Obstructive sleep apnoea syndrome in infants and children: established facts and unsettled issues

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The obstructive sleep apnoea (OSA) syndrome was first identified in infants and children by Guilleminault et al in 1976. Since then, a great deal has been learned about infancy and childhood obstructive apnoea, although several areas remain largely unexplored. Since the first description of the OSA syndrome during infancy and childhood, we have learnt that the clinical symptoms of an increased upper airway resistive load during sleep are not always associated with complete airways obstruction during sleep. Episodes of partial airways obstruction without obstructive apnoea are frequently observed in infants and children, so adult diagnostic criteria for the OSA syndrome may not identify infants and children with sleep-related increases in upper airway resistive loads. As recommended by Carroll and Loughlin, we should consider that infancy and childhood OSA syndrome is not a form of adult OSA but a separate syndrome with specific symptoms, diagnostic criteria, and therapeutic requirements.

Prevalence
We still know little about the prevalence of increased respiratory resistive loads during sleep in infants and children. Reliable data on the incidence of the OSA syndrome during infancy and childhood are not available. Series of patients with OSA published in the paediatric medical literature suggest that the peak incidence is in the 2–5 year age group. This age group may be particularly susceptible to OSA because of the prominence of pharyngeal lymphoid tissue during these years. In children, in contrast to adults, there is no clear male predominance of OSA.

The prevalence of snoring in two large populations of children has been evaluated by questionnaire. Between four and six years of age, the reported prevalence of snoring was 7–10%. In one of these studies children aged 4–5 years were studied at home by overnight video recording and oximetry. The prevalence of sleep and breathing disorders in this age group was estimated at 0–7%. Another questionnaire based study in a wider age range (six months to six years) estimated the prevalence of OSA at 1–6–3–4%. Large scale, well designed studies assessing the prevalence of an increased upper airway resistive load during sleep in infants and children are needed. A reasonable priority would be to develop and validate a questionnaire, use it in the general population to detect high risk individuals, and subject these to polysomnographic recordings.

Clinical symptoms
A careful history of sleep-associated symptoms is the first step in detecting a sleep-related increase in upper airway resistive loads in an infant or child. However, more than a year often elapses between the onset of symptoms and diagnosis. This explains why severe complications such as cardiorespiratory failure are sometimes the presenting complaint.

Clinical symptoms in children differ in several ways from those in adults. Excessive daytime sleepiness, the typical presenting complaint in adults, is not frequent in children. The two major symptoms are sleep-related breathing difficulties and snoring. Parents sometimes report that during sleep their child stops breathing, sweats profusely, is restless, and assumes unusual positions in an attempt to relieve upper airways obstruction. Enuresis has been reported in children with the OSA syndrome. Mouth breathing during wakefulness is common when nasal obstruction is severe. Upper respiratory tract infections are frequently reported in young children. In school age children learning problems may occur. It should not be concluded that a sleep-related increase in upper airway resistive loads invariably causes behavioural abnormalities. Psychological testing before and after treatment can be useful for determining the contribution of upper airway problems to behavioural abnormalities.

Obesity has been reported in a large pro-
portion of adults with OSA but has been found in only a few of the patients in paediatric series. The risk of occurrence of a sleep-related increase in upper airway resistive loads is not clearly established in obese children. However, an abnormally high prevalence of OSA without clinical symptoms has been found in overweight infants. In obese children both low and high percentages of sleep-disordered breathing have been reported. Silvestri et al recommended that obese children with a history of sleep-related breathing difficulties should be referred for polysomnographic evaluation.

Failure to thrive is a not unusual characteristic of infants with OSA. Investigations to look for a sleep-related increase in upper airway resistive loads should be routinely performed as part of the evaluation of growth retarded infants and children and adequate treatment of the upper airways obstruction results in rapid catch-up growth. The mechanisms of growth retardation are not well understood but may include an increase in the metabolic rate during sleep. In a recent preliminary study oxygen consumption during sleep decreased after treatment in children with OSA. These data suggest that children gain weight after treatment because of a decrease in energy expenditure and that before treatment the increase in the work of breathing during sleep is responsible for an increase in the consumption of oxygen by respiratory muscles, leaving less oxygen available for growth. Alternatively and/or simultaneously, repeated interruption of sleep may interfere with the release of growth hormone. One study showed normalisation of growth hormone release after treatment of upper airways obstruction.

