

# We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

5,700

Open access books available

141,000

International authors and editors

180M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index  
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?  
Contact [book.department@intechopen.com](mailto:book.department@intechopen.com)

Numbers displayed above are based on latest data collected.  
For more information visit [www.intechopen.com](http://www.intechopen.com)



## Chapter

# Neuropsychological Alterations in Children Affected by Obstructive Sleep Apnea Syndrome

*Marco Carotenuto, Rosa Marotta, Francesco Precenzano, Maria Ruberto, Lucia Parisi, Beatrice Gallai, Annabella Di Folco, Margherita Salerno, Agata Maltese, Francesca Felicia Operto and Michele Roccella*

## Abstract

Sleep-related breathing disorders are a group of clinical conditions ranging from habitual snoring to obstructive sleep apnea syndrome (OSAS) during the lifespan. In children, other risk factors are represented by adenotonsillar hypertrophy, rhinitis, nasal structure alteration, cleft palate, velopharyngeal flap surgery, pharyngeal masses, craniofacial malformations, genetic syndrome (i.e. Down syndrome, Crouzon syndrome, and Apert syndrome), genetic hypoplasia mandibular (i.e. Pierre Robin syndrome, Treacher Collins syndrome, Shy-Drager syndrome, and Cornelia De Lange syndrome), craniofacial traumas, chronic or seasonal rhinitis, asthma, neuromuscular syndromes, brainstem pathologies (i.e. Arnold-Chiari malformation and Joubert syndrome), achondroplasia, and mucopolysaccharidosis. OSAS may affect the executive functioning such as motivational ability, planning, behavior modulation, ability to complete an action program, identification of functional strategies to achieve the goal, problem solving, flexibility, monitoring and self-assessment of behavior in relation to results, change of task, or behavior in the light of emerging information, which may be all impaired by nocturnal intermittent hypoxia also during the developmental age. The clinical presentation of OSAS can mimic other neurobehavioral symptoms, such as ADHD syndrome, learning problems, or can exacerbate the Fragile X syndrome, and generalized non-convulsive epilepsy symptoms.

**Keywords:** sleep-related breathing disorders, pediatric OSAS, executive dysfunction

## 1. Introduction

Sleep-related breathing disorders are a group of clinical conditions ranging from habitual snoring to obstructive sleep apnea syndrome (OSAS), frequent in all ages of life. OSAS is a clinical condition still underdiagnosed both in adults and particularly in children, with high cost of care for general population [1, 2]. OSAS can be considered the most severe nocturnal respiratory disorder characterized by repeated episodes of obstructive and/or hypopnea during sleep caused by complete or partial

obstruction of the upper airways. The nocturnal episodes of total or incomplete breathing interruption are identified and recorded in the apnea/hypopnea index per hour (AHI), and the nocturnal oxygen desaturation is expressed as oxygen desaturation index per hour (ODI). In children, in contrast to the adult, definition of OSAS, which requires an AHI  $\geq 5$  episodes per hour of sleep lasting more than 10 seconds, with persistent thoracoabdominal movements [1], does not require so.

In 1976, OSAS syndrome was identified and described in pediatric age by Guilleminault et al. [3], and from that time on, studies on this pediatric pathology have multiplied, considering its important impact on all aspects of life often linked to the intermittent nocturnal hypoxia not ever associated with the nocturnal respiratory events (hypopneas and apneas).

## **2. Epidemiology**

In the developmental age, prevalence in preschool and school age for primary snoring ranges from 3.2 to 12.1%, while for OSAS, it varies from 1.1 to 2.9%. The peak incidence is observed between 3 and 6 years and coincides with the age of maximum development of lymphatic tissue. In all the studies found in the literature, it can in fact be noted that the incidence of OSAS is greater in children with adenotonsillar hypertrophy [4].

The prevalence of OSAS in Italy shows a prevalence in children of 4.9% for primary snoring and of 1.8% for OSAS [5].

On the other hand, African American children were reported four to six times more likely to have OSAS than children of Caucasian origin [6], while the predisposition to OSAS in African Americans has been attributed to different upper airway anatomy and pharyngeal neuromotor control in addition to other genetic and environmental factors [6].

