produce the same result: the airway collapses during sleep.

Some people have tongue base collapse, where the back of the tongue falls into the throat. Others have lateral pharyngeal wall collapse, where the left and right sides of the throat squeeze inward. Some have palatal obstruction, where the soft palate sags back or down. Most have a combination of these. Then you add in factors like large tonsils, a deviated septum, turbinate hypertrophy, obesity, menopause or floppy voice box anatomy, you will see why every patient is different, complex and in desperate need for all of this to just stop.

This also means there is not one treatment that works for everyone. CPAP is excellent for most types of collapse because it physically holds everything open with air pressure. But when faced with tongue base collapse or large tonsils, CPAP treatment interestingly, does not always provide the best results as it may do for other patients. The tongue is heavy, and air pressure alone might not be enough to prevent it falling

backwards. The tonsils just are not physically able to move anywhere else, and that is why the NHS guidelines recommend removing large tonsils before CPAP is given.

Lateral wall collapse, meanwhile, does not respond well to mandibular advancement devices or nerve stimulation implants. Those treatments target the tongue, but if your problem is with the sides of your throat, moving the tongue forward does not help much.

This is why a proper assessment matters. Drug-induced sleep endoscopy lets us see exactly what is collapsing and where. Then we can tailor treatment to the specific pattern. I truly hold to the belief that you need to make a diagnosis before you can start treating a patient.

What Bed Partners Already Know

Here is something that fascinates me. I ask patients whether their snoring changes with position, and almost universally, their partner knows the answer. "Oh yes," they'll say, "if I roll him onto his side, the snoring stops." Or, "She's fine when she sleeps on her side, but the moment she rolls onto her back, it's dreadful."

Everyone seems to know this. It is obvious to anyone who shares a bed with a snorer. And yet somehow, this knowledge does not translate into medical advice. Patients come to clinic, they describe their symptoms, they undergo sleep studies, and

the discussion goes straight to machines and devices. Position may get a mention in passing, if at all.

You may have left the clinic with a machine or a date for an operation, but nobody stopped to think that perhaps the simplest intervention was right there in what everyone already observed: rolling onto your side makes the snoring better.

Why are we not thinking about this more?

The Neck Pillow Confusion

When patients start looking for help, many of them turn to pillows. The market is flooded with products claiming to stop snoring or cure sleep apnoea. Most of them focus on neck alignment. They talk about supporting the cervical spine, maintaining the natural curve of your neck, reducing tension. All perfectly reasonable goals if you have neck pain.

But neck alignment has almost nothing to do with keeping your airway open. Your throat does not care whether your cervical spine is in a neutral position. What matters is whether gravity is causing the tissues in your throat to obstruct your airway or not. Neck alignment and throat obstruction are separate issues.

I have seen elaborate memory foam pillows with contoured shapes designed which are excellent for neck support but sadly useless for preventing airway collapse. I have seen wedge pillows that elevate your upper body, which can help with reflux but do not stop you rolling onto your back. I have seen

cervical rolls, ergonomic designs, cooling gel layers, adjustable heights. None of them address the fundamental problem: if you sleep on your back, gravity works against you.

The result is thousands of people buying products that were never designed to do what they need.

The Numbers Behind Positional Sleep Apnoea

When I analysed those 6,044 sleep studies, I was looking for something specific: how many people had positional sleep apnoea, where their AHI was worse on their back than on their side. The traditional definition is quite strict. The American criteria say you have positional sleep apnoea if your supine AHI (AHI on your back) is at least twice your non-supine AHI (AHI on your side). Amsterdam criteria use different ratios and also consider the overall severity.

But I have never been convinced that these strict definitions matter much to patients. If your AHI is 24 on your back and 13 on your side, you do not meet the American definition because 24 is not double 13. But you are still significantly better on your side. That is still a meaningful improvement in your sleep and your health. If a doctor said to you "I can make you 40% better with no surgery or devices", I am guessing most people will still do it, even though officially it is not fixing the problem. In the above example the AHI would have changed to the point that the patient would not officially need CPAP anymore.

So I looked at the numbers differently. 60.3% of the patients in my analysis would have had normal sleep if they had simply stayed on their side all night. Their supine AHI might have been 20 or 30 or 40, but their non-supine AHI was under 5, which is considered within the normal limits.

85.7% would have been at least 20% better on their side. Even if side sleeping did not normalise their AHI, they still got at least 20% improvement in their sleep. 20% Fewer breathing pauses, better oxygen levels, less disrupted sleep. I made sure we had at least an hour of sleep in each position to ensure we had reasonable data to back up these statistics.

The vast majority of people had at least some improvement when they slept on their side, a tiny percentage had no benefit.

Why Position Gets Overlooked

So why, with all this evidence, does positional therapy remain such a minor part of sleep medicine?

Partly, I think, it is because we do not have great tools for it. Telling someone to sleep on their side is easy. Getting them to actually do it all night, every night, is much harder. The traditional advice involves sewing tennis balls into pyjamas or wearing positional devices that buzz when you roll onto your back. These work for some people but are uncomfortable enough that most abandon them quickly. Most just wake up with a perfectly circular bruise on their back, or the device has

continued to keep the bed partner awake all night with the bed vibrating.

Without reliable tools, position becomes something we mention but do not really expect people to follow through on. It is the equivalent of telling someone to eat veg all day, exercise more and live a monk-like existence. Good advice, but lacking a practical mechanism to actually achieve this.

The other issue is that sleep medicine, like much of modern medicine, has become technology-focused. We have sophisticated machines and devices. We can measure oxygen saturations to decimal points. Artificial Intelligence can adjust air pressures autonomously based on real-time feedback. These are impressive achievements. But have they made us forget that sometimes there are low-tech, simpler, safer solutions available.

There is no pharmaceutical company promoting positional therapy. No device manufacturer with a sales force visiting clinics. No expensive equipment requiring specialist training. It is simple, It is cheap, and therefore it does not get the commercial attention it deserves.

None of this is meant to dismiss the treatments we currently have. CPAP saves lives. Mandibular advancement devices help so many people. Surgery has its place. Implants are a remarkable technology. But we need to stop treating these as the only options and start recognising that for many people, position could be a part of the solution.

That might mean using positional therapy alone or in combination with throat exercises and CPAP. It might mean using these options alongside a MAD to reduce the degree of jaw protrusion needed. It might mean trying it before considering surgery to reduce the need for aggressive removal of tissue from the tongue.

What it needs is for doctors to start having conversations about sleeping position, so that at least everyone is aware of their choices. Some patients may choose to ignore it altogether but at least they are not ignorant of the choice in the first place. It is one of the central tenants of medical treatment, a doctor may recommend a particular therapy, but they should inform their patients about all the alternatives as well.

The evidence is clear. The mechanism makes sense. The benefits are obvious. And yet somehow, we are still not talking about it.

It is time to change that.

CHAPTER 3

WHAT HAPPENS WHEN YOU SNORE?

To understand why your sleeping position matters so much, you need to understand what is happening in your throat when you snore. The concepts are not complicated, but it does require thinking about your airway in a way you probably have not done before. Once you grasp the mechanism, everything else makes sense.

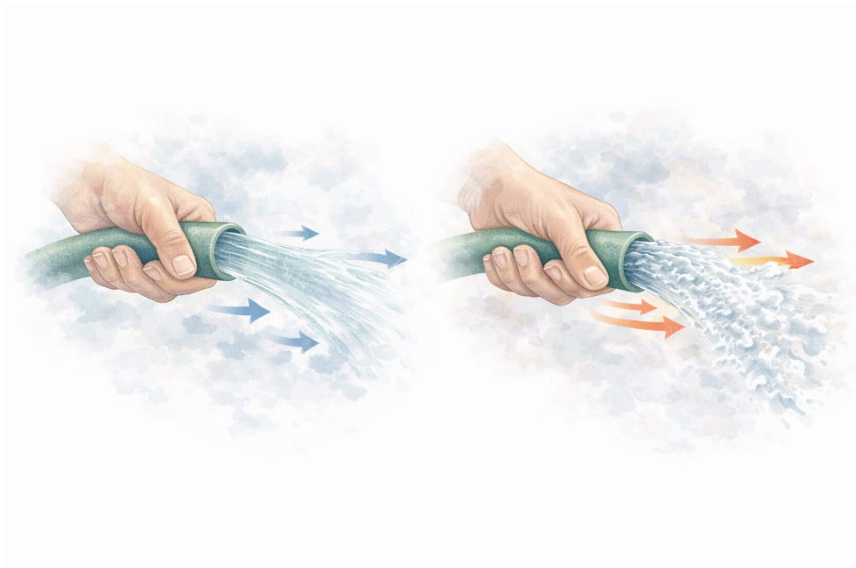
BASIC ANATOMY

Your throat is essentially a squishy tube. Medical terminology calls it the pharynx, but at its simplest, it is a tube that connects your nose and mouth to your lungs and stomach. Unlike the rigid windpipe below it, which is held open by rings of cartilage, the pharynx is soft and compressible. It is made of muscle and tissue that can squeeze food down like a big meal going through a boa constrictor.

Turbulence & Collapse

Now imagine water passing through a garden hose. When the hose is wide open, water flows through smoothly. But if you partially squeeze the hose, reducing its diameter, the water has

to speed up to get through the narrower section. The same amount of water is trying to pass through a smaller space, so velocity increases. The clear water flow changes to turbulent white water fizzing through.



What is happening is that there is a transfer of energy. The moving water has a certain amount of energy. When the hose is wide, more of that energy is exerted sideways, pressing against the walls of the hose. But when the hose narrows and the water speeds up, more of the energy is redirected forward into motion. Because more energy is being used to keep the water moving quickly, less is available to push outward on the walls. So the sideways pressure on the tube walls drops.

The same thing happens in your airway. When your throat narrows, the air has to speed up to maintain the same flow. As it speeds up, more of its energy is transferred into forward

movement and less remains as outward pressure on the airway walls. That reduction in sideways pressure means the surrounding soft tissues can collapse inward more easily.

Because of this complicated physics it becomes a self-reinforcing problem. The narrower your airway gets, the faster the air moves. The faster it moves, the more energy is shifted into speed rather than pushing the walls of the throat out. Because the pressure drops, the airway becomes even more prone to collapse.

This is also why partial obstruction leads to vibration. Your soft palate is essentially a flexible sheet of tissue. When it is hanging down close to the back wall of your throat, and fast-moving air is rushing past it, the physics of fluid dynamics come into play again. When the palate is very close to the back wall, and air is moving quickly, you get turbulent flow, and that turbulence causes the palate to flutter. It is the same principle as holding a sheet of paper near the edge of a table and blowing across it. The paper vibrates. So does your palate. That vibration is snoring.

The situation may get worse if your nose is blocked. When you cannot breathe through your nose, all the air has to come through your mouth. The air becomes turbulent as it passes the soft palate and uvula making it vibrate even more. This is why people snore worse when they have a cold or allergies. The blocked nose forces mouth breathing, the tongue and jaw drops

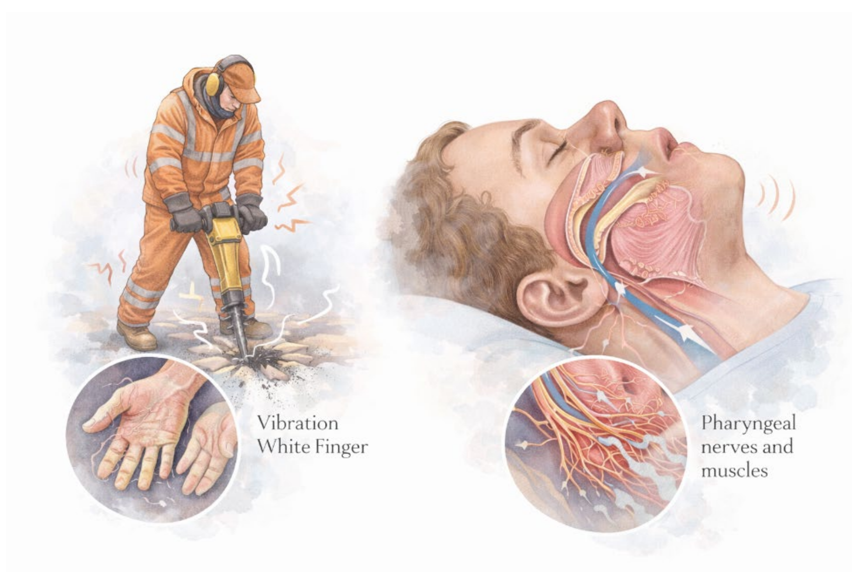
back and creates turbulence as the air passes behind it, and the palate responds by vibrating loudly.

From Snoring to Apnoea

Snoring and obstructive sleep apnoea exist on a spectrum. Snoring is partial collapse with vibration. Apnoea is complete collapse with blockage. The difference is not always clear-cut because many people alternate between the two throughout the night.

So why do some people just snore whilst others develop full obstructive sleep apnoea?

One theory is that snoring vibration may cause damage to the throat, and there is growing evidence to support this. Think about a workman using a jackhammer on the street. After years



of exposure to vibration, many develop a condition called 'Vibration White Finger' where the nerves in their hands become damaged from repeated trauma. Something similar may be happening in the throat. Studies have found that people who snore for years show changes in their pharyngeal nerves and muscles. The tissue becomes less responsive, less able to maintain tone during sleep. The muscles that should be keeping the airway open become weaker and less coordinated.