Cardiovascular complications
The syndrome combining hypoventilation, pul monary hypertension, cor pulmonale, and pul monary oedema was described in the middle of the 1960s in infants and children with chronic upper airways obstruction. Sofer et al described the haemodynamics of this syndrome in a 22 month old child and suggested that the pulmonary oedema was secondary to both right and left heart failure. In their patient pulmonary arterial pressures returned to normal within 48 hours of surgery. Acute cardiopulmonary failure seems to occur mainly in patients with long-standing neglected clinical symptoms. Upper respiratory tract infection is usually the triggering event. Patients with an unrecognised sleep-related increase in upper airway resistive loads are still at risk of acute cardiopulmonary failure. Paediatricians should be aware of this potential complication because it can result in sudden death.

Cardiovascular symptoms are common in adults with the OSA syndrome. It is therefore of interest to review their frequency in infants and children without cardiac failure. However, data on this issue are scant. Radiological and/or electrocardiographic evidence of right ventricular hypertrophy was reported in 55% of a group of infants and children with OSA. In contrast, in a series of 92 children referred for adenoidectomy and tonsillectomy Wilkinson et al found electrocardiographic evidence of right ventricular hypertrophy in only 3-3% of cases. Thus, available data do not provide an adequate basis for estimating the prevalence of right ventricular dysfunction in infants and children with complete and/or partial upper airways obstruction during sleep. Interestingly, low pre-treatment right ventricular ejection fraction values have been shown to increase significantly after tonsillectomy. Recently developed echocardiography techniques allow examination of interventricular septum behaviour during sleep-related upper airways obstruction. In one 11 year old child Guillemaint al reported a leftward shift of the septum, even during heavy snoring. In a preliminary study the severity of clinical symptoms and/or polysomnographic abnormalities was not related to the presence of echocardiographic abnormalities.

Systemic hypertension is found in a large percentage of adult patients with the OSA syndrome. In a series of 50 cases diurnal systemic hypertension was found in 10% of patients, all of whom were older than 10 years. More recently, no abnormalities in systolic or diastolic arterial pressures were observed in 22 children aged 6 (0-4) years. Non-invasive continuous blood pressure measurements were performed in two children whose fingers were big enough to allow use of a cuff designed for adults and pulsus paradoxus was found in one.

There are conflicting data with regard to ECG abnormalities in children with the OSA syndrome. A study carried out in the early 1980s in a group of 50 children with OSA found sinus arrests lasting from 2.5 to 9 seconds in 52% of cases, second degree atrioventricular block in 28%, and paradoxical tachycardia in 16%. However, a more recent study in 12 subjects aged eight months to 14 years with complete and/or partial airways obstruction during sleep failed to find significant changes in heart rate or duration of episodes of severe hypoxaemia. No episodes of severe bradycardia or cardiac arrhythmia were detected. These findings are of clinical relevance since ambulatory ECG monitoring has been used in adults to screen for sinus brady-tachyarrhythmia as a marker for OSA. The data suggest that this method would not detect all children with increased upper airway resistive loads during sleep.

Finally, a recent study of heart rate variability evaluated by power spectral analysis demonstrated a predominance of sympathetic activity throughout the night with surges during periods with apnoeas. This might indicate an increased risk of systemic hypertension at an older age in the event of persistent sleep-related breathing disorders.

Methods of diagnosis
A standardised questionnaire developed by Brouillette et al has proved useful for suspected OSA in children aged one to 10 years. However, more recently Carroll et al reported that primary snoring cannot be differentiated
from OSA by clinical history alone in children. In a population of infants with an abnormal obstructive apnoea index, Kahn et al. found that a history of profuse sweating and noisy breathing during sleep in the absence of upper respiratory infection was useful as an aid to the diagnosis of sleep-related obstructed breathing episodes in infants. Thus, there is no consensus on whether or not an age-specific questionnaire is an adequate tool for identifying infants and children with increased upper airway resistive loads during sleep.