In clinical practice, there are many screening tests for the identification of sleep-related breathing disorders in pediatric age.

Furthermore, in children, sleep is less fragmented than adults because the behavioral awakenings seem to be less frequent in children than in adults with a lower incidence of daytime excessive somnolence.

## **3. Risk factors**

OSAS is a complex and multifactorial syndrome, and it is believed that some specific genes may play a crucial role in its pathogenesis, particularly involved in the expression of the CLOCK gene [7], IL-10 polymorphisms [8], and insulin variable number of tandem repeat (INS VNTR) sequence regulation [9].

In general, there are some conditions that may predispose to OSAS, such as alterations of craniofacial structures, obesity with fat deposition on side walls of the pharynx, endocrine changes, alcohol intake, and cigarette smoking [10] both in adults and in children.

In pediatric population, the main risk factor is adenotonsillar hypertrophy [11, 12], but others are rhinitis [13], nasal structure alteration [14, 15], cleft palate, velopharyngeal flap surgery, pharyngeal masses, craniofacial malformations [16], genetic syndrome (i.e. Down syndrome, Crouzon syndrome, and Apert syndrome), genetic hypoplasia mandibular (Pierre Robin syndrome, Treacher Collins syndrome, Shy-Drager syndrome, and Cornelia De Lange syndrome) [17, 18], craniofacial traumas [19, 20], chronic or seasonal rhinitis [13],

asthma [21, 22], neuromuscular syndromes [23], brainstem pathologies (Arnold-Chiari malformation and Joubert syndrome) [24], achondroplasia [25], and mucopolysaccharidosis [26].

On the other hand, worldwide pediatric obesity tends to be prevalent in children with respiratory disorders during sleep; however, it does not represent the main risk factor unlike the adult and is even a complication of OSAS especially after the adenotonsillectomy [27, 28].

#### **4. Pathophysiology**

In OSAS, due to a reduction in the size of the upper airways and a reduction in the activity of the pharynx dilator muscles, there are an increase in critical pressure (transmural pressure value at which the area of the pharyngeal section is equal to zero) and an enormous reduction in the pharyngeal lumen [29].

The obstructive events will therefore lead to the appearance of hypoxemia and hypercapnia, which will first cause an increase in respiratory effort, and then a wake-up, of a few seconds, which will serve to restore the patency of the upper airways; all these will repeat cyclically during sleep, causing an alteration of the structure.

In the adult, there is a reduction in nonrapid eye movement (NREM) sleep and rapid eye movement (REM) sleep, and consequently, the major symptom is daytime sleepiness; in children, on the other hand, intermittent hypoxia has a role in the appearance of neocognitive deficits, which are the most common signs and symptoms in the case of OSAS in the developmental age [29].

Behavioral awakenings in the child with OSAS are less frequent than in adults, and this on the one hand allows the child to retain the benefits of sleep, and on the other hand, it can cause long periods of hypoventilation. Moreover, in children, the desaturation of O<sub>2</sub> can also be achieved during short apnea due to the reduced functional lung capacity and the most frequent respiratory rate in pediatric age [29].

In OSAS, there is also a state of chronic systemic inflammation, mainly linked to intermittent hypoxia, which promotes the activation of some factors responsible for inflammation such as C-reactive protein (PCR) and IL-6 and is therefore responsible for a state of oxidative stress [30].

Oxidative stress and increased production of oxygen-free radicals represent the pathophysiological substrate of the onset of cardiovascular, cerebrovascular, and metabolic complications [31, 32].

#### **5. Clinical signs**

Clinical signs of OSAS appear to be different in pediatric age with respect to adulthood, and therefore, the diagnostic and therapeutic management overlapping may be considered a severe clinical mistake.

In adults with OSAS, the most common presentation is excessive daytime sleepiness (EDS) that results from sleep fragmentation and from the frequent nocturnal intermittent hypoxic episodes [33], while in nonobese children, EDS is a rare complain. Conversely, children with OSAS tend to be not drowsy but rather hyperkinetic during the day, and often, these children are misdiagnosed with attention-deficit/hyperactivity disorder (ADHD) and treated with methylphenidate.

