

Sleep Disorders in Children

from the library of Robert L. Talley, DDS

The increased awareness of sleep disorders, both public and professional, is reflected in the patient demographics we now see. Not long ago, we rarely diagnosed or treated children with sleep-disordered breathing (SDB). This is no longer the case. The relationship between sleep and a number of childhood maladies such as attention deficit hyperactivity disorder, enuresis and various cognitive, behavioral, and developmental conditions is better understood and recognized.

Fortunately, the majority of children with SDB are effectively treated by the removal of hypertrophied tonsils and adenoids. Others can be treated orthodontically with nonsurgical means such as rapid palatal expansion and traditional orthodontic correction.

Until recently, the very young and petite have not had many treatment options. Recent advances in the field of dental or orthognathic surgery allow us to treat children and infants with confidence.

If we accept the premise that SDB is primarily a developmental or structural problem resulting from a soft tissue-skeletal discrepancy, we can now begin to consider the causes and, more important, prevention through early recognition and intervention. Dentists are in a unique position as health care providers in that we have long-term relationships with timely access to our patients that allows us to monitor their development and general health. We are particularly qualified when it comes to orofacial, denial, skeletal and, subsequently, airway development, affording us the opportunity to help screen and treat these patients.

In 1903, the literature first makes mention of the treatment of infants with micrognathia (mandibular insufficiency) by suturing of their tongues to their lips in an effort to maintain a patent airway. In 1934, Pierre Robin became the first to use oral appliances to maintain the airway and only as recently as 1976 were maxillomandibular osteotomies or advancement surgeries performed to treat patients with SDB.

Sleep deprivation may be the most common sleep disorder that affects daytime function in children. Daytime symptoms of poor or insufficient sleep in children overlap considerably with those of ADHD. Parents of children with ADHD and other disorders that affect behavior and school performance frequently describe problems relating to sleep.

Parents are more likely to bring their child to their primary care provider for evaluation of daytime behavior/school problems than for problems related to sleep; therefore, the astute clinician should recognize that sleep problems may be continuing to the presenting symptoms complex. This is particularly important to investigate in children previously diagnosed with ADHD. An evaluation should begin with a detailed sleep history with the parent completing a pediatric sleep questionnaire. Reviewing a typical day beginning with the sleep routine can provide some structure. Bedtime resistance, sleep onset and maintenance, snoring and obstructive pauses, restless sleep and difficulties with waking on school days should be identified and detailed. Daytime behavior and school performance, sleepiness and naps (at any age) should

be discussed to include the duration and severity of these problems. Family history, a physical examination and other testing should follow.

If your child or a child you know is suffering from excessive daytime sleepiness, difficulty concentrating, attention deficient disorder, snoring, grinding of teeth, academic difficulties, nightmares or other behavioral disruptions, consultation should be sought from your pediatrician, an otorhinolaryngologist (ear, nose and throat doctor) or a sleep disorders trained dentist.

This office is dedicated to assisting people in the recognition, identification and correction of sleep-disordered breathing related problems. These include snoring, Obstructive Sleep Apnea (OSA), Upper Airway Resistance Syndrome (UARS) and other related sleep disorders.