This progression from simple snoring to obstructive sleep apnoea may take years, but it seems to follow a logical path of cumulative vibration damage.

The Problem with REM Sleep

Sleep is not uniform. You cycle through different stages throughout the night, and one of these stages, REM sleep, creates particular problems for breathing.

REM stands for Rapid Eye Movement, and it is the stage where most vivid dreaming occurs. During REM, your brain does something unusual: it paralyses all your muscles. This is called muscle atonia, and it is a protective mechanism to stop you acting out your dreams. Your arm and leg muscle movements are supressed crucially, the muscles in your throat also lose muscle tone.

This means that obstructive sleep apnoea is often worst during REM sleep. Whatever narrowing or collapse you had during

lighter sleep stages becomes more severe when muscle atonia kicks in. The tongue falls back further. The lateral walls collapse more. The soft palate sags down and gets stuck behind the tongue. And because REM tends to occur more in the second half of the night, many people experience their worst apnoeas in the early morning hours.

Alcohol makes this worse. It suppresses muscle tone throughout sleep, essentially giving you a preview of what REM sleep will do later. This is why people who do not normally snore will snore after drinking. The alcohol reduces the muscle tone in their throat just enough to allow partial collapse and vibration. For someone who already snores, alcohol can tip them into having full apnoeas. Interestingly alcohol has the effect of dampening down REM sleep, and if you drink enough, you do not get dreams at all. So you get all the disadvantages of having poor muscle tone whilst also not getting the benefits of dreaming. Without dreams we get brain fog, concentration issues, memory problems, and our general productivity tanks.

Why Obesity Changes Everything

Weight gain does not just add fat to your belly and thighs. It adds fat everywhere, including in and around your airway. We see this particularly in the lateral pharyngeal walls. This is the area directly behind the tonsils in our throats, making the walls thicker and more likely to collapse inward when you breathe.

During sleep, when muscle tone drops, keeping your airway open becomes increasingly difficult.

Obesity also affects how you breathe. The extra weight on your chest and abdomen makes it harder for your diaphragm to work efficiently. You have to generate more negative pressure to pull the same amount of air into your lungs. That increased suction makes your airway even more likely to collapse. It is a compounding problem where weight affects both the structure of your airway and the forces acting on it.

Lastly there is Obesity Hypoventilation Syndrome. In this condition, the weight is such a problem that expanding your lungs becomes mechanically difficult, particularly when lying flat. There is simply too much weight pressing on the chest and abdomen to allow full inspiration. As a result, you do not clear carbon dioxide effectively and levels begin to rise. This is not OSA alone, but a separate condition layered on top of it. As BMI rises further, the hypoventilation component becomes increasingly significant. I generally see this as a factor in sleep when the BMI is greater than 35.

The Loss of Muscle Mass with Age

We lose approximately three per cent of our muscle mass every year after the age of thirty. This affects our whole body, including the muscles in our throats. The muscles that keep your airway open during sleep slowly become weaker. They cannot maintain tone as well and fatigue more easily. And

because this loss is gradual, you do not notice it happening until the cumulative effect becomes too much.

There is another factor that I find rather interesting. We do not exercise our throat muscles the way we used to. Consider how much people sang a generation or two ago. Hymns in church, songs around the piano, choir participation. Choir singers seem to have lower rates of snoring (though they are not immune to getting sleep apnoea). The act of controlled singing, maintaining tone and pitch, requires precise muscle control and strength in the throat. It is exercise, even if we do not think of it that way.

Modern life involves less of this. We do not sing as much. Fewer people play wind or brass instruments. Our throat muscles do not get the workout they once did, and this likely contributes to

the increasing prevalence of sleep-disordered breathing as we age.

This is why exercising the throat seems to help snoring and sleep apnoea. Some reports suggest that these exercises reduce snoring and sleep apnoea by 50%. There are videos on my YouTube channel that explain these exercises to you.

More Physics

To tie this all together, let's think back about our garden hose. When the hose is fully open, water flows easily. You can run a lot of water through it without any resistance. But if you partially step on the hose, restricting its diameter by just half, the resistance does not just double, It increases sixteen-fold. This is because resistance to flow is related to the fourth power of the radius (at least in the simplified physics of smooth flow through rigid tubes). Your throat is neither smooth nor rigid, so the real numbers are messier, but the principle holds. Halve the radius, and resistance increases somewhere in the region of sixteen-fold. The exact number matters less than the concept: small narrowing causes dramatic increases in breathing difficulty. This mathematical relationship, described by Poiseuille's law, explains why even small amounts of airway narrowing cause dramatic increases in breathing difficulty.

When your airway narrows during sleep, you have to work much harder to breathe. Your diaphragm has to generate more negative pressure to overcome the increased resistance. But

that increased negative pressure makes the airway want to collapse even more. It is like trying to suck water through a collapsing straw. The harder you try, the more it collapses.

If the narrowing is partial, you get vibration and snoring. If it is complete, you get apnoea. Either way, your brain has to wake you up slightly to restore muscle tone, work muscles harder and reopen the airway. Then you fall back to sleep, the muscles relax again, and the cycle repeats.

This is exhausting for your body. Every micro-awakening disrupts your sleep architecture. Every drop in oxygen stresses your cardiovascular system. Every surge of adrenaline to wake you up keeps your nervous system on high alert. Over months and years, this adds up to significant health consequences.

CHAPTER 4

SIDE SLEEPING vs RECOVERY POSITION

If you have ever done a first aid course, you will have learned about the 'Recovery Position'. It is one of the first things they teach: if someone is unconscious but breathing, roll them onto their side in a specific way. One arm extended, the other bent, top leg bent at the knee for stability, head tilted back slightly.

The position is so fundamental to emergency care that it is taught worldwide, practiced until it becomes automatic, and used countless times every day by paramedics, nurses, and bystanders dealing with medical emergencies.

But have you ever stopped to ask why? Why is the recovery position so critical that it is considered a basic life-saving skill? The answer is simple: it keeps the airway open. And if the recovery position is good enough to keep an unconscious

person breathing safely, perhaps we should be paying more attention to it when we are thinking about sleep.

What Side Sleeping Actually Achieves

When you sleep on your side instead of your back, several things happen simultaneously. The most obvious is that your tongue no longer falls directly backward into your airway. Gravity still pulls it downward, but now "downward" means toward the side you are lying on, not toward the back of your throat. The tongue rests against your cheek and lower teeth rather than blocking the passage of air.

If you have large tonsils, they also move out of the way. When you are on your back, the tonsils can fall backward over your airway like an obstruction. On your side, they fall sideways instead. They are no longer directly in the path of your breathing.

The soft palate behaves differently too. On your back, it sags straight down onto the posterior pharyngeal wall, the back surface of your throat. This creates a flutter point where the palate vibrates against the wall as air rushes past. On your side, the palate still hangs down due to gravity, but it hangs to the side rather than creating a seal against the back wall. There is less contact, less vibration, less snoring.

All of this happens automatically, without any conscious effort, simply because you have changed your relationship with gravity.

Why The Recovery Position is Better

The recovery position takes side sleeping and optimises it further. When paramedics place someone in the recovery position, they are not just rolling them onto their side. They are positioning the body in a specific configuration designed to maximise airway patency whilst keeping the person stable and safe.

Crucially, the head position is different from ordinary side sleeping. In the recovery position, the head is tilted back slightly, extending the neck. This extension does two things: it opens the airway more fully by straightening the path from mouth to lungs, and it tightens the pharyngeal muscles slightly, providing more structural support to the throat. The head is also allowed to rest in a way that keeps the face angled slightly downward, so that if the person vomits, fluid drains away from the airway rather than pooling at the back of the throat.

This combination of lateral positioning, neck extension, and downward face angle creates the safest possible airway configuration for someone who cannot protect their own airway consciously. It is so effective that it is credited with saving thousands of lives every year in situations ranging from stroke and seizure to overdose and head injury.

If the recovery position is the gold standard for keeping an unconscious person's airway open, why would we not apply the same principles to sleep?

Comparing The Two Positions

Most people who try to sleep on their side do not actually achieve proper side sleeping, let alone the optimised version that the recovery position represents. They lie on their side initially, but without support, they normally roll on to their back. The reason for this is their shoulder compresses, causing discomfort. Their arm goes numb. Their neck bends at an awkward angle. By morning, they would have spent most of the night on their back anyway.

Or some people find that their body is in a good side sleeping position, but they turn their neck so their head is still pointing towards the ceiling allowing the tongue to fall back.

Even in those people who are able to sleep on their side, standard side sleeping does not usually involve the neck extension that the recovery position uses. Most people sleep with their head on a pillow that flexes the neck forward, bringing the chin toward the chest. This narrows the airway. It reduces the tension in the pharyngeal muscles. It makes collapse more likely, not less. The position might feel comfortable for the neck in the short term, but it is working against airway patency.

The recovery position, by contrast, the face angles slightly downward, allowing the tongue to flop forwards rather than rolling back and blocking the throat where it can trigger an apnoea.

This is not just theory. When we perform sleep endoscopy and position patients in the recovery position rather than simple side sleeping, we see measurably better airway patency. The pharynx stays more open. The tongue sits further forward. The soft palate places itself over the surface of the tongue in a position where it is unlikely to vibrate. The improvement is visible on the camera.

Why "Just Sleep On Your Side" Does not Work

When patients tell me they have tried side sleeping and it did not help, I usually ask them to describe what they actually did. Almost always, they went to bed intending to sleep on their side, perhaps with a pillow behind their back to stop them rolling. But they did not think about their neck position. They did not stabilise their body properly. They did not consider whether their shoulder would hold up under prolonged pressure. They tried a version of side sleeping that was never going to succeed long-term.

The problem is that maintaining any sleeping position requires either conscious effort or physical support. Conscious effort does not work during sleep because you are, by definition, unconscious. So it comes down to support. If your setup does not physically prevent you from rolling onto your back, you will roll onto your back, probably multiple times throughout the night.

Even if you manage to stay on your side, the typical side sleeping position causes problems. Your lower shoulder bears your body weight all night, compressing nerves and reducing blood flow. This causes numbness and tingling, the sensation of "pins and needles" that wakes you up. Your upper arm has nowhere comfortable to rest. Your neck either flexes forward if the pillow is too high, or extends backward if the pillow is too low, and neither position is ideal for prolonged sleep. Your

spine is not properly supported, leading to lower back discomfort.

These issues make pure side sleeping unsustainable. People give up not because side sleeping does not work, but because uncomfortable side sleeping does not work. They conclude that they "cannot sleep on their side" when what they actually cannot do is sleep on their side without proper support.

The Evolutionary Context

This discomfort is not entirely our fault. Human beings did not evolve sleeping on flat mattresses. For most of our history as a species, we slept on uneven ground. A slight depression for the shoulder. A raised area for the head. Natural contours that accommodated our anatomy rather than forcing it to adapt to a perfectly flat surface.

Modern mattresses are too uniform. They do not provide the varied support that natural sleeping surfaces offered. Your shoulder needs somewhere to go that is not compressed under your body weight. Your head needs support at a specific height that maintains neck extension without excessive flexion or rotation. Your body needs something to prevent posterior rolling without creating uncomfortable pressure points.

Indigenous peoples around the world, who still sleep on traditional surfaces, often naturally adopt positions very similar to the recovery position. They are not doing this

because they have learned about airway physiology. They are doing it because it is comfortable and natural when you have the right support. The configuration works because it aligns with our anatomy.

First aid training rediscovered this through necessity. When you need to keep someone's airway open and you cannot use mechanical devices, you use position. The recovery position is not an invention; it is a recognition of how human anatomy works when properly supported against gravity.

Making It Work During Sleep

The challenge is translating the recovery position from a first aid technique into a sustainable sleeping position. You cannot sleep with your arm extended straight out in front of you all night; it will go numb. You cannot maintain the exact head position that works for an unconscious patient because you need to be able to move slightly, shift when uncomfortable, and adjust throughout the night.

What you can do is create the essential elements of the recovery position in a way that is compatible with sustained sleep. You need lateral positioning that resists rolling back. You need neck extension rather than flexion. You need shoulder clearance so nerves are not compressed. You need body support that creates the stability that the bent leg provides in the classic recovery position. And you need all of this to be

comfortable enough that you will actually use it night after night.

This is the gap between understanding what works and being able to implement it practically. We know the recovery position opens the airway. We know that the recovery position is better than side sleeping. We know that side sleeping is better than back sleeping. We know that proper positioning can dramatically reduce or eliminate snoring and sleep apnoea for many people. What we have not had until recently is a practical way to make this happen during actual sleep.

The Natural Solution

There is something rather elegant about the fact that the answer to a complex medical problem is a position we already teach as basic first aid. We do not question whether the recovery position works; we know it does because we have used it successfully for decades. We do not debate whether lateral positioning is better for airway protection than supine positioning; the evidence is overwhelming and the mechanism is clear.

What we have failed to do is make the connection between emergency airway management and chronic sleep-disordered breathing. We treat these as separate domains. Emergency medicine uses position as a primary intervention. Sleep medicine barely mentions it. Yet the anatomy is the same. The physics is the same. The benefit should be the same.