This common diagnostic mistake is derived from the lack of evaluation of sleep habits in children presenting with suspected hyperactivity behavior

that may highlight the presence of ADHD-like symptoms and not of ADHD syndrome [34, 35].

In pediatric age, the symptoms and major signs of suspected nocturnal respiratory problems are mainly oral breathing [36], nocturnal hyperkinesia, snoring or breathing pauses [37], nocturnal positional abnormalities [38], behavioral problems [39, 40], poor academic performance [41], failure to thrive and growth delay, recurrent airway infections [37], recent enuresis onset [42, 43], and night sweating and drooling [44].

## **6. Polysomnography (PSG)**

Pediatric respiratory disorders during sleep find their diagnostic gold standard in the overnight polysomnography. This term commonly means the simultaneous and continuous recording during the night of functional parameters suitable for defining the cardiorespiratory events in relation to the various phases of sleep. Normally, during the test, two or more electroencephalogram (EEG) channels, two or more electromyographic channels, chest and abdomen movements, oronasal flow, oxygen saturation in the blood, and CO<sub>2</sub> measurement are recorded. The polysomnographic result must always be contextualized with the symptoms and signs and referred to the general clinical picture since there is not always a correspondence between the severity of the polysomnographic instrumental data (in terms of number of events and levels of O<sub>2</sub> desaturation) and the gravity of symptoms [45].

The severity identification of SRBD is identified by apnea/hypopnea index (AHI) and oxygen desaturation index (ODI). In pediatric age, AHI cut-off has been established between 1.2 and 1.3 nocturnal events per hour, while for ODI are conflicting and nonconclusive results.

## **7. Diagnosis and classification**

For the diagnosis of OSAS, the anamnesis, the physical examination, and the polysomnographic examination that allows an early diagnosis and therefore an early therapy to prevent the development of complications are fundamental.

During the visit, a careful history assessment must be made, considering if there is the presence of familiarity for OSAS and if there are symptoms such as snoring, attention deficit, predominantly oral breathing, nocturnal hyperkinesia, behavioral problems and academic performance, recurrent airway infections, recently onset enuresis, night sweats, and nocturnal sialorrhea [43].

On physical examination, the signs and findings most closely linked to a high risk of respiratory disorders in sleep are adenotonsillar hypertrophy, rhinitis, macroglossia, and obesity [43].

Analyzing the oronasal flow is used to assess ventilation and to identify and differentiate central apnea from obstructive apnea, whereas hypopneas are more difficult to identify as they are not greater than 50% of respiratory flow. Analyzing thoracoabdominal movements and respiratory effort, on one hand, and quantitative and qualitative information on breathing, on the other hand, can be obtained.

The respiratory parameters are useful for the diagnosis of OSAS, and the American Academy of Sleep Medicine distinguishes respiratory events in central, obstructive, and hypopneic episodes [46].

Central apnea is caused by the damage to the nerve centers that regulate ventilation and is characterized by a complete cessation of ventilation with no thoracoabdominal movements. In the child, it can be an occasional event that becomes

pathological if there are more than three episodes per hour of sleep with a desaturation of  $>3\%$  [46].

The obstructive apnea is instead caused by a complete or partial obstruction of the upper airways associated with inspiratory effort evidenced by the variation of thoracoabdominal movements in an attempt to overcome the obstruction. In children, even only one obstructive event per hour of sleep has a pathological character ( $AHI \geq 1/h$ ) [46].

Obstructive hypopnea consists of a reduction in oronasal flow  $>50\%$ , with a desaturation of  $>3\%$  for at least two respiratory cycles, and accompanied by thoracoabdominal movements [46].

Children may present four grades of OSAS severity classified by the Italian Society of Sleep Medicine [46] as follows:

- minimum OSAS:** AHI between one and three episodes per hour and/or the presence of continuous snoring for at least 50% of sleep associated with  $O_2$  desaturations above 4% and average  $SaO_2 > 97\%$ ;
- mild OSAS:**  $3 < AHI < 5$  and average  $SaO_2 > 97\%$ ;
- moderate OSAS:**  $5 < AHI < 10$  and average  $SaO_2 > 95\%$ ; and
- severe OSAS:**  $AHI > 10$  or with average  $SaO_2 < 95\%$ .