Polysomnographic examination remains the gold standard diagnostic investigation. However, a full overnight polysomnographic study is technically difficult and can be performed only by trained personnel. Some laboratories study a daytime nap. One study compared a nap and overnight polysomnography recordings in 40 children aged one month to 16.3 years, two thirds of whom received chloral hydrate sedation for the nap polysomnography. The results showed that nap studies had a sensitivity of 74%, a specificity of 100%, a positive predictive value of 100%, and a negative predictive value of 17% for the diagnosis of sleep-disordered breathing. Thus, a negative nap study does not rule out the diagnosis and must be completed by an overnight sleep study. Natural sleep for a daytime polysomnographic study is sometimes difficult to obtain. Sleep deprivation or sedation has been used to induce daytime sleep. However, sleep deprivation has been shown to increase significantly the number of obstructive respiratory events in healthy infants, and sedation by chloral hydrate is sometimes associated with a dramatic worsening of upper airways obstruction.

Use of home monitoring using either a microphone or video recording and oximetry has been suggested. However, none of these techniques has been validated against overnight polysomnography in a large number of subjects with different levels of severity of OSA. More work is needed to verify the reliability of ambulatory methods of diagnosis of sleep-related resistive load increases in infants and children.

**Polysomnographic findings**

There are few data on the occurrence of obstructive apnoea during overnight sleep in normal infants and children. In infants older than six weeks the index of obstructive apnoea episodes lasting more than three seconds was found to be less than 1. No episodes of obstructive apnoea were detected in children or in a small group of adolescents. However, in a more recent study of 50 children aged 1-18 years there were 0-1 (0-5) (range 0-31) obstructive apnoeas lasting less than 10 seconds per hour of total sleep time. We clearly need more normative data to improve our ability to interpret polysomnographic data in paediatric patients.

Polysomnographic recordings can be divided into two categories - those with and those without obstructive apnoeas. When obstructive apnoeas are found, their duration and rate of occurrence are usually greatest during REM sleep. Associated with obstructive apnoeas, polygraphic recording shows laboured breathing during the ventilatory periods. Wide swings in oesophageal pressure have been found during ventilatory periods. Paradoxical inward rib cage motion during inspiration has been reported throughout REM sleep periods in children and during non-REM sleep. Accessory respiratory muscles, including abdominal muscles, are recruited during non-REM sleep with snoring. Compared with non-REM sleep, REM sleep is associated with inhibition of accessory respiratory muscle activity which results in a decrease in the diaphragmatic work of breathing.

Guilleminault et al. were the first to point out in 1982 that some children with clinical symptoms do not have obstructive apnoeas during sleep. However, these children have significantly increased respiratory resistive loads during sleep and wide swings in oesophageal pressure. Their breathing is most laboured during REM sleep. Recently, Rosen et al. documented partial airways obstruction during sleep in a group of 20 patients aged eight months to 16 years; 80% of their patients had sustained partial airways obstruction characterised by cyclic decreases in SaO2, hypercarbia, laboured paradoxical respiratory efforts, and snoring. Such episodes of partial airways obstruction are described as obstructive hypopnoeas in adult patients. However, there is no consensus among laboratories on the definition of obstructive hypopnoea. Studies are needed to determine the clinical usefulness of oesophageal pressure measurements during sleep in asymptomatic infants or children with no obstructive apnoeas on polysomnographic recordings. However, data on the normal range of oesophageal pressure swings during sleep in children are scant. The lowest negative oesophageal pressures have been reported to range from -8 to -20 cm H2O in two groups of healthy children aged 2-14 years.

Early studies in children with the OSA syndrome found abnormalities in the sleep pattern with a decrease in the duration of slow wave sleep. These findings were not borne out by recent investigations in which the sleep pattern was normal. Differences in the severity and duration of the disease may at least partially explain these discrepancies.

