



Appendix A: Sleep Apnea in Children^{1,31,32}

- The prevalence of OSA in children is 1 – 4% with one of the more common causes being tonsillar hypertrophy.
- Nasal congestion or enlarged adenoids can aggravate oral-pharyngeal obstruction by causing increased negative pressure when trying to inhale through a restricted nasal airway. A trial of a nasal steroid may be helpful followed by a referral to ENT for persistent nasal restriction.
- Other common conditions associated with OSA are micro or retrognathia, Down's Syndrome, craniofacial syndromes (including cleft palate pre and post repair), obesity, neuromuscular disorders and metabolic disorders.
- Severe craniofacial disorders require an ENT evaluation or referral to a craniofacial clinic at BC Children's Hospital.
- OSA symptoms in children are similar to adults with snoring, pauses in breathing, snorting, choking, gasping, daytime fatigue and sleepiness. In addition, impaired daytime concentration may be misdiagnosed as ADHD, behavioural and emotional problems or learning disabilities. Children can also present with slow growth, failure to thrive, and secondary enuresis.
- Polysomnography remains the gold standard for OSA diagnosis in children. HSAT is not recommended as it is not sensitive enough to be accurate. Children with suspected OSA should be referred to a physician with pediatric sleep experience or the Sleep Clinic at BC Children's Hospital.