

## **Management of obstructive sleep apnea syndrome in children**

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### **Abstract**

Sleep related breathing disorders are observed at all ages. In Greece, at a study of 3.680 patients (1-18 years) from Thessaly, the prevalence of OSAS was 4.3%. The main risk factors for OSAS in children are adenotonsillar hypertrophy and obesity. The only reliable diagnostic method for the diagnosis of the syndrome is the full night polysomnography. Pulse oximetry is also a useful diagnostic tool but negative results must be confirmed with a full sleep study. The appropriate treatment is based on the AHI. Children with mild OSAS ( $AHI \leq 5$ ) and adenotonsillar hypertrophy can be treated with nasal corticosteroids for six weeks and leukotriene receptor antagonists and reexamined after 6 months. Most of them show a significant improvement after this kind of treatment. Adenotonsillectomy has not been proved to improve the AHI in this category of children. Children with moderate to severe OSAS ( $AHI > 5$ ) and adenotonsillar hypertrophy are treated with adenotonsillectomy and most of them show a significant improvement in the AHI postoperatively. Obese children with adenotonsillar hypertrophy are treated as children with normal weight but concomitant weight control is a complementary treatment. In obese children without adenotonsillar hypertrophy weight control and possible use of CPAP (if  $AHI > 5$ ) are indicated. Children with residual OSAS can be managed with nasal corticosteroids and montelukast (very helpful especially in atopic children), body weight control (in obese children), use of CPAP (if  $AHI > 5-10$  events/hour).

### **Biography**

Avlonitou Eirini has completed her PhD from the Physiology Department of Athens Medical School in the field of Sleep Apnea Syndrome. She has published more than 17 papers in reputed journals and participated in more than 50 congresses in Europe and USA.

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