Side sleeping, done properly with the principles of the recovery position in mind, is not an alternative therapy or a fringe treatment. It is applied anatomy. It is practical physics. It is using what we already know about airway protection in a different context.

The question is not whether it works. The question is whether we can make it practical, comfortable, and sustainable enough that people will actually do it. Because if we can solve those practical challenges, we have a solution that is simple, safe, low-cost, and based on principles that are already taught to every first aid student in the country.

CHAPTER 5

WHY YOU CANNOT SLEEP ON YOUR SIDE

Understanding that side sleeping helps is one thing. Actually managing to do it all night, every night, is quite another. I have lost count of the number of patients who have told me they tried side sleeping for a few nights and gave up. When I ask why, the answers are remarkably consistent. Their ear hurt. Their shoulder went numb. They could not breathe properly into the pillow. Their neck ached in the morning. The list goes on.

These are not trivial complaints. They are legitimate anatomical problems that make sustained side sleeping genuinely difficult without the right support. And because they are so common, they represent the main barrier between knowing what works and being able to implement it practically.

Let's go through them one by one so we understand the barriers to side sleeping.

The Sore Ear Problem

After a few nights of sleeping on your side, many people develop a painful spot on the upper part of their ear where it presses against the pillow. This is not just mild discomfort. It can become genuinely painful, sometimes progressing to a

condition called chondrodermatitis nodularis helicis, which is inflammation and thickening of the skin and cartilage of the ear.

The ear is mostly cartilage covered by a thin layer of skin with very little cushioning tissue. When you press it against a pillow for hours at a time, you are compressing the blood supply continuously which can eventually lead to issues. The tissue becomes inflamed. A tender nodule can develop, usually on the rim of the ear where the pressure is greatest. Once this happens, any pressure on that spot becomes acutely uncomfortable, making side sleeping feel impossible.

The pain is enough to wake you up, shift position to relieve it (often rolling onto your back), and the relief is immediate. Your brain learns that back sleeping equals no ear pain, and side sleeping equals discomfort. Even when you consciously try to stay on your side, you unconsciously shift away from the pain during the night.

The Pillow Height Problem

Standard pillows are designed primarily for back sleeping. When you lie on your back, the distance from the mattress to the back of your head is relatively small, perhaps eight to twelve centimetres for most people. A typical pillow fills this gap adequately, supporting your head and keeping your neck in reasonable alignment.

But when you turn onto your side, the distance changes dramatically. Now the distance is not from mattress to back of head. It is from mattress to the side of your head; importantly, it needs to account for the width of your shoulder. For most adults, this distance is somewhere between fifteen and twenty five centimetres, depending on shoulder width and head size (assuming that the pillow does not compress at all).

If you use a standard pillow, your head is not supported enough when you are on your side. Your neck bends creating lateral flexion. The weight of your head pulls your cervical spine out of alignment. Your neck muscles have to work throughout the night to prevent excessive bending. By morning, you have neck pain, sometimes radiating into your shoulder or up into your head.

Some people try to solve this by stacking two pillows, but this creates its own problems. The pillows shift during the night. The height becomes too much. And if you roll onto your back, you are now propped up far too high, with your neck flexed forward in a position that is uncomfortable and potentially harmful.

The neck pain from inadequate pillow height is often severe enough to make people conclude that side sleeping "does not work for them." But it is not side sleeping that does not work. It is side sleeping with the wrong pillow height.

The CPAP Mask Problem

For people who use CPAP, side sleeping presents additional challenges. CPAP masks need to form a relatively airtight seal against your face. Even small gaps may cause leaks, which reduce the therapeutic pressure and create noise that disturbs sleep. Most masks work reasonably well when you are on your back because the pillow is behind your head, not pushing against the mask.

But when you turn onto your side, standard pillows push against the mask from the side. This breaks the seal. Air leaks out, often directed straight into your eye, which is both uncomfortable and disturbing. The machine compensates by increasing pressure, which makes the leak worse. You wake up with a dry eye, the hissing noise of escaping air, and the frustration of knowing your therapy is not working properly.

Some people with CPAP give up on side sleeping entirely because of mask leaks. Others persevere but end up with suboptimal therapy. Either way, the combination of CPAP and side sleeping becomes unnecessarily difficult when it should be complementary. The side sleeping / recovery position should reduce CPAP pressure requirements, making the whole system more tolerable. But the practical reality of mask interference prevents this from happening.

The Face-Down Breathing Problem

The recovery position involves angling the face slightly downward to allow drainage. This is excellent for airway protection in an unconscious person, but it creates an obvious problem during sleep: if your face is pressed into the pillow, you cannot breathe.

People trying to adopt a recovery position-like sleeping configuration quickly discover that they need their nose and mouth clear of the pillow surface. But standard pillows do not provide anywhere for your face to go. You end up either rotating your head into an uncomfortable position to keep your nose free, or you abandon the position entirely because the sensation of not being able to breathe freely is too distressing.

This is a fundamental design problem. The pillow that supports your head is the same pillow your face presses into. There is no separation between the two functions. You cannot have face clearance and head support simultaneously with a conventional pillow design.

Some people try to sleep on the edge of the pillow which makes complete sense, except it can place too much pressure on the downfacing eye, or lead to you trying to balance in that position all night.

The Facial Wrinkle Concern

This might seem cosmetic rather than medical, but it is a genuine concern for some people. When you sleep with your face pressed against a pillow all night, the skin compresses and folds. Over time, this can contribute to the formation of sleep lines and wrinkles, especially on the side you favour for sleeping.

The skin on your face becomes less elastic with age. It does not bounce back as readily from compression. The lines that form during the night start to persist into the day. Eventually, they become permanent features. Dermatologists recognise this as a real phenomenon, and some people are sufficiently concerned about it that they actively avoid side sleeping to protect their skin.

All those expensive creams are wiped off or dry off from the constant pressure of sleeping face down on a pillow.

Whether or not this concern is proportionate to the actual risk is debatable. But the fact remains that it is one more reason people give for avoiding side sleeping, especially those in their forties and beyond who are already noticing changes in their skin. I have met some where the fear of accelerating facial aging is enough to make them choose back sleeping despite the breathing problems it causes.

Shoulder Pain and Compression

Your shoulder was not designed to bear the weight of your entire upper body for eight hours at a time. When you lie on your side, that is exactly what happens. The shoulder joint compresses. The bursa, a fluid-filled sac that provides cushioning around the joint, can become irritated. The rotator cuff tendons get compressed between bones. People with existing shoulder problems find that side sleeping makes them worse.

Even without pre-existing pathology, prolonged shoulder compression causes discomfort. The weight of your torso presses down through your ribcage onto your shoulder. Blood flow to the area reduces. Inflammatory mediators accumulate. You wake up with a deep, aching pain in the joint that takes hours to resolve.

The body's response is predictable: you shift position to relieve the pressure. You roll onto your back or your other side. If you try to force yourself to stay on one side despite the discomfort, you wake up with genuine shoulder injury. Rotator cuff tendinitis. Subacromial bursitis. These are not trivial conditions. They can take months to resolve and may require physiotherapy or even surgery.

Arm Numbness and Nerve Compression

Related to shoulder pain but distinct from it is the problem of what happens to your arm when you are sleeping on your side. The classic side sleeping position leaves your lower arm trapped under your body or compressed against the mattress. This puts pressure on nerves, particularly the ulnar nerve as it passes around the elbow and the median nerve as it passes through the wrist.

Reduced blood flow and nerve compression produce the characteristic sensation of pins and needles. Your hand goes numb. Your fingers tingle. The feeling can extend up into your forearm. It is uncomfortable enough to wake you up, sometimes multiple times per night. When you move your arm, blood flow returns and the nerves start working again, but the recovery process itself can be painful as sensation returns.

Chronic nerve compression can lead to lasting problems. Ulnar nerve entrapment at the elbow, sometimes called "cubital tunnel syndrome," can develop from repeated episodes of compression during sleep. Carpal tunnel syndrome can be aggravated by wrist position during side sleeping. These are genuine medical conditions requiring treatment, not just temporary annoyances.

Hip Pain and Bursitis

The hip bears similar compressive forces to the shoulder when you are lying on your side. The greater trochanter, the bony prominence on the outside of your hip, presses into the mattress. Between the bone and your skin is a bursa, similar to the one in your shoulder, and it can become inflamed from prolonged pressure.

Trochanteric bursitis is a common cause of hip pain, It causes a deep, aching pain on the outside of the hip that is worse when lying on that side. People with this condition find side sleeping extremely uncomfortable. They shift position repeatedly through the night, or they avoid side sleeping altogether and end up on their back.

The pressure on your hip also affects the lower back. When your hip sinks into the mattress whilst your torso stays relatively supported, your spine twists slightly. The lumbar vertebrae are not aligned properly. Your lower back muscles have to work to maintain position. By morning, you have lower back pain on top of any hip discomfort.

The Accumulated Burden

Individually, each of these problems might be manageable. But they do not occur in isolation. Someone trying to maintain side sleeping often experiences several of them simultaneously. Their ear hurts, their shoulder is uncomfortable, their arm is

going numb, and their hip aches. The cumulative discomfort becomes overwhelming.

The natural response is to roll onto your back. The relief is immediate. Your ear is not compressed. Your shoulder is not bearing weight. Your arm is not trapped. Your hip is not pressed into the mattress. Every source of discomfort resolves at once.

Your brain, even during sleep, learns this pattern. Discomfort on side equals relief on back. After a few nights, the rolling becomes automatic. You do not consciously decide to abandon side sleeping. Your body does it for you, seeking comfort and relief from pain. By the time you wake in the morning, you have spent most of the night on your back despite your best intentions.

This is why telling someone to "just sleep on your side" rarely works. It is not that they are unmotivated or non-compliant. It is jsut that the physical realities of maintaining that position are genuinely difficult without specific solutions to each of these anatomical problems.

The Missing Solutions

What is needed is not willpower or discipline. It is design. Something that addresses ear pressure. Something that provides correct pillow height for side sleeping. Something that works with CPAP masks rather than against them. Something that allows face clearance whilst supporting the head. Something that does not cause shoulder compression or arm numbness or hip pain.

This is not about comfort for comfort's sake. It is about removing the barriers that make side sleeping unsustainable. Because if we can solve these practical problems, we can make an effective treatment actually usable. And that is the difference between knowing what works in theory and having something that works in practice.

CHAPTER 6

WHO BENEFITS FROM THIS?

One of the most common questions I hear in clinic is whether positional therapy will work for a particular patient. They have read about it, or their partner has mentioned it, or they have seen something online, and they want to know if it applies to them. The honest answer is that positional therapy helps far more people than most assume. You do not need to fit into a narrow category or meet specific criteria. If you snore, if you have sleep apnoea, or if you simply wake up feeling unrested, There is a reasonable chance that position is at least part of the answer.

The question is not really whether you will benefit. The question is how much you will benefit, and whether that benefit is meaningful enough to be worth pursuing. And here is something important that most doctors do not appreciate: most people will accept a ten per cent improvement if it does not require devices, procedures, or pain. Even partial benefit matters when the intervention is simple and safe.

Sleep Apnoea Patients Across the Spectrum

The traditional view is that positional therapy is only for mild sleep apnoea. If your apnoea-hypopnoea index is under fifteen,

perhaps you are a candidate. If it is over fifteen, you need CPAP. This binary thinking misses the reality that position helps across the severity spectrum, just to different degrees.

If you have mild sleep apnoea with an AHI between five and fifteen, positional therapy might normalise your breathing entirely. Many people in this range have completely normal sleep when they are on their side, with all their events occurring when they are on their back. For these patients, positional therapy is not a partial solution. It is the solution.

Moderate sleep apnoea, with an AHI between fifteen and thirty, is more variable. Some patients still achieve normal breathing with side sleeping alone. Others improve significantly but do not normalise completely. Their AHI might drop from twenty-five to twelve, which is still technically mild sleep apnoea but represents a substantial reduction in the number of times they stop breathing each hour. That is fewer oxygen desaturations, less disrupted sleep architecture, and reduced cardiovascular stress.

Even severe sleep apnoea patients can benefit from positional therapy, though these patients may need additional treatment. You may be lucky and your severe sleep apnoea completely resolves when you are sleeping on your side. However if your AHI is fifty on your back but thirty on your side, that is still severe sleep apnoea. But it is forty per cent less severe. If you are using CPAP, that reduction in baseline severity means the machine can operate at lower pressures. If you are considering

surgery, addressing position first might make the difference between needing aggressive intervention (e.g. removing a lot of tongue muscle or getting an implant), and getting by with something more conservative (e.g. only removing the lingual tonsil sitting on top of the tongue muscle).

The point is that benefit does not have to mean cure. A meaningful reduction in sleep-disordered breathing is worthwhile even if it does not eliminate the problem completely. And for many people, especially those in the mild to moderate range, the improvement is substantial enough to avoid or delay other treatments.

Here is the key question your sleep study should answer: is your sleep apnoea severe in all positions, or only in some? If your AHI is 55 when you are on your back but 6 when you are on your side, your problem is primarily positional, and keeping yourself on your side is the logical first approach. If your AHI is 55 on your back and 48 on your side, your problem is mostly not positional, and you ought to think of the other treatment options as well (CPAP, surgery, or another intervention regardless of position). The overall AHI number can be misleading because it averages across all positions. What you need to know is: what is my AHI in each position, and can I maintain that position all night?