Different categories of arousal have been characterised, such as behavioural arousal, EEG arousal, and movement arousal. However, several laboratories are still working on the development of standardised criteria for arousal detection in infants and children. Few reports have documented the occurrence of arousal at the end of sleep-related obstructive events in infants or children. In a study of preterm infants with apnoeas, behavioural arousal occurred more frequently after obstructive apnoeas than after central apnoeas, but no attempt was made to characterise EEG arousal. An important study in infants with increased upper airway resistive load during sleep found an abnormal number of EEG arousals compared with age matched control infants. Interestingly, EEG arousals occurred...
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at the nadirs of the oesophageal pressure recording. In a group of prepubertal children with OSA the end of non-REM sleep apnoea was marked by EEG arousal in 12% of events and by movement arousal in the remaining events.88 During REM sleep only movement arousals occurred.48 Another study reported a similar low rate of occurrence of EEG arousal in children and adults.59 The fact that EEG and behavioural arousals are uncommon in children may be related to the less frequent occurrence of excessive daytime sleepiness in children than in adults.4 However, more extensive multicentre studies using standardised criteria for arousal detection and assessment of daytime behavioural disturbances are needed in different age groups of infants and children with increased upper airway resistive loads.

Pathophysiology

The pathophysiology of increased upper airway resistive load in infants and children is not fully understood. Several factors may place infants and children at risk for developing the OSA syndrome. The leading cause of sleep-related increases in upper airway resistive load in the paediatric population is the prominence of lymphoid tissues.9 10 However, the severity of OSA is not always proportional to the size of the tonsils and adenoids.56 57 This suggests involvement of other risk factors such as abnormal ventilatory drive and/or mechanical and anatomical abnormalities of the upper airways.

Few studies have evaluated ventilatory drive in children with OSA. One early study found that some children had low hypercapnic ventilatory responses when awake several years after adenotonsillectomy.58 However, Marcus et al recently reported normal hypercapnic ventilatory responses when awake in children with tonsilloadenoidal hypertrophy.59 The ventilatory response to chemical stimuli during sleep has not been studied. It can be speculated that the sleep-related decrease in ventilatory responses to hypercapnia may differ between healthy children and children with chronic upper airways obstruction. On the other hand, children with OSA appear to have normal central control of the upper airway muscles during sleep. Continuous upper airway muscle activity was found during airway obstruction, and this muscle activity increased with the degree of hypercapnia and hypoxaemia.60 Furthermore, a decrease in genioglossus muscle activity at the onset of obstructive apnoeas has been found in adults61 but not in children.62 In children, obstructive apnoeas may, rather, be the result of a sudden increase in upper airways resistance. Fibroscopic63 and fluoroscopic64 studies in children with enlarged tonsils have shown that inspiratory movements of the tonsils and pharyngeal walls tend to narrow the upper airways and occasionally lead to occlusion. A narrow airway is an additional risk factor. A relationship has been reported between the size of the posterior airway and the severity of the OSA syndrome.57 65 A recent study evaluated the mechanical properties of the pharynx in children with OSA.66 Closing pressure is increased in children with OSA compared with age matched subjects with primary snoring; similar findings have been reported in adults.67 Interestingly, closing pressure was lower in children than in adults with snoring, suggesting differences in upper airways collapsibility between children and adults. Further investigations are needed to document changes in the mechanical properties of the upper airways in healthy children. Currently, data are available only in healthy infants.68 Little attention has been paid to the functional and anatomical consequences of chronic obstruction on the growth of the upper airways. Experiments in rhesus monkeys have demonstrated interactive mechanisms between abnormal nasal breathing and abnormal growth of the mandible starting at birth.69 These environmental factors may explain why residual symptoms are sometimes seen after tonsillectomy70 and why symptoms can recur after puberty.71 Finally, a racial predisposition for OSA due to hypertrophy of the lymphoid tissues has been suggested, since young black subjects have more lymphoid tissue than young white subjects.72

Of the craniofacial abnormalities that have been found to be responsible for sleep-related upper airways obstruction, the Pierre Robin syndrome has been extensively studied.73 Using flexible fibreoptic endoscopy Sher et al showed that obstruction of the airways is due not only to glossoptosis but also to many other abnormalities.74 In infants with micrognathia the pharyngeal airway closing pressure during nasal occlusion trials was correlated with genioglossus muscle activity, suggesting that this muscle contributes to pharyngeal airway patency in micrognathic infants.75