Adenotonsillectomy is the main treatment in children, but if this failed or in the case of obese patients, continuous positive airway pressure (CPAP) or other positive pressure devices need to be considered [43].

## 8. The link between the severity of respiratory disturbance in sleep and neurocognitive disorders

According to many reports [47–49], neurocognitive alterations seem to be the direct effect of nocturnal intermittent hypoxia, sleep fragmentation, hormonal imbalance, systemic subclinical inflammation [50, 51], and endothelial dysfunction [52].

Nocturnal intermittent hypoxia causes a chronic state of neuroinflammation due to the production of proinflammatory cytokines such as interleukin (IL)-10, IL-6, IL-1, and  $TNF-\alpha$  [53], although also serum C-reactive protein (CRP), pentraxin-3 (PTX-3), procalcitonin (ProCT), IL-33, and its soluble receptor ST2 (sST2) may be identified as putative biomarkers for OSAS severity almost in adults [54]. Interestingly, in children affected by OSAS and cognitive alteration, there is an increase in PCR and proinflammatory cytokines that are reduced following the adenotonsillectomy [51, 52].

Oxidative stress also directly and indirectly causes endothelial and vascular alterations that provoke an alteration in cerebral perfusion and play an important role in the onset of neurocognitive alteration in OSAS children [53].

Although IGF1, the insulin-like growth factor, is mainly produced by the liver under the stimulation of growth hormone (GH), its mechanism of action is mediated by its specific receptor, IGF1R, which is present on many cell types in many tissues, where it promotes cell proliferation and differentiation, especially at cartilage and muscle levels, so it is essential for growth processes in children. IGF1 can also be produced from other tissues as well as from the liver, including the brain, where it is synthesized without control by circulating GH. IGF1 promotes neuron survival and differentiation. It is involved in brain plasticity processes and regulates synapse formation, neurotransmitter release, and neuronal excitability. In children with OSAS, it was seen that high systemic levels of IGF1 appear to have a neuroprotective role because they reduce the risk of cognitive impairment [55, 56].

In children, sleep is essential for the processes of learning and memorization, and therefore, any alteration, such as its fragmentation, can cause impairment in the executive and behavioral functioning and in the emotional recovery [57].

Furthermore, in many children with OSAS and neurocognitive deficits, there was a high presence of  $\epsilon$ 4APOE allele, known to be present above all in people suffering from Alzheimer's disease [58]. Through magnetic resonance spectroscopy studies, it has been shown that in children with OSAS, there is a decreased hippocampal volume and focal reductions of gray matter in the frontal and parietal lobes [59, 60].

Moreover, in children with OSAS, in addition to the presence of neurocognitive disorders, a growth retardation is frequently found, in which at least three causes contribute to provoke it, namely, a feeding difficulty secondary to adenotonsillar hypertrophy, an increase in metabolic activity for respiratory effort during sleep, and an alteration of hormonal regulation with reduction of the nocturnal secretion of growth hormone and insulin-like growth factor [48].

Frequently endocrine alterations are associated with OSAS, as sleep fragmentation can have an impact on hormones that regulate glucose tolerance. In fact, diabetic children suffer more frequent and longer-lasting episodes of sleep apnea than healthy controls [61, 62].

However, in the developmental age, neurocognitive impairment due to OSAS seems to be more relevant than endocrinological and cardiovascular effects since it might not be reversible.

## **9. Executive functions: a complex construct**

The executive functions (EFs) are defined as those cognitive skills necessary to plan, implement, and successfully complete a behavior aimed at a purpose. They do not represent a single entity but a complex of distinct, independent, and “subtly” interacting “subprocesses” necessary to perform a task and to achieve an end in an articulated and flexible way. Lezak et al. [63] attribute to them the concept of “umbrella term,” as the umbrella is a compound of distinct elements that together support a “structure,” in the same way that the executive functions constitute a unique and “meta-construct” all-inclusive to think, intuit, concentrate, adapt in order to achieve goals, and develop problem-solving strategies. EFs may be identified as a “module” of the mind that regulates the processes of planning, control, and coordination of the cognitive system, which, in turn, governs the activation and modulation of cognitive processes and schemes. EFs are transversal functions, differently from the so-called vertical functions (i.e. motor skills, language, reading, writing, calculation), and therefore, they can only be partially isolated and studied in their singularity. In this perspective, EFs are invisible as they are inextricably linked to the task and domain in which the activity is carried out and, therefore, cannot be analyzed independently of the performance. “They are higher-level, non-domain-specific cognitive functions, which enable us to formulate objectives/plans and to remember them over time; to choose and initiate actions that allow to achieve the objectives, to monitor the behavior and adjust it in order to reach those objectives” [64, 65].