Simple Snorers

Not everyone who snores has sleep apnoea. Many people vibrate their soft palate loudly enough to disturb their partner but maintain normal oxygen levels and do not have significant breathing pauses. These "simple snorers" often get told that their snoring is just an annoyance rather than a medical problem, which overlooks two important facts.

First, snoring is not harmless. Children who snore without sleep apnoea show reduced educational performance. The vibration disrupts sleep quality in ways that do not show up on oxygen saturation measurements but still affect daytime function. You might not be stopping breathing, but you are not sleeping well either.

Second, snoring often seems to progress to sleep apnoea over time. There is a theory that the vibration from snoring damages the nerves and muscles in your throat, making it collapse later on in life. Today's simple snorer may be tomorrow's sleep apnoea patient. Addressing snoring early, before it progresses, seems like a reasonable step.

Positional therapy is remarkably effective for snoring. Most snoring is worse on the back because the palate often flops back and rests on the back wall of the throat, airflow then has to pass through this narrow gap, leading to vibration. Using gravity to get the palate to flop forward out of the way and this time rest on the tongue (allowing airflow through the nose normally), widens this gap so there is not so much turbulence

and therefore less snoring vibration. Partners report immediate improvement, which is perhaps the most reliable measure of success.

If you snore, even without diagnosed sleep apnoea, positional therapy is worth trying. The intervention is simple, the risks are minimal, and the potential benefit extends beyond just keeping your partner happy.

Pregnancy and Side Sleeping

Pregnant women are often told to sleep on their left side, particularly in the third trimester. The standard explanation is that it improves blood flow to the baby by avoiding compression of the inferior vena cava (the large vein that returns blood from the lower body to the heart). This is true and important, but There is another reason that gets less attention: pregnancy makes sleep-disordered breathing worse, and side sleeping helps.

As pregnancy progresses, fluid and weight gain increases tissue bulk in the neck and throat. Hormonal changes cause narrowing of the nasal passages and swelling of throat tissues. The growing uterus pushes the diaphragm upward, reducing lung capacity and making it harder to breathe deeply. All of these factors make the airway more likely to collapse during sleep.

Many women who never snored before pregnancy start snoring in the second or third trimester. Some develop frank sleep apnoea and the lack of oxygen cannot be good for the baby or the mother. There is a higher risk of preterm, and stillbirth, low birth weight issues with mothers who get sleep apnoea during pregnancy.

Side sleeping addresses several of these problems simultaneously. It keeps the airway more open, reducing snoring and apnoea. It improves blood flow to the placenta. It reduces pressure on the back and hips, which often become painful in late pregnancy. For pregnant women, positional therapy is not optional. It is one of the most important interventions available, and it is completely safe for both mother and baby.

The challenge is that pregnancy makes side sleeping uncomfortable in many of the ways we have already discussed. The weight of the belly pulls on the lower back. Hip pain is common. Standard pillows do not provide adequate support. This is why pregnant women often end up with elaborate pillow arrangements, trying to support their belly, their back, their knees, and their head simultaneously. When done properly, these setups work. When done poorly, they collapse during the night and women end up back on their backs despite knowing they should not be.

Improving CPAP Compliance

For people using CPAP who struggle with tolerance, positional therapy can be transformative. When you sleep on your side, your airway is naturally more open. This means your CPAP machine does not need to work as hard. The pressure required to keep your airway patent is lower when gravity is helping rather than working against the machine.

Lower pressures have multiple benefits. Mask leaks become less likely because There is less pressure trying to force air past the seal. When leaks do occur, they are smaller and less disturbing. Aerophagia, the swallowing of air into the stomach that causes bloating and discomfort, happens less because the pressure gradient from the mask to the oesophagus is reduced. The sensation of air being forced into your lungs is less intense, making the whole experience more tolerable.

Some people find that combining side sleeping with CPAP allows them to use the machine successfully when they could not tolerate it before. Others find they can reduce their pressure settings whilst maintaining therapeutic benefit.

This does not mean everyone can abandon their CPAP. Many people have severe enough sleep apnoea that they need mechanical support regardless of position. But even for these patients, the combination of position and CPAP is better than CPAP alone. The therapy is more effective, more comfortable, and more likely to be used consistently.

There is a subtlety to CPAP and tongue base collapse that most people are not told about, and it is worth understanding. When sleep apnoea is primarily caused by the tongue base falling backward, CPAP can actually be working against itself. Many full face masks use straps that pull the mask firmly against the face and, in doing so, push the jaw slightly backward. A backward jaw means a backward tongue. Which is precisely the problem you are trying to solve in the first place.

This is most pronounced with full face masks, which cover both nose and mouth and require firm strapping to maintain a seal. If your sleep apnoea is driven by tongue base collapse, this strap pressure compounds the very problem that the air pressure is trying to compensate for. You are using a machine to force your airway open with one hand whilst inadvertently pushing the obstruction back with the other.

There is also the practical matter of sleeping position. Standard CPAP tubing can create uncomfortable pressure against your cheek or ear, and most people respond by rolling onto their back to relieve it. Sleeping on your side can lead to the mask being tilted a bit from the pressure of the pillow and this can lead to air leaks that can disturb the patient (especially if the leak goes into the eyes).

Some CPAP mask setups, quite unintentionally, penalises side sleeping and encourages exactly the position that worsens your apnoea.

For people with tongue base collapse who want to combine CPAP with positional therapy, the choice of mask matters considerably. Nasal masks or nasal pillow systems, which sit only under the nose and use lighter, less intrusive strapping, avoid the jaw-retraction problem. The straps do not pull across the cheeks in the same way, so the jaw sits where it wants to sit rather than being held slightly back. Nasal pillow systems in particular are remarkably unobtrusive and work well for people who want to maintain side sleeping without fighting their equipment. Pillows also have the advantage of splinting open your nostrils and stopping them from collapsing.

If you are using CPAP and struggling with mask leaks when you try to sleep on your side, or if your equipment seems to be working against you rather than with you, it is worth having a conversation with your sleep clinic specifically about mask selection for side sleeping. They can assess your individual collapse pattern with a drug induced sleep endoscopy, look at where your leaks are occurring, and recommend a mask that works with your preferred position rather than against it. There is no universal best mask. The right choice depends on your anatomy, your apnoea pattern, and how you sleep. Getting this right can make the difference between CPAP you can actually tolerate and one that is hidden under the bed.

Mandibular Advancement Devices

Mandibular advancement devices (MAD) work by holding the jaw forward, which pulls the tongue forward and opens the airway. They look like gum shields and they are effective for many people, but the degree of jaw advancement required varies. Some people need only a few millimetres of protrusion. Others need substantial advancement, sometimes eight or ten millimetres, to achieve adequate airway opening.

The more you advance the jaw, the more strain you place on the temporomandibular joint and the more force you apply to the teeth. Excessive advancement can cause TMJ pain, clicking, limited mouth opening, and long-term joint problems. It can also cause tooth movement or loosening, particularly if the teeth are not perfectly healthy to begin with. These complications are significant enough that a few people abandon MAD therapy despite it being effective for their breathing.

Side sleeping reduces the amount of advancement needed. Because gravity is already pulling the tongue forward when you are on your side, the device does not have to work as hard. This means you can use a less aggressive advancement setting, reducing the mechanical stress on your jaw and teeth whilst maintaining therapeutic benefit for your breathing.

For people considering a mandibular advancement device, trying positional therapy first makes sense. You might find you do not need the device at all. If you do still need it, using it in

combination with side sleeping allows a gentler, less aggressive approach that is more likely to be sustainable long-term.

Gastro-Oesophageal Reflux Disease

Gastro-oesophageal reflux disease, or GORD (or GERD in America), involves stomach acid flowing back up into the oesophagus, causing heartburn and sometimes breathing problems during sleep. The reflux is worse when lying flat because gravity no longer helps keep stomach contents where they belong. It is even worse on the right side because of the anatomy of the stomach.

Your stomach is shaped a bit like a J, with the entrance from the oesophagus at the top and the exit to the small intestine on the right side. When you lie on your right side, the pool of stomach acid sits right against the entrance to the oesophagus. It is easy for acid to flow backward into the oesophagus from this position.

When you lie on your left side, the anatomy works in your favour. The pool of acid is away from the oesophageal opening, sitting instead near the exit to the small intestine. Gravity and the shape of the stomach make reflux less likely. People with GORD report significantly fewer symptoms when sleeping on their left side compared to their right or their back.

This is relevant to sleep apnoea because reflux can worsen breathing problems. Acid in the oesophagus can trigger coughing and throat irritation, making sleep more disrupted. Some reflux can reach the larynx and even the lungs, causing inflammation that narrows the airway. For people with both sleep apnoea and GORD, left-sided sleeping addresses both problems simultaneously.

It should be said also that OSA also makes GORD worse (increased pressure in the abdomen that ends up forcing

gastric contents up causing issues in the throat), so side sleeping would help both things.

Obesity Hypoventilation Syndrome

Obesity hypoventilation syndrome is a condition where excessive weight affects breathing so significantly that carbon dioxide builds up in the blood even during wakefulness. It is often more severe than sleep apnoea alone, and it carries serious health risks including heart failure and respiratory failure.

The mechanism involves both mechanical and neural factors. The weight of the chest wall and abdomen makes it harder for the respiratory muscles to expand the lungs. The increased effort required to breathe leads to fatigue. Over time, the brain's respiratory control centres become less sensitive to rising carbon dioxide levels, a process called resetting of the respiratory drive. This creates a dangerous cycle where breathing becomes progressively more inadequate.

During sleep, when respiratory drive decreases naturally and muscle tone drops, the problems worsen dramatically. Many people with obesity hypoventilation syndrome have severe sleep apnoea on top of their breathing difficulties.

Positional therapy helps by reducing the mechanical load on the respiratory system. When you are on your back, the weight of the abdomen and chest presses down on the lungs and

diaphragm from above. When you are on your side, this weight is distributed differently. The diaphragm can move more easily. Lung expansion is less restricted. The work of breathing decreases.

The Common Thread

What all these conditions share is that position matters. Whether you have mild snoring or severe sleep apnoea, whether you are pregnant or using CPAP, whether you have reflux or obesity hypoventilation, the configuration of your body relative to gravity affects your breathing and your sleep.

This is not alternative medicine or fringe therapy. It is applied physiology. Your anatomy responds to position in predictable, measurable ways. The question is not whether position matters but whether you can implement positional therapy in a way that is practical and sustainable.

If you recognise yourself in any of these categories, you are a candidate for positional therapy. The degree of benefit will vary. The need for additional treatments will vary. But the fundamental principle remains: sleeping on your side, done properly, will help. And for an intervention that is safe, simple, and costs almost nothing, even a modest improvement is worth having.

CHAPTER 7

WILL THIS WORK FOR ME?

I understand the scepticism. You have probably tried multiple solutions already. You have bought pillows that promised to fix your snoring. You have attempted side sleeping with makeshift arrangements of cushions. Perhaps you have persevered with CPAP for months despite hating every minute of it. Or maybe you abandoned it within weeks because you simply could not tolerate sleeping with a mask strapped to your face. And now someone is suggesting that a different pillow might help, and you are thinking, "Surely it cannot be that simple."

This chapter addresses the objections I hear most frequently in clinic and through emails from people considering positional therapy. These are legitimate concerns, and they deserve honest answers.

"CPAP is the gold standard — why bother with positional therapy?"

This objection comes up constantly, and it is based on a genuine truth: CPAP is the most effective treatment for moderate and severe obstructive sleep apnoea. It delivers continuous positive airway pressure that physically holds your airway open, preventing collapse regardless of your anatomy or position. For

someone with an AHI of 50 or 60, CPAP can be life-saving. I prescribe it regularly, and I have seen it transform people's health.

But here is what we do not talk about enough: between 40% and 60% of people abandon CPAP within the first year. Not because they do not understand its importance but because sleeping with a mask profoundly uncomfortable for some people.

The mask leaks. It creates pressure sores on the bridge of your nose or your cheeks. The air pressure makes some people feel like they are suffocating rather than being helped. Others develop aerophagia, where air gets swallowed into the stomach, causing painful bloating. Some people simply cannot tolerate the sensation of something strapped to their face all night. The claustrophobia is overwhelming.

When someone struggles with CPAP, the medical response is usually to try different masks, adjust pressure settings, add humidification, perhaps switch to a different type of machine. All reasonable approaches. But rarely does anyone say, "Have you tried combining this with side sleeping?"

This is where the "gold standard" thinking becomes limiting. It is not about replacing CPAP. It is about recognising that for many people, particularly those with positional sleep apnoea, combining treatments makes both more effective and more tolerable.

Side sleeping reduces the baseline severity of your airway collapse. When your airway is naturally more open because gravity is helping rather than hindering, your CPAP machine does not need to work as hard. Lower pressures mean fewer leaks, less aerophagia, less sensation of air being forced into your lungs. The therapy becomes more comfortable, and comfortable therapy is therapy that people actually use.

There are no contraindications to combining positional therapy with CPAP. You are not choosing between them. You are using both to achieve better results than either would provide alone. For someone with severe positional OSA, this combination might reduce pressure requirements enough that CPAP becomes tolerable for the first time. For someone with moderate positional OSA, it might eliminate the need for CPAP entirely.