Endoscopic observations in children with the OSA syndrome due to other craniofacial anomalies such as Crouzon syndrome, Treacher-Collins syndrome, and other disorders have shown that the mechanism of airflow collapse is variable.76 The midfacial and mandibular hypoplasia and glossoptosis seen in Down’s syndrome increase the risk of OSA. Undiagnosed OSA may contribute to the unexplained pulmonary hypertension seen in some of these children.77

Other disorders associated with an increased risk of OSA in children include sickle cell anaemia,78 brainstem disorders such as Arnold-Chiari malformation79 and myelomeningocele,8081 achondroplasia,82 neuromuscular disorders,83 and Prader Willi syndrome.84 In infants laryngomalacia can be responsible for severe OSA.85

Familial factors

A familial basis for the OSA syndrome is suggested by reports of families with several affected members.84 85 One recent pilot study showed an increased frequency of sleep-disordered breathing in relatives of non-obese adult patients with sleep apnoea/hypopnoea syndrome.86 Preliminary data on the prevalence of snoring in the parents of children who snore
have been reported.85 Ventilatory control dys-
function and craniofacial morphology ab-
normalities have a familial basis85 and may be
risk factors for OSA in adults. Guilleminault
et al reported five families in which several
members, covering three generations, had OSA
associated with a small upper airway.88 Thus,
there is evidence that familial factors influence
the risk of developing an increase in upper
airway resistive loads. Adult physicians and
paediatricians should look for symptoms of
sleep-disordered breathing in the relatives of
their patients.

OSA and sudden infant death syndrome
(SIDS)
It is unclear whether the risk factors for SIDS
and OSA operate similarly, but there is some
evidence that SIDS and OSA aggregate within
the same families. Guilleminault et al88 observed
clinical symptoms of OSA and abnormal num-
bers of obstructive apnoeas among the parents
or grandparents of SIDS or near-miss SIDS
cases in five families. The risk was apparently
related to the presence of a small posterior
airway, which was found in several family mem-
bers including children. Infants with near-miss
SIDS were followed up and found to develop
OSA during childhood.89 90 These are the first
patients who have been studied during the
development of OSA. More recently the same
group found sleep-related increases in upper
airways resistance in infants with a family his-
tory of SIDS, apparent life-threatening events,
and parental sleep-related breathing dis-
orders.94 These infants may be at the highest
end of the spectrum of at risk infants. However,
these findings are in agreement with those of a
Belgian case control study that found a sig-
ificant increase in the rate of occurrence of
obstructive events in infants who later died of
SIDS compared with control infants.91 In two
ongoing studies of the familial aggregation of
OSA, families with both OSA in adults and
SIDS or near-miss SIDS have been identified.92 93
All these data suggest that there is a subset of
families at risk for both disorders. From a
clinical point of view, paediatricians and adult
physicians should look for familial histories of
both disorders and should recommend a careful
investigation in at risk infants.

Treatment
The optimal treatment strategies for paediatric
OSA are still the focus of intensive research,
taking into account not only obstructive
apnoeas but also sleep-related increases in
upper airways resistive load. Treatment
should be considered only after objective testing
to determine the severity of the syndrome and
after orthonasal laryngological and maxillofacial
studies. The pretreatment examination should
include radiological evaluation,92 94 cephalo-
metric measurements,95 fluoroscopic and
fibroscopic studies,94 96 computed topo-
graphic scanning and magnetic resonance
imaging.70 The respective indications of these
procedures are not yet standardised in infants
and children. Further investigations and multi-
centre studies are needed to clarify their clinical
usefulness for elucidating the pathophysiology
of OSA and for determining the best treatment
strategy.