On the other hand, the “label” of “skills that come into play in situations and tasks in which the use of routine behaviors and skills is no longer sufficient for their success” by addressing the set of mental processes aimed at development of adaptive cognitive-behavioral patterns in response to new and demanding environmental conditions [63].

EFs are essential and basic for the following:

- learning new actions;
- making the action plan and decision-making processes;
- selecting the correct answer and inhibiting the wrong one;
- correcting the errors;
- requiring the variable combinations of actions for new behaviors;
- conducting the complex activities;
- constant monitoring of behavior and evaluating the result; and
- having the ability to regulate and overcome the strong habitual responses.

Over the past 40 years, cognitive psychology and neuropsychology have paid particular attention to these skills, and despite the progress made in their study and description in the event of injury or developmental deficit, their multicomponent nature continues to make them difficult to analyze as well as a fully shared definition. The literature has provided different definitions and interpretations, and to date, there is still no unanimous agreement on the construct; different subdomains of executive functions are identified, which are the basis of other higher-order functions such as reasoning, problem solving, planning, understanding the behavior, and thinking of others.

Specifically, the main EFs are as follows:

- working memory: it is the ability to keep the plan and the work area mentally active and to have a mental set of reference on which to operate even in the presence of distracting tasks or situations;
- inhibition: it is the ability to self-control, to resist temptations, and to act impulsively; the ability to focus attention on relevant data by ignoring distractors and inhibiting inadequate motor and emotional responses;
- selective and sustained attention;
- flexibility: understood both in cognitive terms (shifting from one set to another based on information from the context) and in terms of creativity and sudden adaptation; and
- fluency: thinking ability capable of generating new and different solutions to a problem.

Their use is indispensable in all types of problem solving, not only the most complex and abstract ones such as solving mathematical problems, but also those related to the acquisition of social skills and the understanding of others' thoughts (metacognition) since the sensitivity to other people's goals, emotions, or desires requires an uncoupling from one's internal mental states. We turn to multiple domains that extend from the simple to the most complex and are in any case



interrelated. It is precisely the transversal nature and the structural complexity that characterizes them, associated with their slow development process, to explain why multiple neuropsychiatric disorders of the developmental age (pervasive developmental disorders, behavioral disorders, speech disorders, learning disorders, and disorders of the nonverbal area) present, with varying degrees of symptomatic severity, a common deficit for executive functioning. There are also motivated situations in which a deficiency of theirs manifests itself with clinical signs and symptoms that are often nuanced, nonspecific, and not immediately diagnostic (instability of behavior and emotionality, distractibility, difficulty in moving from one activity to another, and atypia communication). To this lively theoretical debate on what and what the EFs are, a new theoretical contribution has recently been added linked to the different types of cognitive and behavioral deficits that have emerged from injuries to the different areas of the prefrontal cortex, which has allowed a further classification in hot and cold executive functions [63].

The “hot” executive processes involve the emotional-emotional sphere and are associated with the activity of the ventromedial prefrontal cortex (VMPFC); the “cold” executive ones concern cognitive and nonemotional processing and are associated with the activity of the dorsolateral prefrontal cortex and can be measured by neuropsychological tests used in clinical practice (DLPFC) [66].

The “hot” executive functions recall phenomena such as empathy, the theory of the mind, emotional, and affective regulation, which coordinate the cognitive with the emotional sphere in order to adequately address the primary impulses with socially acceptable strategies. The “cold” executive functions intervene in cognitive, abstract, and decontextualized tasks (problem solving, abstraction, planning, working memory, and elaboration of strategies). Despite this distinction, they are closely related and combined in different situations of daily life.