The question is not whether CPAP is effective, because it is. The question is whether we are doing everything we can to make it tolerable, and whether we are considering alternatives for people who genuinely cannot use it despite their best efforts.

"I have tried side sleeping—it does not work for me"

When someone tells me this, I always ask them to describe exactly what they tried. Almost universally, the answer is some variation of: "I always go to sleep on my side”.

When I then look at the sleep study, it seems they are right, they go to bed sleeping on their side, but then during the night they roll over on to their back multiple times through the night. There is invariably 20% of sleep on their back, which is certainly enough to cause symptoms.

This is not side sleeping failing. This is unsupported side sleeping failing, which is completely expected. Without physical support preventing rolling over, your body will naturally seek its habitual position during sleep.

Some people try more elaborate setups. A pillow behind their back, another between their knees, something under their head. These work initially but collapse during the night. The pillows shift, separate, end up scattered across the bed. By morning, you are back on your back with a pile of cushions around you.

Others persevere and manage to stay on their side but develop significant discomfort. Shoulder pain from compression. Arm numbness from trapped nerves. Hip bursitis from prolonged pressure. Ear pain from cartilage being compressed against the pillow for hours. These are not trivial problems. They are genuine barriers that make continued side sleeping intolerable.

After a few nights of this, you conclude that "side sleeping does not work for me." But what you have actually discovered is that uncomfortable, unsupported side sleeping does not work. You have tried side sleeping but you have not had the right support system to make it sustainable.

The Side Sleeping Pro addresses each of these problems specifically. The shoulder gap removes compression on your shoulder joint. The body wedge prevents rolling without uncomfortable straps or bumps. The letterbox opening eliminates ear pressure. The extended body section supports your hip. These are not luxury features. They are solutions to the specific anatomical problems that make conventional side sleeping difficult.

Most people need two to four weeks before the new position feels natural. This is not a character flaw. Your brain has decades of habit to overcome. Give yourself time to adapt before deciding whether it works.

"It sounds too simple—surely positional therapy cannot help real OSA?"

This objection reveals something interesting about how we think about medicine. We have become conditioned to believe that effective treatments must be complex, expensive technology, or invasive. Simple solutions feel suspicious, as if they cannot possibly work for "real" problems.

But the evidence for positional therapy is not speculative. We know that at least 60% of people with OSA have a significant positional component and the rest will have some positive changes when sleeping on the side. We know from sleep studies that AHI can drop dramatically with position changes. We know

from drug-induced sleep endoscopy that airways visibly open when patients are rolled from back to side.

Consider what "real" OSA means. If your AHI is 30 when you are on your back and 10 when you are on your side, that is still technically mild sleep apnoea. But it is a 67% reduction in the number of times you stop breathing per hour. That is not a trivial improvement. That is dramatically fewer oxygen desaturations, substantially less disrupted sleep architecture, and significantly reduced cardiovascular stress.

Even if positional therapy does not normalise your AHI completely, meaningful improvement is worthwhile. Reducing your AHI from 90 to 45 is still a 50% reduction. For an intervention that is simple, safe, and costs a fraction of what we spend on machines and devices, even modest improvement represents excellent value.

Sleep apnoea implants like Inspire and Genio generally reduce sleep apnoea by about 70% - 75% on average. MMA / BiMax operations reduce sleep apnoea by about 68% on average. These are great improvements in whom CPAP was not an option, but they are relatively invasive compared to just learning to sleep on your side.

The simplicity is a feature, not a flaw. Gravity is incredibly powerful. When you are on your back, gravity pulls your tongue, soft palate, and throat tissues posteriorly into your airway. When you are on your side, gravity pulls these same tissues laterally, out of the airway. This is basic physics. The

question is not whether it works. The question is whether we can make it practical and sustainable.

For some people with purely positional OSA, proper side sleeping eliminates the problem entirely. Their AHI normalises, their symptoms resolve, and they avoid the need for more complex interventions. For others with mixed anatomical and positional components, it provides substantial benefit whilst still requiring additional treatment. Either way, it is worth trying the simple thing first.

"I cannot sleep on my side—it hurts my shoulder or hip"

This is probably the most valid objection because it is based on real experience. Standard side sleeping does cause shoulder and hip pain. Your shoulder joint was not designed to bear your body weight for eight hours. Your hip bursa becomes inflamed from sustained pressure. These are legitimate anatomical problems.

But notice the language: "I cannot sleep on my side." What you have actually discovered is that you cannot sleep on your side with standard pillows that provide no shoulder clearance and no hip support. You have tried uncomfortable side sleeping, and correctly concluded it is unsustainable.

The shoulder gap in the Side Sleeping Pro solves the compression problem by removing the load from your

shoulder joint entirely. Your shoulder sits in the gap whilst the body wedge supports your torso. When positioned correctly, There is no weight on your shoulder at all. The body section takes the load.

Similarly, the extended body wedge that reaches to your knees, provides support under your pelvis and hip, distributing pressure across a much larger surface area. Instead of your greater trochanter pressing into the mattress with all your weight concentrated on that single bony prominence, the load is spread along the entire length of your side. This prevents the localised pressure that causes trochanteric bursitis.

If you have tried side sleeping before and developed pain, you have not failed at side sleeping. You have discovered that unsupported side sleeping causes predictable anatomical problems. The solution is not to give up on side sleeping. It is to address the support problems that caused the pain.

"Will sleeping on my side cure my sleep apnoea?"

This is perhaps the most important question, and it requires an honest answer: it depends on your type and severity of sleep apnoea.

If you have purely positional OSA, where your AHI normalises when you are on your side, then yes, maintaining side sleeping throughout the night can effectively eliminate your sleep apnoea. Your AHI stays under 5, which is considered normal.

You have addressed the problem by working with gravity rather than against it.

If you have mixed OSA with both positional and anatomical components, side sleeping will improve your condition substantially but might not normalise it completely. Your AHI might drop from 30 to 12, which is still technically mild sleep apnoea but represents a massive improvement in your health outcomes. You might still need CPAP or other interventions, but at reduced intensity.

If you have a type of sleep apnoea where your airway collapses regardless of position, positional therapy will not be sufficient. You will need a DISE followed by treatment with CPAP, MAD, surgery or nerve stimulation implants.

The only way to know definitively is through a sleep study. If you have already had one, look at your positional data. Compare your supine AHI to your non-supine AHI. If There is a substantial difference, you are a candidate for positional therapy. If the numbers are similar in all positions, your sleep apnoea is non-positional and you will need other interventions.

You can also use the real world test – ask your bed partner. If they say that they are spending their nights rolling you over on to your side to reduce the noise and improve your breathing, then surely that is evidence enough?

But here is the crucial point: "cure" is not always the goal. Meaningful improvement is the goal. If this reduces your AHI by 50%, improves your sleep quality, reduces your CPAP

pressure requirements, and helps you wake feeling more rested, that is a successful intervention even if it does not eliminate sleep apnoea completely.

We do not abandon treatments for diabetes or hypertension just because they manage rather than cure the condition. We recognise that effective management produces substantial health benefits. The same principle applies to sleep apnoea. Meaningful improvement matters, even when complete resolution is not achievable.

"What if I move in my sleep? Will not I just roll onto my back anyway?"

This is perhaps the most common concern, and it is completely legitimate. Everyone moves during sleep. The average person changes position between 10 and 30 times per night, often without any conscious awareness.

The pillow addresses this through passive resistance rather than physical restraint. The body section is deliberately broad so that when you lie on it, you sink slightly into the surface. If you try to roll onto your back, you are essentially rolling uphill against this gentle depression. Your sleeping brain registers this as uncomfortable and resists the movement without you ever waking up.

The body section is also thin enough that if you do roll all the way onto your back, you start to feel like you are sliding off the

edge. Again, your sleeping brain does not like this sensation and pulls you back toward the centre. This happens unconsciously throughout the night.

It is not a perfect system. Some people, particularly those with Restless Legs Syndrome or Periodic Limb Movement Disorder, will still end up on their back for portions of the night. The idea of the Side Sleeping Pro is not to force you into a position but to make it more comfortable for you to sleep on your side. This hopefully will reduce another reason to sleep on your back, or to encourage your sleeping self to spend more time on your side. And even if you spend 20% of the night on your back instead of 60%, that is a meaningful improvement in your breathing and sleep quality.

The other factor is adaptation. In the first few nights, your brain is fighting the new position because it is unfamiliar. After two to four weeks, side sleeping with proper support becomes your new normal. Your unconscious position preferences shift. You stop trying to roll onto your back as frequently because your brain has accepted that side sleeping is comfortable and safe.

This is why I recommend giving it a proper trial of several weeks before deciding whether it works. The first few nights are not representative of what sustained use looks like once your body has adapted.

"Shouldn't I just lose weight instead?"

This comes up constantly, and it is worth addressing directly. Yes, weight loss helps sleep apnoea. Bringing your BMI down to mid-normal levels (around 20 - 22.5 for most people) typically reduces AHI by 30% to 40%. Blood pressure improves, glucose control improves, cardiovascular risk drops. Weight loss is genuinely beneficial and I encourage it.

But Secretary@PrivateGP.Doctor what the evidence actually shows: in a long-term study of 216 patients who achieved significant weight loss through diet, only six maintained their weight reduction, and of those, only three had resolution of their sleep apnoea (Sampol et al., European Respiratory Journal 1998). The study followed patients for five years and found that whilst weight loss improved sleep apnoea when achieved, maintaining that weight loss long-term proved extremely difficult. Most patients regained the weight, and their sleep apnoea returned.

This is because obesity is often layered on top of other anatomical problems (large tonsils, tongue base collapse etc.) that do not disappear when you lose weight. You improve one component but the underlying anatomy remains.

There is also a vicious cycle that most people do not realise exists. Sleep apnoea causes weight gain. The hormonal changes, the fatigue, the stress response, all of these make it harder to lose weight and easier to gain it. Studies show that people with untreated OSA lose significantly less weight during

weight-loss programmes than people without it. Your body is actively fighting to hold onto fat because it interprets the physiological stress of interrupted breathing as a signal that something bad is coming.

This is why I often see patients suddenly start losing weight after their sleep apnoea is treated, even without major dietary changes. Fix the breathing, and the physiological pressure to gain weight releases. The diet that was not working suddenly starts working.

So the honest answer is: you should pursue both. Positional therapy addresses the mechanical problem of airway collapse during sleep. Weight loss addresses the metabolic and anatomical load. They work together, not instead of each other. And for many people, fixing the sleep apnoea first makes the weight loss actually achievable, rather than the grinding uphill battle it becomes when you are exhausted and your hormones are working against you.

Waiting to lose weight before treating your sleep apnoea means suffering with poor sleep, increased cardiovascular risk, and hormonal disruption that makes weight loss harder. It is putting the harder thing first when the simpler intervention, sleeping on your side, could improve your sleep tonight and make the weight loss easier tomorrow.

The Real Question

The objections in this chapter all circle around the same underlying concern: is this worth trying? Will it actually help, or is it just another product making exaggerated claims?

Here is my perspective as someone who has spent years treating sleep disorders: if you have any positional component to your sleep apnoea or snoring, this addresses the specific barriers that make positional therapy difficult to implement. It will not help everyone, but for people whose breathing improves with side sleeping, it provides a practical way to maintain that position sustainably.

The intervention is simple, safe, and low-cost compared to machines, devices, and surgery. The downside risk is minimal. If it does not help after a proper trial of several weeks, you have lost very little. If it does help, you have gained better sleep, better health, and potentially avoided more complex interventions.

That seems like a reasonable trade-off to me. But ultimately, you will need to make that decision based on your own situation, your sleep study results, and your tolerance for your current treatments or lack thereof.

What I can tell you with certainty is that positional therapy works when implemented properly. The challenge has always been making it practical and sustainable. This pillow is my attempt at helping you sleep more comfortably on your side, in the hope you can maintain that position for longer. Whether it

works for you depends on if positional therapy is a useful treatment option for you.

The only way to find out is to try something similar to it at home with standard pillows and see what your app says or if your parter managed to get any sleep next to you. If you snore less and feel more rested in the morning, then you can make your own pillow or buy one of mine.

CHAPTER 8

MY JOURNEY TO CREATE A SOLUTION

After analysing those 6,044 sleep studies and realising that the majority of people would benefit from side sleeping, I faced a frustrating problem. I knew what would help. I just did not have anything practical to recommend to my patients. The conversation would go something like this: "Your sleep apnoea is much better when you are on your side, so try to sleep that way." And they would nod politely, knowing full well they had tried that before and ended up on their back by morning anyway.

I started looking at what was available. Surely someone had solved this already. Surely there was a pillow or device I could recommend with confidence. So I did what any modern person does: I searched online, watched reviews, and in April 2022, I made a YouTube video reviewing every major sleep pillow I could find. I wanted to tell my viewers and my patients which one to buy.

The conclusion was disappointing. They were all essentially neck support pillows. Unusual shapes, clever marketing, impressive claims, but fundamentally designed for cervical alignment rather than airway management. None of them addressed the actual problems that make side sleeping difficult. None of them prevented you from rolling onto your

back. And none of them put you into something resembling the recovery position, which I knew from my endoscopy work was the most effective configuration for keeping airways open.

