INTRODUCTION

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Snoring is both a social and a medical problem and is one sign of a number of different disorders. Patients who snore heavily are more likely to be hypertensive, suffer strokes, and experience angina pectoris than nonsnorers of similar age and weight***(Hassan N et al., 1998, Olsonl G et al., 1995)***.

The most advanced stage of snoring, obstructive sleep apnea syndrome (OSAS), causes profound cardiac, pulmonary, and behavioral problems ***(Quan SF et al., 1997)***.

OSAS may affect as many as 2% of adult women and 4% of adult men ***(Kyzer S, Charuzi I, 1998)***.

The sounds of snoring and OSAS originate in the collapsible portions of the airway and may involve the soft palate, uvula, tonsils, tonsillar pillars, base of tongue, pharyngeal muscles, and pharyngeal mucosa as a result of vibration of any of these collapsible portions while air is drown inward by expansion of the thoracic cavity ***(Teculescu D, 1998)***.

Management of snoring is directed at eliminating the source of vibration and can be accomplished either through the application of continuous positive airway pressure (CPAP) to keep the airway expanded or surgery designed to remove or stiffen the vibratory portions of the airway. The use of CPAP requires the nightly application of an appliance that can be both uncomfortable and itself socially disruptive ***(Alarcon et al., 1995)***.

The surgical management of patients with snoring and OSAS continues to be a challenge until 1980, when uvulopalatopharyngoplasty (UPPP) was introduced, the only surgical options were tonsillectomy, adenoidectomy, or tracheotomy ***(Fujita S., et al., 1998)***.

Although effective in the management of snoring, UPPP is associated with significant perioperative pain, can lead to velopharyngeal incompetence, and has been shown to be only 30% to 50% effective in the long-term management of patients with OSAS ***(Sher AE et al., 1996)***.

There are recent options for the management of snoring and OSAS. These options currently include staged serial excision of the soft palate with either electrocautry or the Co_2 laser. The Most recent one is Radio frequency ablation to the soft palate. The extent of reduction of the size of the soft palate and its relation to the post operative period is not accurately evaluated ***(Kamaniy V, 1994)***.