In summary, the EFs are a particular set of cognitive operations activated in pursuit of objectives, responsible for planning, the ability to set goals, to classify, to know how to execute an order, to control and monitor one’s behavior, to know how to order a series of activities in order to achieve a goal, and to manage, more generally, all mental activities [63].

These functions are modified in some pathological conditions such as posterior cranial fossa neoplasms [67], localized posttraumatic lesions to the frontal lobe [68], neurodegenerative syndromes (i.e. Parkinson’s disease and Alzheimer’s disease) [69, 70], cerebrovascular malformations (i.e. Moya-Moya syndrome) [71], ADHD [72], and OSAS [73].

The close relationship between cognitive functions has long been known and sleep, with particular reference to disorders respirators for which it has been widely demonstrated in the developmental age the association with learning disorders and more generally with alterations of the cognitive performance [74] that appears in such subjects dominated by slowness in concept development [75, 76] which however do not seem to be related to degree of severity of the respiratory disorder [77].

Several studies have focused on the role of the frontal lobes as possible relay zones between the OSAS and the cognitive alterations [78, 79]; however, studies conducted on executive functions of subjects with OSAS have pay attention exclusively to adulthood [79], leaving aside the impact of this disease in the developmental age.

In this context, the close interconnection between OSAS and alteration specifications charged to executive functions. Furthermore, as reported in other studies, the modified card sorting test (MCST) is related especially to changes in blood flow for the frontal and hippocampal regions [80]. These data reflect the conclusions of recent neuroimaging studies on subjects suffering from OSAS, which would present a level reduction of the gray substance of the fronto parietal regions and

hippocampus [81, 82], confirming the presence of an interconnection between sleep mode and performance also in subjects of the developmental age.

The neurocognitive OSAS effects have been known for over a century. In 1892, Sir William Osler described, in the child, an association between night snoring, upper respiratory tract obstruction, and intellectual retardation [83].

In 1889, William Hill confirmed what Osler had previously described and showed that the removal of adenoids and tonsils caused not only the disappearance of night-time respiratory symptoms but also the recovery of intellectual function [84].

In general, children affected by OSAS may present many specific problems in different day-life functioning areas including reductions in working memory, speed movement, cognitive flexibility, and planning. As main effect of this alteration, learning ability and scholastic efficiency may be altered precociously [85].

The exact etiopathogenetic link between nocturnal respiratory disorders and daytime behavioral symptoms is not still known. Certainly, the fragmentation of sleep due to frequent microarousal, hypoventilation, and the imbalances in blood gases that these children experience during sleep plays an important role in the genesis of these disorders.

Brain studies in rodent models have shown that hypoxia and anoxia produce cellular damage [86] within the CA1 region of the hippocampus and adjacent cortex.

This laid the groundwork for further studies, which confirmed the reduction of gray matter in subjects with OSAS in the right upper temporal sulcus and in the left cerebellum area, areas dedicated to attention processes, working memory, and motor coordination. In fact, many studies [87, 88] have revealed reductions in gray matter in the inferior temporal gyrus, including the parahippocampal gyrus, extended toward the anterior temporal pole. The precise function of the average time frame is unclear. Recent attempts to link structural deficits resulting from OSAS with functional consequences have concluded that structural deficits are associated with memory impairment and difficulty in motor coordination, although these data are not conclusive [89].

On the other hand, the complete brain magnetic resonance imaging (MRI) scanning in OSAS subjects showed loss of gray matter in a single large region of the cerebellum, more dominant on the left. Patients with right focal lesions often show verbal deficits, while those with lesions on the left seem to suffer more from spatial deficits. The left region, in fact, is the one most involved in the development of the movement. Moreover, Yaouhi et al. [90] reported significant loss of gray matter in bilateral inferior parietal gyrus, right temporal cortex, occipital cortex, right thalamus, left putamen, left caudate nucleus and left pallidum, right hippocampal gyrus, right cerebellar hemisphere, and cerebellar vermis in OSAS subjects.