At the end of that video, slightly frustrated and perhaps somewhat rashly, I said I would make my own pillow. At the time, I had no idea what I was getting myself into.

Testing on Myself

Before designing anything, I needed to understand the problems properly. So I became my own test subject. I wore a WoodyKnows backpack that forces you to sleep on your side all night. Before long I started getting all the things my patients were complaining about. My ear hurt where it pressed against the pillow, a sharp pain in the cartilage that got worse each night. My neck ached from the angle. My shoulder felt compressed, and after a while, my hand started going numb with pins and needles from poor circulation. My hip developed a bursitis, a painful inflammation that had me hobbling for the first hour each morning.

These were not minor annoyances. They were genuine barriers that made me want to roll onto my back for relief. And if I could not tolerate it, how could I expect my patients to? I realised that all those positional devices on the market, the straps and backpacks and bumps, might prevent back sleeping, but they did not solve the fundamental problem: side sleeping needs to be comfortable, or people simply will not do it.

Coming Up With A Design

Now I knew where the pain points were, and I knew that the recovery position would be the best position to sleep in. All I had to do was achieve that comfortably. Which, as it turned out, was considerably harder than it sounds.

I got into bed with an assortment of pillows and started experimenting. One behind my back to prevent rolling. One between my knees for hip alignment. One under my head at various heights. One tucked under my upper arm. I tried combinations and configurations that my wife found increasingly baffling, and which I found increasingly uncomfortable. The first few nights, I was optimistic. By the end of the first week, I was mostly just tired.

The problems were not theoretical. They were very specific and they appeared in a reliable sequence. My ear would start hurting after about an hour, that sharp cartilage pain I mentioned earlier. Then my shoulder would begin to ache from being compressed against the mattress. Then my hand would go numb. Then, usually in the small hours, my hip would register its objection. By this point, the pillow arrangement I had constructed so carefully at bedtime had migrated across the bed and was no longer doing what I had intended. I would roll onto my back for relief, and the whole experiment would be over for the night.

What I was learning, even in the failures, was useful. Every problem I encountered was information about what the design

would eventually need to solve. The ear needed somewhere to go that was not a solid surface. The shoulder needed genuine clearance, not just a slightly softer surface to compress against. The hip needed distributed support across its full length, not a single pillow that could be displaced. And the whole arrangement needed to prevent rolling onto the back not by force, which creates its own discomfort, but by making back sleeping simply less comfortable than side sleeping.

After several weeks of this, I had a clearer picture of what I actually needed. Not a collection of separate pillows trying to cooperate, but a single integrated design where every element worked together. The recovery position geometry had to be built into the shape rather than constructed each night from scratch. The materials had to provide genuine support without creating the pressure points that had been defeating me.

I wrote up the design with dimensions, materials, and specifications. It took a while to get right on paper, longer than I expected, because the geometry of keeping someone in recovery position turns out to involve more variables than it initially appears. But eventually I had something I was confident would work. The challenge then was turning it into an actual pillow, which led me directly into a set of entirely different problems.

The Design Agency Disaster

Once I had worked out what was needed, I did what seemed like the next most sensible thing. I spent a lot of money on a professional design agency in central London. I thought spending money on expertise would save time and produce better results. I explained what I wanted, I showed them my designs, I held lectures to explain snoring and sleep apnoea and why I think my design works.

They took my designs and then promptly dismissed my ideas and spent a few months in 'development'. What they came back with was a standard pillow with a V stitched into it. "It is a V, like your name," they explained. "People will buy it".

It was, I thought, an ambitious interpretation of the brief. I began to suspect we were solving branding rather than breathing.

This had nothing to do with airway management or sleep position. It was marketing thinking applied to a medical problem.

They showed me a few other concepts, but none of them made sense. None of them addressed the issues I had identified. I had spent a significant portion of my savings, and I had nothing useful to show for it. It was an expensive lesson.

The Agent Disappointment

I saved up again and tried a different approach. I hired agents to find manufacturers, source materials, and navigate the production process. I gave them specifications: the types of foam I needed, the structure, the dimensions. They came back with nothing, either it 'was not possible' or options that were wholly inadequate. More money spent. More frustration.

At this point, I made a decision. I would do it myself. Every step. However long it took, whatever I needed to learn, I would manage the process personally. It was the only way to ensure the pillow actually solved the problems it was meant to solve.

Learning CAD Design

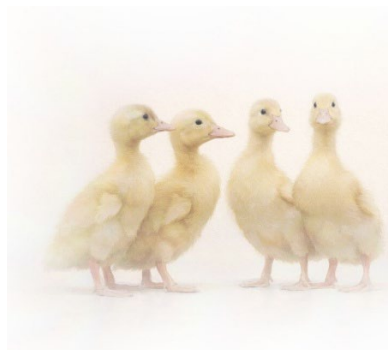
I realised that factories will not talk to you without CAD designs. CAD stands for computer-aided design, and it is the technical drawings that manufacturing equipment requires. I

had no experience with this, but I started learning. It was not easy, and I sought help where I needed it, but gradually I began to understand the language that factories spoke. If could communicate in file formats and specifications, I could cut out all these middle men who were sponging off my ignorance.

Pillow Fillings – Memories of Ducks

Then came the question of what to fill the pillow with. Initially, I wanted really soft luxury duck down feathers. It is premium, soft, breathable, supportive. Everything I thought would be ideal.

Then I discovered how duck down is sourced. Some feathers are plucked from live birds, which seemed unconscionably cruel.



But even humanely sourced duck down required approximately 320 ducks to die for a single pillow. If I made 500 initial units, that was 160,000 dead ducks. I just could not live with myself if I did that.

So I switched to memory foam. But that opened another rabbit hole: toxic chemicals, off-gassing, environmental concerns. I

went through factories methodically, asking about their processes, their materials, their chemical treatments. Eventually, I found a manufacturer who could provide certified non-toxic foam with no hazardous off-gassing. It was much more expensive and more complicated, but I hate off gassing, I makes me feel light headed and it takes weeks to clear it out before I can tolerate it. I did not want to produce something that I would not use myself.

The Regulatory Mountain

Once I had the design and materials sorted, I discovered an entirely new layer of complexity: regulations. Fire safety standards. Washing instructions. Labelling requirements. These varied by country and required different certifications. I spent weeks researching regulations, learning about testing protocols, ensuring compliance. It was tedious work that nobody sees in the final product, but without it, the pillow could not legally be sold.

I learned more about manufacturing, supply chains, safety standards, and international commerce than I ever imagined I would need to know as a surgeon. But gradually, piece by piece, the pillow came together.

The Final Design

What I eventually created has two distinct sections: a head area and a body area. The head section has a central slit (I call it the 'letter box'), not just for ear pressure relief, though that is useful, but to allow recovery position sleeping. You can place your chin into the opening, which keeps your jaw aligned properly rather than twisted to the side, which can cause temporomandibular joint problems.

This position also slightly extends your neck, which opens the airway and naturally keeps your mouth closed. No need for mouth tape or chin straps. The support comes from the foam around the opening, not underneath your face, leaving your ear free and allowing plenty of space to breathe. The opening is large enough that CPAP masks fit comfortably without being compressed against the pillow, preventing the leaks that plague people trying to use CPAP whilst side sleeping.

The body section sits under your shoulder and extends down to your knee. This takes the weight off your shoulder joint entirely, preventing the compression and numbness I had experienced in my own testing. There is a valley between the head and body sections where your shoulder sits freely, with no pressure on the joint or the nerves running through your arm.

Some people cross their arms, one up and one down, to prevent any circulation problems. Others wrap an arm around the body section, which is curved for exactly this purpose. Some sleep in a skydiver position with arms out. The design needed to accommodate different preferences.

The body section extending to your knee provides hip support, preventing the bursitis I had developed during my early testing. And if you try to roll onto your back, the pillow makes it uncomfortable. The height difference between sections means your neck feels wrong when you are supine. The body section creates a physical barrier. It gently but firmly encourages you back onto your side without the aggressive discomfort of straps or bumps.

The Size Challenge

The pillow is designed ideally for people five foot nine, which represents the typical size of adults with obstructive sleep apnoea in the Western world. I am five foot seven, so it is slightly large for me. But There is a workaround: you can push the sides together, making the central opening smaller. This adjusts the fit for smaller heads and bodies.

I have tested it on people ranging from my son, who weighed about forty kilograms at the time, up to adults of 140 kilograms. The adjustment mechanism works across this range, from roughly four feet five tall to six foot four. Not every size fits

perfectly, but it accommodates a much wider range than I initially thought possible.

What It Does not Do

I need to be clear about something important: this pillow does not magically cure sleep apnoea. It is not a medical device that treats the condition. What it does is help you maintain side sleeping or recovery position comfortably. That is all. But if you already know that your snoring reduces when you sleep on your side, if you know you breathe better and wake more refreshed after a night of side sleeping, and you find this position difficult to maintain, then this pillow might help you actually achieve that consistently.

If your sleep study shows significant positional improvement, if your partner knows the difference between your back sleeping and side sleeping, if you have tried side sleeping before and given up because it was uncomfortable, then this addresses those specific barriers. It is a tool for implementing something you already know would help but have not been able to maintain.

I am not going to make exaggerated claims or promise universal solutions. The last thing I want is to oversell this. I want it to be genuinely useful for the people who need it, not marketed as a cure-all like so many other sleep products.

To date I have sold over 1000 pillows and for the people who have tried it, most have emailed me back saying it has made a subjective improvement. As time passes, I am getting more and more objective improvement as well. I have seen the evidence during drug induced sleep endoscopy; I have seen the sleep studies that show the clear benefits. Most importantly, I have had so many lovely emails and reviews from people saying that their sleep has been transformed. For me, this is what matters most.

CHAPTER 9

HOW TO USE THE SIDE SLEEPING PRO

If you have not purchased the Side Sleeping Pro pillow, feel free to skip this chapter entirely. What follows is detailed instruction for people who own the pillow and want to get the most out of it. I have included it here because many customers have asked for written guidance they can refer back to, but it is not essential reading for understanding positional therapy. If you are still just wanting to know more about positional therapy, please jump ahead to Chapter 10.

When people first receive the Side Sleeping Pro, many make the same mistake: they try to do everything at once. They attempt the full recovery position on the first night, trying to remember shoulder placement, hip positioning, ear clearance, chin angle, and neck extension simultaneously. This is too much. Your brain needs time to adapt to new sleep positions, just as it needs time to adjust to jet lag or a new CPAP machine. Trying to master everything immediately usually leads to frustration and abandonment.

The key is to progress gradually. Start simple, master each element, then add complexity. This chapter will guide you through that progression, from basic side sleeping in the first week to full recovery position once you are ready.

Before You Start: Position the Pillow Properly

Push the pillow firmly against your headboard or the head of your bed frame. This gives you a stable anchor point and prevents the pillow from shifting during the night. This seems obvious, but many people skip this step and then wonder why the pillow moves around whilst they are trying to sleep.

Focus on Side Sleeping Only

For your first week, ignore the recovery position entirely. Do not think about the central opening or the chin placement or the neck angle. Just concentrate on comfortable side sleeping. This means closing the central slit completely by pushing the sides together until the opening disappears. You are essentially creating a normal pillow. The recovery position can wait.

Get into bed and position yourself carefully. Your shoulder needs to go into the gap between the head section and the body section. Do not just place your shoulder on top of the pillow. Roll into it. Push your shoulder into that gap so the body section takes your weight. When done correctly, your shoulder joint will not be taking any weight at all. The pillow is supporting your torso, not your shoulder.

Your hip should be in the centre of the body section. The body pillow is deliberately broad so that when you lie on it, you sink in slightly. This creates a gentle hollow. If you try to roll onto your back from this position, you are essentially rolling uphill,

which your sleeping brain resists. The pillow is also thin enough that if you do roll onto your back, you start to slide off, and your sleeping brain instinctively pulls you back to centre. It is a passive anti-roll mechanism that works without conscious effort.

Your head rests on the closed head section in whatever position feels natural. Do not overthink it. Your neck might angle slightly to one side. That is fine. You might rotate your head position during the night. That is fine too. The goal right now is just to stay on your side with your shoulder and hip properly supported.

For the first few nights, you are learning three things: shoulder placement, hip positioning, and staying centred on the pillow. That is enough. Your body needs time to accept this as normal. Most people take a week or two to stop unconsciously fighting the new position.

Understanding Your Baseline

If you have had a sleep study, check your positional data. Look at your AHI when lying on your back compared to your AHI when lying on your side. This is your baseline for what simple side sleeping should achieve. If your back-sleeping AHI is 25 and your side-sleeping AHI is 8, then sleeping on your side as I have just described should reduce your breathing disturbances to around 8 events per hour. This is still mild sleep apnoea technically, but it is a substantial improvement from 25.

For many people, simple side sleeping with proper support is sufficient. If you are in this category, you might not need to progress to the recovery position at all. You have achieved meaningful benefit with minimal complexity. Do not let perfect become the enemy of good.

Graduating to the Recovery Position

Once you are comfortable with basic side sleeping and you are consistently staying in position through the night, you can start thinking about the next element: ear pressure relief.

