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Medi Quest BRS Hospital

A monthly News letter from BRS Hospital

SLEEP DISORDERS IN CHILDREN

Dr.S.Ramesh M.D.,D.C.H. - Consultant Pediatrician
BRS HOSPITAL

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Editors

Dr.B.Madhusudhan,
MS.MCh.,DNB(Plastic)

Dr.S.Ramesh,MD,DCh

28,Cathedral garden Rd,
Nungambakkam,
Chennai - 600 034.
Phone:
044 - 61434250
044 - 61434230
Email:
brsmadhu@yahoo.co.in
Web:
www.brshospital.com

Parent seeking medical advice for sleep related issues in their offspring are becoming increasingly commonplace

The following are the most common sleep complaints

1. Difficulty initiating or maintaining sleep
2. Excessive day time sleepiness
3. Snoring or other breathing problem during sleep
4. Abnormal movements or behaviour before or during sleep

Specific sleep disorders:

1. Insomnia of Childhood Behavioural sleep problems in children
2.Sleep related movement disorders
3.Parasomnias of Childhood including sleep walking
4. Narcolepsy
5. Obstructive sleep apnoea in children

Medical problems leading to disturbances in sleep

1. Chronic or recurrent pain
2. GERD
3. Medications like stimulants used for ADHD
4. Asthma /Allergic Rhinitis
5. Infantile colic /Causes of incessant cry

Psychiatric Causes

Anxiety and Depression in the child
Sleep disorders involves the specialities of Pulmonology, ENT, Neurology and Psychiatry .

Assessment of sleep disorders in children

Sleep disorders in children interferes with physical, cognitive, emotional and social development.

Sleep history:

A variety of check list are available for evaluating sleep problems.
BEARS is a screening tool which has 5parameters regarding sleep.

B equals bedtime issues
E excessive day time sleepiness
A night Awakeners
R regularity and duration of sleep
S sleep disorder breathing

Once the chief sleep complaint is identified the history can focus on details the distinguish among disorders in that category. Parents can maintain sleep diaries for 2weeks prior to evaluation.

Appropriate use of smart phone videos can be used to record episodes of abnormal behaviour or movements.

Specific Sleep Disorders
Insomnia of Childhood

Difficulty initiating or maintaining sleep

resulting in some degree of impairment of day time functioning for the child and parents

Insomnia in infants and toddlers

The most common presentation of insomnia found in infants and toddlers is the sleep onset association type. In this situation child learns to fall asleep only under certain circumstances which requires parental presence such as being rocked or fed and does not develop ability to self soothe.

During the night the child experiences normal arousal which occurs during the end of a sleep cycle or awakens for some other reason and child is not able to get back to sleep without those same associations being present.

The presenting complaint is typically one of prolonged night waking resulting in insufficient sleep for both child and parent.

Management

Involves Set Sleep Schedule , bed time routine and behavioural program

The principle behind management, is the withdrawal of parental assistance to fall asleep

The treatment approach can be rapid withdrawal (extinction) or more gradual withdrawal (graduated extinction)

Extinction- " cry it out "

This involves putting the child at a designated time , drowsy but awake , then systematically ignoring any protests by the child until a set time the next morning. However extinction is often not an acceptable choice for families.

Graduated Extinction

Involves gradually weaning the child from parental presence. The parent leaves the room at lights out and periodically returns to check at periodic intervals at fixed or increasing intervals to provide brief reassurance till child falls asleep. The exact time interval is determined by parents tolerance for crying.

The goal is to allow the infant or child to develop skills in self soothing during bedtime.

Parents have to be forewarned that crying behaviour often temporarily escalates at the beginning of treatment (post extinction burst)

Stalling and Refusing to go to bed in pre school and older Children.

This is often due to parental difficulties in setting limits and managing behaviour in general -and the inability or unwillingness to set consistent bed time rules and enforce a regular bed time in particular **inadequate limit setting** .

Involves parental education regarding appropriate limit settings and decreased parental attention for bed time delaying behaviour.

Handout to Parents for Healthy sleep in Children (From Nelson Textbook of Pediatrics 20e)

1. Have a set bedtime and routine for your child
2. Bed time and wake up time should be the same during school and non school days
3. Make the hour before bed shared quiet time . Avoid rough play , TV and computer games
4. The child should not be hungry or have heavy meals within an hour or two of bed time interferes with sleep.
5. Avoid Caffeine containing products several hours before bed time , this includes chocolates.
6. Make sure your child spends time outside everyday.
7. Keep your child's room quiet and dark
8. Keep your child's room at the right temperature
9. Do not use your child's bedroom for time out or punishment
10. Keep the television out of your child's bedroom.

www.babysleepsite.com

Psychophysiologic or Primary or Learned Insomnia or Mind Body Insomnia in Adolescents

Occurs in adolescence characterized by a combination heightened physiologic arousal and learned sleep preventing associations resulting in sleepless ness and decreased day time functioning

This is a disorder of learned, sleep-preventing associations, such as not being able to sleep because either body or mind is not relaxed. The hallmark of primary insomnia is excessive, daily worries about not being able to fall or stay asleep when desired and worry that their efforts to fall asleep will be unsuccessful. Heightened physiological arousal is another feature – cognitive hypervigilance such as racing thoughts. Many people with this condition are concerned that they will never have a good night of sleep again.

Stress is the most common cause of psychophysiological insomnia.

While sleep problems are common when going through a stressful event, some people continue to have sleep problems long after the stressful event is over. Sometimes the stress and sleep problems create an ongoing, worsening cycle of each problem.

Management :

1. Educating the adolescent about health sleep practices
2. Institution of a consistent sleep wake schedule
3. Avoidance of day time napping
4. Instructions to use the bed for sleep alone, get out of bed if unable to fall asleep and restricting time in bed to the actual time asleep.
5. Relaxation techniques
6. Hypnotic medications rarely needed.

Delayed Sleep Wake Phase disorder .

Most common sleep disorder in adolescence , affected individuals go to bed late , and get up late. Have a night owl circadian rhythm. Bed times are delayed by two or more hours . As a result they have sleep deprivation , impaired daytime function or distress and increased incidence of depression.

Management

Minimize or eliminate caffeine, nicotine and alcohol
Avoid daytime naps
Refrain from engaging in stimulating activity for at least two hours prior to the desired sleep onset time
Avoid sleeping in on weekends by more than 30 minutes compared with week day time
Adherence to earlier bed and rise times

Timed melatonin

Melatonin used in doses of 3 to 5 mg administered 1.5 to 2 hours before bed time has shown improved sleep onset times . The duration of therapy to be individualised .

Several studies which followed up children and adolescents on Melatonin in doses ranging from 2.7 mg to 15 mg for more than a year have shown no major adverse effects

Morning light therapy

Morning light exposure would be expected to shift circadian rhythms earlier and thereby correct a phase delay.Light boxes with 10,000 lux at 5 feet should be used every morning with gradually advancing sleep wake time until target time is reached.

Subsequent Bulletins will cover

1. Obstructive Sleep Apnoea syndrome
2. Parasomnias
3. Sleep Related Movement Disorders
4. Narcolepsy

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