Tonsillectomy and adenoidectomy have been
the most commonly recommended treatments.
However, associated problems such as an ab-
normally long soft palate, retroposition of the
mandible, or soft tissue infiltration behind the
base of the tongue must receive attention. Such
problems may lead to residual symptoms after
tonsillectomy. Long term monitoring is re-
quired in infants and children treated for sleep-
related upper airway symptoms. Follow up
evaluations should include a physical ex-
amination, detailed questionnaires, and
polysonomographic recordings if necessary.
Symptoms sometimes recur after puberty, espe-
cially in boys.71 The usefulness of orthodontic
treatment in children with mandibular ab-
normalities after tonsillec
tomy is still under
investigation.

In 1986 Guilleminault suggested that nasal
continuous positive airway pressure (CPAP)
could be used as an alternative to tracheostomy
in young patients with OSA due to craniofacial
abnormalities.72 The preliminary findings of a
multicentre study conducted in North America
and France have recently been reported.98 99
The patients were obese or had craniofacial
abnormalities or residual problems after tons-
illec
tomy.100 The mean level of positive pres-
sure used was lower than in adults with OSA.
However, pressure requirements changed with
growth, suggesting that CPAP requirements
should be routinely re-evaluated at regular in-
tervals. In general, the level of pressure was set
to maintain the Sao2 above 95%. However,
further investigations are needed to establish
the best criteria for selecting the optimal pres-
sure. In infants with sleep-related increases in
upper airway resistance Guilleminault re-
commended that the level of nasal pressure
should be selected to maintain the oesophageal
pressure no lower than −8 cm H2O during
sleep.100 Commercial masks for infants are avail-
able, but in patients with craniofacial ab-
normalities custom-made masks may be
necessary. Finally, the BiPAP system may be
useful in some cases. Further studies are needed
to determine the specific indications of both
CPAP and the BiPAP system.

In patients with craniofacial abnormalities
treatment with CPAP enables the patient to
wait until optimal surgery can be performed
and avoids the use of a tracheostomy in young
patients. Close follow up is mandatory. In
patients with the Pierre Robin syndrome some
studies have found that clinical and poly-
sonomographic abnormalities persisted during
childhood and adolescence.90 101 Finally,
larngomalacia can be treated successfully by
epiglottoplasty.84

Summary
The presence of increased upper airway res-
istive loads during sleep can now be diagnosed
by paediatricians. However, diagnostic criteria
need to be further clarified to allow accurate identification of episodes of partial airway obstruction. New technological advances can be expected to help to determine the clinical usefulness of ambulatory monitoring during sleep and thus to establish the indications for polysomnographic investigations in the laboratory. A thorough investigation of the anatomical abnormalities that contribute to airways obstruction is essential for selecting the most appropriate therapy. However, the order in which these investigations should be performed remains unclear. The diagnostic tools, including questionnaires and sleep testing, and methods aimed at investigating pathophysiologic mechanisms should be standardized for multicentre studies. Familial factors should be taken into account. The best strategy for preventing the complications of the OSA syndrome is to identify the disorder as early as possible. This requires close cooperation between adult physicians and paediatricians called upon to evaluate sleep-related disorders.


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52. Rechtschaffen A, Kales A. A manual of standardized techniques, and scoring for sleep stages of human subjects. Brain Information Service, Brain Research Insti-
tute, University of California Los Angeles, UCLA (Publ 204). NIH, Bethesda, MD: 1968.


57. D’Allest AM, Brockbank MJ, Wright A, Svanholm AR. Ob-


66. Sher AE, Shrimpton RJ, Thorpy MJ. Endoscopic ob-
v


77. Teculescu D, Daniel MC, Mauffret E, Gaultier C, Monin P. Habitual snoring prevalence and associated factors in a sample of children aged 4 to 12 in Lorraine, France. 1er Congrès international de Pneumologie Pédiatrique Nicos, France, 3-5 June 1994.


80. Kahn A, Grosswasser J, Rebuffat E, Sootiaux M, Blum D, Foester M, et al. Sleep and cardiorespiratory char-


83. Francois M, Elmaleh M, Gare C, Nancy P. Dimensions du pharynx en fonction de la position chez le nouveau-


89. D’Allest AM, Laquin DN, Rosen CL. Continuous posi-