Open the central slit slightly, just a small gap. Now when you position your head, try to get your ear into that opening. This removes pressure from the cartilage and prevents the pain that develops after multiple nights of ear compression against a solid surface.

You are still keeping most of the opening closed at this stage. Just enough gap for your ear. The weight of your head is still supported by the foam around the opening, not falling into the hole. If you are finding pressure on your ear even with the gap, you have not opened it quite enough. If your head feels like it is falling into the hole, you have opened it too much.

Continue to focus on shoulder and hip placement. These remain your primary concerns. The ear is an addition, not a replacement for proper body positioning.

After two or three weeks of comfortable side sleeping with ear clearance, you might be ready to attempt the recovery position. Not everyone needs to reach this stage. If your side sleeping is working well and your symptoms have improved adequately, you might choose to stop here. But if you want to optimise your airway opening further, the recovery position offers additional benefit.

The recovery position requires you to rotate your face into the pillow opening. This sounds counterintuitive because normally you cannot breathe with your face pressed into a pillow. But the central opening allows your mouth and nose to hang freely whilst your head remains supported.

Start by opening the slit wider. Now, when you position yourself, think about four points of contact: the weight of your head resting on the foam around the opening, your chin placed gently in the lower part of the slit, your ear in the upper part of the opening, and your shoulder in the valley below. This is complicated. Take your time.

The most common mistake is putting too much head weight into the hole rather than on the surrounding foam. If you do this, your face presses into the pillow and you feel like you cannot breathe. The correct position has nearly all your head weight supported by the foam (most of the pressure you will feel should be on the forehead), with only your chin gently resting in the gap. Think of it as your chin finding a place to hang rather than your whole head dropping into a hole.

It is important to say at this point that you must not have any pressure on the front of your neck. Firstly it pushes your tongue back and makes your obstruction worse, and secondly it can make you feel like you are suffocating. You should just be able to feel the pillow, rather than it causing a lot of pressure. A lot of people get this wrong, so please think about it. If you find that it is still pressing against your neck, then use your shoulder to press down the head pillow slightly (pushing it down by about one centimetre is enough in most cases).

You should be able to slide your fingers between your throat and the pillow. If you cannot, adjust your shoulder position until you can. The front of your neck should be completely free of pressure.

When positioned correctly, your mouth and nose point slightly downward into the opening. There is plenty of space to breathe. Your tongue falls forward with gravity rather than backward into your airway. Your soft palate hangs down and lays on the back of the tongue, but at least it is not against the back of your throat. The more you can look down into the pillow, the more effective this position can be.

Neck Extension

As you rotate your face into the opening, you will notice that the pillow naturally extends your neck slightly (it is like you are looking up). This is intentional. Neck extension opens your airway and stretches the tissues to avoid bunching up in the

airway. We sometimes use this after anaesthetic to keep the airway open whilst a patient is waking up.

Arm Positioning Options

People vary considerably in how they position their arms during side sleeping. The Side Sleeping Pro accommodates several options.

Some people bring both arms forward in front of them and cross them over. This is most common in the side sleeping position. Avoiding the arm laid out flat on bed is useful to prevent any circulation problems and keeps both arms comfortable.

Others wrap their upper arm around the curved edge of the body section. The curvature is designed specifically for this, giving your arm somewhere to rest without awkward angles or pressure points. This is what I call the 'Superman Flying' position. One arm is up above your head and one is down to your side. People tend to move to this position once they are moving to a more extreme recovery position with the face pointing even more into the pillow rather than just at a three quarter side sleeping position in the traditional recovery position.

Some people end up in what I call the 'Skydiver' position, with arms extended above the head as if falling through the air. This happens naturally as you rotate even further into recovery

position. It looks unusual but can be remarkably comfortable once you are accustomed to it.

There is no single correct arm position. Experiment and find what works for your body. The important thing is that your arms are not trapped under you causing numbness, and they are not positioned in ways that strain your shoulders.

The Progressive Opening Technique

When you first start practising the recovery position, keep the opening relatively small. At this stage, only your mouth and nose fit into the gap. You might feel the edges of the opening against your forehead or cheek. This is expected. You are learning the position.

As you become more comfortable over subsequent nights, gradually open the slit wider. This gives your face more space and allows deeper rotation into the recovery position.

Eventually, you might progress to a nearly full prone position, with your mouth and nose pointing almost straight down and your tongue hanging completely forward out of your airway.

This progression can take weeks or even months. Do not rush it. Each incremental adjustment gives your brain time to accept the position as normal. Trying to jump to full recovery position immediately usually results in discomfort and abandonment.

What Success Looks Like

You will know the pillow is working when several things happen. Your partner reports reduced snoring or snoring that is disappeared entirely. You wake feeling more rested, with better energy in the morning. You are no longer waking multiple times during the night. Your concentration during the day improves. If you are tracking with a device, your oxygen saturations stay higher and your heart rate is more stable during sleep.

These improvements might be immediate, or they might develop gradually over the first few weeks as your body adapts. Do not expect perfection on night one. Sleep position habits take time to change.

Common Problems and Solutions

My head keeps falling into the hole

You are probably keeping the hole too big. Push the body pillow up more to close the letterbox hole more. Remember you want all the weight of the head on your forehead down to at least over your eyebrows (if not lower).

The front of my neck feels constricted

Push your shoulder down slightly to lower the lower half of the head section. This depresses the pillow away from your throat.

My shoulder hurts

Rolling your shoulder forward into the gap as much as possible. The body section should be taking your weight, not your shoulder joint pressing into the mattress below. Reach with your arm forward to make sure that if the shoulder is touching the mattress, it touching the back of the shoulder, not the tip.

I keep rolling onto my back

Ensure you are centred on the body section. If you are too far to one side, you will naturally roll off. Also check that the pillow is pushed firmly against your headboard.

The opening is pressing on my eyes / crushing my nose

Open the slit very slightly wider. As you progress into the recovery position, you will need more space.

I cannot breathe through my nose

Stick with side sleeping and do not progress to full recovery position yet. The recovery position works best with nasal breathing. If you are a habitual mouth breather, focus on shoulder and hip positioning instead. If your nose is blocked on one side, sleep on that side. You make need to speak to your doctor about this.

My hip hurts in the morning

Check that your hip is centred on the body section. If it is too far forward or back, you are not getting proper support.

Using With CPAP

If you use CPAP, the central opening accommodates most mask designs. The mask sits in the gap rather than being compressed against the pillow. The tubing can run along the length of the pillow or underneath it, depending on which side your machine is positioned.

Because side sleeping reduces your airway collapse, you might find that your CPAP pressure requirements decrease. The

machine may feel more comfortable at lower pressures. Some people discover they can tolerate CPAP for the first time when combining it with proper side sleeping. The interventions work synergistically.

Using With Mandibular Advancement Devices

If you wear a mandibular advancement device, you can use it alongside the pillow. The device sits inside your mouth and does not interfere with the face positioning. In fact, combining side sleeping with a MAD might allow you to use less aggressive advancement settings, reducing strain on your jaw and teeth whilst maintaining therapeutic benefit.

"How is your pillow different from any other sleep pillow?"

Walk into any department store and you will find dozens of pillows claiming to help with sleep. Memory foam contours. Cooling gel layers. Ergonomic shapes. Adjustable heights. All marketed with impressive-sounding descriptions of how they support your neck and align your spine.

These pillows are designed by pillow designers and marketed by people who understand consumer preferences. They focus on what makes a pillow feel comfortable in the first few minutes of lying down. They target neck pain, which is what the pillow industry was designed to deal with from the start. They

optimise for the back-sleeping position because that is what most people are accustomed to.

But they are not designed by someone who spends their days looking at airways collapsing during sleep. They are not designed by someone who has performed thousands of sleep endoscopies and seen exactly what happens when people roll from back to side. They are not designed with the specific goal of keeping someone in recovery position throughout the night whilst addressing all the anatomical problems that make that difficult.

The Side Sleeping Pro exists because I could not find anything that solved the actual problem. I needed something that would prevent rolling onto the back without uncomfortable straps. Something that provided shoulder clearance so people would not develop numbness. Something with a central opening that allowed recovery position without pressing on the face. Something that worked with CPAP masks rather than crushing them. Something that supported the hip to prevent bursitis.

These requirements came from trying this out myself. They came from watching what happens to airways during sleep and from listening to patients describe why they abandoned previous attempts at side sleeping. I used this to identify the various pain points so I could design a pillow system that would help you sleep comfortably on your side.

Realistic Expectations

This pillow will not magically cure sleep apnoea. If you have severe anatomical narrowing, if your sleep apnoea is non-positional, or if you have central sleep apnoea rather than obstructive, the pillow alone will not solve your problem. It is a tool for helping you sleep comfortably on your side, not a medical device that treats the underlying condition. It is the side sleeping and Recovery position that actually helps you. If you can achieve those positions now, then there is no need to buy my pillow.

What it does is remove the barriers that make side sleeping and recovery position difficult to maintain. It addresses ear pressure, provides correct support height, creates shoulder clearance, prevents rolling, and works with CPAP masks. These are significant practical problems, and solving them makes positional therapy viable for many people who could not manage it before.

If you already know from your sleep study that your breathing improves substantially when you are on your side, this pillow helps you actually stay there. If you do not have positional data, try it and see. Track your symptoms. Ask your partner about snoring changes. Note your morning energy levels. The proof is in how you feel after consistent use.

It is important to realise that ‘normal’ people sleep poorly on some nights, there is considerable night-to-night variation in normal sleep as well as OSA sleep. Some nights with a perfect

set up may not lead to feeling perfect in the morning. Remember you have a serious multi-layered condition, so fixing this is not a simple task. I am trying to help you achieve normality, not superhuman sleep levels.

Getting Help

Everyone's anatomy is slightly different, and everyone's comfort preferences vary. If you are struggling with positioning, if something hurts that should not, or if you cannot work out how to progress to the next stage, email me through the newsletter. I have helped hundreds of people troubleshoot their setup, and most problems have straightforward solutions once we understand what is happening.

Do not persevere with discomfort assuming it is normal. The pillow should make side sleeping more comfortable, not less. If it is not working as expected, There is usually a positioning adjustment that will help.

The Learning Curve

Changing sleep position is genuinely difficult. Your brain has decades of habit to overcome. You might feel frustrated in the first month or so when you wake up on your back despite your best intentions. This is normal. The pillow creates passive resistance to rolling, but it is not a physical restraint.

Persistence matters. Most people need two to four weeks before the new position feels natural. Some take longer. This is not a failure of willpower. It is your brain slowly accepting new proprioceptive information about what constitutes a safe and comfortable sleeping position.

Keep with it. The benefits, when they come, are worth the adjustment period. Better sleep is not just about the hours you spend in bed. It is about the quality of life you have when you are awake. And for many people, that transformation starts with something as simple as sleeping on your side in the right position with the right support.

CHAPTER 10

WHAT YOU CAN DO TONIGHT

You have read about the mechanism. You understand why position matters. You have seen the evidence from thousands of sleep studies. And perhaps you have recognised yourself in the descriptions of people whose breathing improves dramatically when they are on their side. The question now is: what do you actually do with this information?

The answer depends on how seriously you want to test whether positional therapy could help you. You have options ranging from simple observation tonight to a structured trial over several weeks. Let me walk you through them.

Start With Simple Observation

Tonight, before you go to bed, make one conscious decision: you are going to try to sleep on your side. Not with elaborate equipment or complicated setups. Just a deliberate choice to start the night on your side rather than your back.

If you have a smartphone, get the SnoreLab app (or an alternative), and place it on your bedside table and let it capture the sounds of your sleep. There are numerous apps designed for this, or you can simply use the voice recording

function. The goal is to document your baseline snoring so you have something to compare against later.

If you have a partner, ask them to pay attention to your sleep position and your snoring tonight. Do you start on your side but roll onto your back? Does the snoring change depending on position? Most bed partners already know this information intuitively, but making it conscious and documenting it turns observation into data.

When you wake tomorrow morning, before you get caught up in the day, take a moment to note how you feel. Are you refreshed or still tired after hours of sleep? Is your nose blocked? Write it down. Your subjective sense of sleep quality is actually quite informative, even if it is not as precise as a sleep study.

This simple observation costs nothing and requires minimal effort. But it establishes your baseline and helps you understand whether position makes a difference for you.

Review Your Sleep Study Data

If you have had a sleep study done, dig out the results. Do not just look at the overall AHI number that summarises your apnoea severity. Look for the positional breakdown. Most sleep studies record whether you were on your back, left side, right side, or front during each apnoea event.

If you live in the UK, you can ask your GP to get you a sleep study free on the NHS or call my secretary for a WatchPAT or NoxT3s sleep study to be sent to you via the private sector. We will send you back the results to your email.

You are looking for the comparison between supine AHI (on your back) and non-supine AHI (on your side or front). If your supine AHI is 30 but your lateral AHI is 8, you have strong evidence that position matters enormously for you. That 30 versus 8 is the difference between moderate sleep apnoea requiring treatment and mild sleep apnoea that might not require any intervention at all.

If your sleep study report does not include positional data, contact the clinic that performed it and ask for the breakdown. They have this information. It is recorded during the study. They just might not have included it in the summary report because many clinicians do not prioritise positional data when writing up results.

