PAEDIATRIC ENT SERVICES
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SNORING & OBSTRUCTIVE SLEEP DISORDER

This condition, due to obstruction of the upper airway (nose/adenoids and tonsils), has varying degrees of severity from mild snoring through to severe obstruction with growth failure and cardiac complaints. About 10% of all children snore, but only about 3% have obstructive sleep disorder.

The obstruction to the air passages can be due to either blockage of the nose, enlarged adenoids or enlarged tonsils, or a combination of all of these. In addition, children with other conditions such as Down Syndrome, Cerebral Palsy or Cranio-facial abnormality may have an increased susceptibility to this condition due to either lax or floppy tissues or narrow breathing passages.

OSD can affect children within the first days of life, or present later in life with enlarged tonsils and adenoids, particularly in allergic children.

SYMPTOMS AND SIGNS OF OSD

The following symptoms and signs of Obstructive Sleep Disorder in children is presented in order of frequency. The more severe symptoms relate to children who stop breathing (obstructive sleep apnoea) for 5 - 10 seconds or more, are restless at night, and have periods of cyanosis (blue tinge around the lips).

Snoring
Chronic mouth breathing
Periods of apnoea (breath holding)
Sweating
Restless sleep
Frequent wakening
Sleep walking/night terrors
Sleeping in unusual positions e.g. head arched back
Frequent need of afternoon sleep (if over 4 years)
Tired and grumpy in the mornings
Difficulty swallowing meat
Overweight/Growth Retardation
Underweight for age
Bed wetting
Cyanosis
Hyperactive during the day/ADHD
Learning Difficulties/Concentration Problems
Behavioural Problems

If you observe your child breathing whilst asleep about one hour after they have settled at night, you will be able to note whether your child has these symptoms and signs.

Some children with many of the symptoms and signs in the above list need a normal sleep study where they are observed overnight and monitored for the severity of their OSD in a hospital.

TREATMENT OF OSD

This depends on the source of the problem. It occasionally will respond to treatment of the nasal blockage by a steroid nasal spray, but often with a congested allergic nose there are enlarged adenoids and tonsils which require surgery as well. If these OSD children require adenoidectomy or tonsillectomy and cautery of the turbinates, they are usually monitored postoperatively with an oximeter (oxygen level meter on the finger or toe) to ensure they do not have breathing problems postoperatively. These children are more sensitive to narcotics such as Pethidine and to sedative agents such as Phenergan or Vallergan and these agents, if used, are often given in reduced amounts.

In Paediatric hospitals throughout the world, OSD is the commonest reason to perform tonsillectomy and adenoidectomy, rather than recurrent tonsillitis. Parents are often concerned that removal of the tonsils and adenoids will reduce the child's ability to fight infections. There is no evidence to suggest the removal of the tonsils and adenoids after the age of 3 years causes any change in the child's immunity. If the child is under 3 years and required surgery for OSD, the necessity for the surgery outweighs any concern about the child's immunity.

Not every snoring child should undergo a tonsillectomy and adenoidectomy. All procedures have their risks and benefits. Your doctor will decide if your child's problem is severe enough to warrant surgery.

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