

Emerging roles of dental professionals in the management of obstructive sleep apnea

Sir,

Obstructive sleep apnea (OSA) in children has emerged not only as a relatively prevalent condition but also as a disease that imposes a large array of morbidities, some of which may have long-term implications, well into adulthood. The etiology of childhood OSA is quite different from that of the adult condition. In adults, OSA is usually associated with obesity and other causes. Obese children are also at risk for OSA, while most children with OSA are not obese. Instead, the vast majority of cases of OSA in children are associated with adenotonsillar hypertrophy and skeletal malocclusion. According to Brouillette *et al.*^[1] increasing awareness of OSA and examination of sleeping patients should result in earlier treatment and less morbidity for infants and children with OSA.

As adenotonsillar hypertrophy is one of the main causes of OSA among children, investigating the prevalence of OSA among children with adenotonsillar hypertrophy is an important clinical and research task. There is evidence that physicians may not always recognize childhood OSA.^[2] According to Konno *et al.*^[3] the average delay of 23 months occurred between identification of pediatric patients with large tonsils and their referral to a sleep clinic. Among the physicians treating children, dentists/orthodontists are most likely to identify adenotonsillar hypertrophy; thus, it may be in the patient's best interests if dentists/orthodontists act as "gatekeepers" in identifying children with adenotonsillar hypertrophy. Once a dentist/orthodontist identifies children with adenotonsillar hypertrophy, they should inform the parents about the risk of OSA and further

inform their family physician about the importance of sleep assessment in children with enlarged tonsils. Involvement of dentists/orthodontist in this process can contribute significantly to the health of patients, as OSA, with such significant developmental consequences, can be diagnosed and treated at an early stage, preventing later problems and complications.

Sanjeev Kumar Verma, A. Balamani², K. C. Prabhat

Department of Orthodontics and Dental Anatomy,
Aligarh Muslim University, Aligarh, Uttar Pradesh,

¹Department of Orthodontics, MGPGI, Puducherry, India

Address for correspondence:

Dr. K. C. Prabhat,

Department of Periodontics, Aligarh Muslim University,
Aligarh, Uttar Pradesh, India.

E-mail: dr.prabhatkc@gmail.com

REFERENCES

1. Brouillette RT, Fernbach SK, Hunt CE. Obstructive sleep apnea in infants and children. *J Pediatr* 1982;100:31-40.
2. Tamay Z, Akcay A, Kilic G, Suleyman A, Ones U, Guler N. Are physicians aware of obstructive sleep apnea in children? *Sleep Med* 2006;7:580-4.
3. Konno A, Hoshino T, Togawa K. Influence of upper airway obstruction by enlarged tonsils and adenoids upon recurrent infection of the lower airway in childhood. *Laryngoscope* 1980;90:1709-16.

Access this article online	
Quick Response Code:	Website: www.ejgd.org
	DOI: 10.4103/2278-9626.115993