Understanding your positional component gives you a clear answer to the question: "Will this help me?" If you are significantly better on your side, positional therapy is worth pursuing. If your AHI is similar in all positions, you are non-positional and you will need to focus on other treatments.

The DIY Trial

If you want to test positional therapy properly before investing in a Side Sleeping Pro, you may recreate a set up in your own bed with various pillows. This was how I did it in the early stages and with a bit of determination you should be able to do something similar. Alternatively I have a video on my channel which explains how to make your own Side Sleeping Pro from a block of memory foam.

This gives you a taste of what supported side sleeping feels like, and it costs very little to try.

Track your results for at least 3 weeks (this is how long it takes for you to gain the benefits of better sleep). Keep a simple log: which side did you sleep on, did you wake up on your back, how was your snoring according to your partner or recording, how

did you feel in the morning? Use a scale of 1 to 10 for morning energy if that helps make it concrete.

If you have a sleep tracking device or smartwatch, use it. These are not as accurate as formal sleep studies, but they can show trends in your sleep quality, your restlessness, and sometimes even your oxygen saturation. You are looking for patterns over multiple nights, not perfection on any single night.

When to consider buying a Side Sleeping Pro

These are the things you should consider before buying a Side Sleeping Pro pillow system.

1. Do you breathe / sleep better on your side? There is no point going ahead if you do not get any benefit from sleeping on your side. Look at your Non-Supine AHI vs your Supine AHI. If there is a significant difference between the two values, then you should consider the positional therapy option long term.

2. Learn to sleep on your side or buy a WoodKnows Backpack to force you to sleep on your side. If you can get on with this, with no significant aches and pains and you still feel like your breathing and snoring have improved, you need to decide if it is worth carrying on with this route. If it is, there is no need to buy my pillow.

3. If sleeping on your side is useful, but you cannot get comfortable, and you can breathe through your nose, then consider the Side Sleeping Pro. Obviously if you are comfortable or not getting benefit, then there is no need to purchase it. If you have a blocked nose, I personally would get that fixed first.

Taking the Next Step

If you have read this far, you are taking the possibility seriously. You have learned about the mechanism, understood the evidence, recognised the limitations, and considered whether you might benefit. Now it is decision time.

Go to www.IWantGreatSleep.com If you want to buy it, or you can join up with my specialist newsletter for the Side Sleeping Pro.

What Success Looks Like

You will know it is working when several things happen, usually over the course of the first few weeks (typically after 3 weeks sleeping on it perfectly). Your partner stops complaining about your snoring, or mentions unprompted that it is better. You wake feeling more rested, with the kind of clear-headed energy that is been missing for months or years. Your concentration during the day improves. Tasks that felt overwhelming become manageable again.

You suddenly feel like exercising and choose to eat healthy foods.

If you are tracking with devices, your oxygen saturations stay more stable through the night. Your heart rate does not spike repeatedly. Your sleep tracking shows fewer disturbances and more time in deep sleep.

These improvements might be dramatic or they might be subtle. Some people notice the difference after the first night. Others take two or three weeks to adapt before the benefits become obvious. Your body needs time to accept the new position as normal and to recover from the accumulated sleep debt of months or years of poor-quality sleep.

The goal is not perfection. The goal is meaningful improvement that makes a difference to your quality of life. If this reduces your snoring enough that your partner is willing to share a bedroom again, that is success, you are now less 'anti-social'. If it reduces your AHI enough that you avoid needing CPAP, that is success. If it makes your existing CPAP more tolerable by reducing pressure requirements, that is success.

Tonight, when you go to bed, try sleeping on your side. Just that. See how you feel tomorrow. Notice whether your partner mentions any difference. Pay attention to your energy levels during the day. This costs nothing and takes no preparation.

Then decide whether you want to pursue it further. The information in this book has given you the knowledge you need to understand why position matters and what proper

positional therapy requires. What you do with that knowledge is up to you.

But if you are still reading this, if you have made it through nine chapters of anatomy, physics and clinical evidence, then something has resonated. You recognise the problem in yourself or someone you care about. You understand the mechanism. I hope you see the logic.

CHAPTER 11

BETTER SLEEP CHANGES EVERYTHING

One of the best parts of my job is seeing someone who has regained their sleep. It is one of the most rewarding experiences knowing that we have both worked hard together to get a particular result. Sometimes it is a few years of a series of operations, sometimes it is trying one thing that made a vast improvement.

Then I see them months later, after treatment has worked. The difference is remarkable. Not just "a bit better" or "somewhat improved." Transformed. They walk into the room with energy. Their eyes are bright. They respond quickly, with humour even. This is what proper sleep restoration does. It does not just reduce your AHI numbers or make your oxygen saturations look better on a graph. It gives you your life back.

Most people do not realise quite how much poor sleep costs them until it is fixed. They have forgotten what normal is. The tiredness is obvious, certainly. You wake up exhausted despite spending eight hours in bed. You need multiple coffees just to feel vaguely functional. Afternoons are a struggle. But the tiredness is just the surface.

Underneath, There is irritability that you cannot quite control. Small frustrations that should be manageable become

overwhelming. Your fuse is shorter with your children, your partner, your colleagues. You snap at people and then feel guilty about it, but you are too exhausted to apologise properly.

Your concentration suffers in ways you might not even notice until it improves. Reading becomes difficult because you lose track of what you have just read. Following conversations requires genuine effort. Making decisions feels harder than it should. You find yourself staring at your computer screen, knowing you need to do something but unable to quite organise your thoughts into action.

Memory becomes unreliable. You forget appointments, lose track of where you put things, struggle to recall names and details that should be readily available. People start to think you are not paying attention when actually you are, desperately, but your brain simply is not recording information properly.

Your mood deteriorates in ways that feel like depression but might not be. Everything seems harder, heavier, more effortful than it should be. Enjoyment leaches out of activities you used to love. Optimism becomes difficult to sustain. You are not exactly depressed, not clinically, but you are certainly not happy either. You are just existing, getting through each day, waiting for bedtime so you can try again to get rest that never quite comes.

Relationships strain under this weight. Your partner is frustrated with your snoring, certainly, but also with your

mood, your irritability, your absence even when you are physically present. Intimacy suffers because you are too tired or too disconnected. Conversations become transactional rather than meaningful. You are both living in the same house but increasingly separate lives.

And all of this feels normal after a while because it has been your reality for so long. You forget what it felt like to wake up refreshed. You accept exhaustion as your baseline. You assume this is just what getting older feels like, or what life with responsibilities feels like, or what your particular genetic hand has dealt you. The idea that you could feel genuinely good in the morning seems almost absurd.

What Changes When Sleep Improves

The first thing most people notice is morning clarity. They wake up and their head feels clear for the first time in years. Not groggy, not foggy, not needing forty-five minutes and a strong coffee to achieve basic functionality. Just clear. Awake. Present. It is such an unexpected sensation that many people comment on it immediately.

Energy follows. Not manic energy or artificial stimulation, but the kind of steady, sustainable energy that lets you move through your day without constantly fighting exhaustion. You can focus on tasks without your mind wandering. You can have conversations without losing the thread. You can make it to evening without collapsing. You do not feel like eating rubbish

or hooked to caffeine, eventually people just feel like exercising again.

Mood improves in ways you might not have realised were connected to sleep. The irritability fades. Your patience returns. Small frustrations become manageable again instead of triggering disproportionate reactions. That heavy feeling that made everything seem effortful lifts. You find yourself interested in things again, engaged with life rather than just getting through it.

Relationships repair. Your partner is happier because the snoring has stopped, yes, but more importantly because you are present again. You have the energy and attention for actual conversations. You are not too exhausted for intimacy. You are not snapping at trivial annoyances. You are recognisable as the person they chose to be with, rather than the exhausted fraction of the human you had become.

Work performance improves, sometimes dramatically. Tasks that took hours when you were foggy take minutes when your brain is working properly. Decisions that felt overwhelming become straightforward. Memory returns to something resembling normal. Your colleagues notice you are sharper, more engaged, more creative.

The cardiovascular benefits take longer to manifest but matter enormously. Blood pressure tends to drop when sleep apnoea is treated. The strain on your heart reduces. The risk of stroke decreases. These are not immediate changes you feel, but they

are protecting your long-term health in ways that extend your life expectancy measurably.

This is not magic. It is not a miracle transformation. It is simply what happens when your body finally gets the restorative sleep it has been trying to achieve for months or years. Your brain has time to consolidate memories, clear metabolic waste, regulate neurotransmitters. Your cardiovascular system gets a break from the repeated stress of oxygen desaturations and arousal responses. Your endocrine system stabilises. Your immune function improves. Everything works better when you are actually sleeping rather than fighting for breath all night.

I see patients who have been struggling with sleep apnoea for a decade or more before seeking treatment. Their blood pressure is established hypertension now, requiring medication. Their weight has increased substantially, making the sleep apnoea worse in a vicious cycle. Their relationships are damaged, sometimes irreparably. Their careers have stalled because they could not maintain the focus and energy needed for advancement. They have gained so much weight that it has become an additional barrier to success.

If you recognise yourself in this book, if you know your sleep is disrupted and your days are exhausted and your quality of life has diminished, then the time to do something about it is now.

The vast majority of people with sleep apnoea do not know they have it. The Wisconsin Sleep Cohort Study, which tracked over 1,500 adults for decades, found that 93% of women and

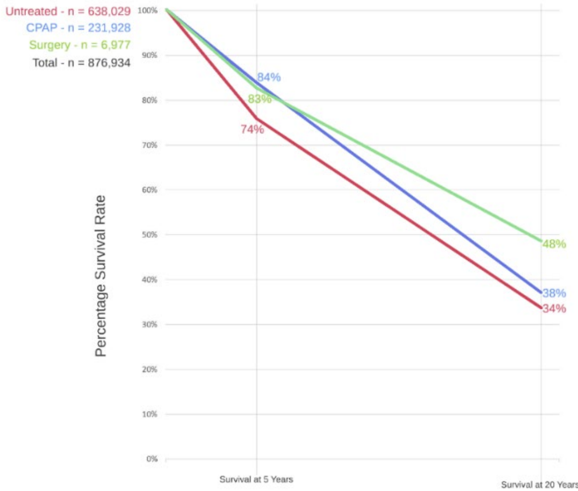
82% of men with moderate-to-severe OSA were undiagnosed (Young et al., American Journal of Respiratory and Critical Care Medicine, 1997). More recent studies suggest these figures remain largely unchanged, with an estimated 80-90% of cases still going undetected. Many people live with the condition for years before seeking help. Of the minority who do get diagnosed, over 80% still are not receiving adequate treatment or continue to feel dreadful.

So before you close this book, I want to say one more thing. Please go and see your GP / family doctor.

I mean this seriously. Not as a vague suggestion buried at the end of a chapter, but as a genuine recommendation from a specialist who sees, week after week, the consequences of people waiting too long.

A large study following 638,039 veterans with untreated sleep apnoea found that after five years, 26 out of every 100 people had died. After twenty years, that number rose to 66 out of 100 (Jara et al., Sleep 2018). Waiting or avoiding the doctor simply does not make sense given these statistics.

In the UK, healthcare is free at the point of contact. There is no financial reason to delay. If you do not know where to start, or you would like to go to your appointment prepared, I have put together a set of questionnaires online that you can complete in a few minutes and receive by email. They cover the standard screening tools your GP will recognise, and having them completed and printed before your appointment means you



can have a focused, useful conversation rather than spending the whole slot trying to describe your symptoms from scratch.

You can find the questionnaires here:

Armed with these results, you will be in a much better position to explain what is happening to your sleep, to ask for a sleep study, and to start down the path towards proper treatment.

It is also worth knowing how many options are now available, because the picture looks very different from even ten years ago. When I trained, the toolkit was fairly limited: CPAP, and occasionally a gum shield if someone could not tolerate the mask. Today it is considerably more interesting. We have

multiple CPAP variants, including auto-adjusting machines (APAP), bilevel devices (BiPAP), and other configurations designed for specific patterns of collapse. We have a wide range of mandibular advancement devices from simple off-the-shelf versions to sophisticated, adjustable custom-fitted appliances. We have throat exercises, now supported by decent evidence, that can meaningfully reduce sleep apnoea severity by strengthening and tightening the pharyngeal muscles. We have weight loss medications that are genuinely transforming outcomes for obese patients with sleep apnoea. And on the surgical side, I perform 43 different procedures on the NHS for snoring and sleep apnoea, ranging from straightforward nasal surgery to hypoglossal nerve stimulation implants such as Inspire and Genio.

Positional therapy, which is what this book is about, is just one small part of this landscape. An underused and underappreciated part, in my view, but still just one part. For many people it will be sufficient. For others it will be something to combine with CPAP, or an MAD, or surgery. And for a few, it will not be the right answer at all, and something else will serve them better.

The NHS waiting lists are longer than any of us would like, and appointments are rarely as long as the problem deserves. I am not pretending otherwise. But the options available now are genuinely better than they were, and new treatments appear every year. The important thing is getting into the system,

getting a proper diagnosis, and starting treatment before the problem compounds further.

You have now finished this book. You understand more about your airway than most people ever will. Now use that knowledge. Sleep on your side tonight. Fill in the questionnaires. Book the appointment. Tell your GP what you know.

Your sleep is worth fighting for.

Vik Veer – ENT Surgeon