## 10. Conclusions

Motivational ability, planning, behavior modulation, ability to complete an action program, identification of functional strategies to achieve the goal, problem solving, flexibility, monitoring and self-assessment of behavior in relation to results, change of task, or behavior in the light of emerging information may be all impaired by nocturnal intermittent hypoxia also during the developmental age. The final effects of this impairment may be identified in such clinical condition mimicking other neurobehavioral symptoms, such as ADHD [34], while learning problems may be sustained by OSAS [91, 92], or in Fragile X syndrome [93], in epilepsy [94], and in EEG abnormalities [95], suggesting that the sleep screening may be considered as mandatory in neurodevelopmental disorders.

IntechOpen

### Author details

Marco Carotenuto<sup>1\*</sup>, Rosa Marotta<sup>2</sup>, Francesco Precenzano<sup>1</sup>, Maria Ruberto<sup>3</sup>, Lucia Parisi<sup>4</sup>, Beatrice Gallai<sup>5</sup>, Annabella Di Folco<sup>4</sup>, Margherita Salerno<sup>4</sup>, Agata Maltese<sup>4</sup>, Francesca Felicia Operto<sup>6</sup> and Michele Roccella<sup>4</sup>

1 Sleep Lab for Developmental Age, Clinic of Child and Adolescent Neuropsychiatry, Department of Mental Health, Physical and Preventive Medicine, University of Campania “Luigi Vanvitelli”, Caserta, Italy

2 Department of Medical and Surgical Sciences, University “Magna Graecia”, Catanzaro, Italy

3 CDR Santa Maria del Pozzo, Somma Vesuviana, Naples, Italy

4 Department of Psychology, Educational and Science and Human Movement, University of Palermo, Palermo, Italy

5 Department of Surgical and Biomedical Sciences, University of Perugia, Perugia, Italy

6 Child Neuropsychiatry Unit, Department of Medicine, Surgery and Odontostomatology, University of Salerno, Italy

\*Address all correspondence to: marco.carotenuto@unicampania.it

### IntechOpen

© 2020 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/3.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. 

## References

- [1] Heinzer R, Vat S, Marques-Vidal P, et al. Prevalence of sleep-disordered breathing in the general population: The HypnoLaus study. *The Lancet Respiratory Medicine*. 2015;**3**:310-318
- [2] Toraldo DM, Passali D, Sanna A, De Nuccio F, Conte L, De Benedetto M. Cost-effectiveness strategies in OSAS management: A short review. *Acta Otorhinolaryngologica Italica*. 2017;**37**(6):447-453. DOI: 10.14639/0392-100X-1520
- [3] Guilleminault C, Tilkian A, Dement WC. The sleep apnea syndromes. *Annual Review of Medicine*. 1976;**27**:465-484
- [4] Brockbank JC. Update on pathophysiology and treatment of childhood obstructive sleep apnea syndrome. *Paediatric Respiratory Reviews*. 2017;**24**:21-23. DOI: 10.1016/j.prrv.2017.06.003
- [5] Brunetti L, Rana S, Lospalluti ML, Pietrafesa A, Francavilla R, Fanelli M, et al. Prevalence of obstructive sleep apnea syndrome in a cohort of 1207 children of southern Italy. *Chest*. 2001;**120**(6):1930-1935
- [6] Joosten KF, Larramona H, Miano S, Van Waardenburg D, Kaditis AG, Vandebussche N, et al. How do we recognize the child with OSAS? *Pediatric Pulmonology*. 2017;**52**(2):260-271. DOI: 10.1002/ppul.23639
- [7] Moreira S, Rodrigues R, Barros AB, Pejanovic N, Neves-Costa A, Pedroso D, et al. Changes in expression of the CLOCK gene in obstructive sleep apnea syndrome patients are not reverted by continuous positive airway pressure treatment. *Frontiers in Medicine (Lausanne)*. 2017;**4**:187. DOI: 10.3389/fmed.2017.00187
- [8] Özdaş S, Özdaş T, Acar M, Erbek SS, Köseoğlu S, Göktürk G, et al. Association of Interleukin-10 gene promoter polymorphisms with obstructive sleep apnea. *Sleep & Breathing*. 2016;**20**(2):855-866. DOI: 10.1007/s11325-015-1216-9
- [9] Carotenuto M, Santoro N, Grandone A, Santoro E, Pascotto C, Pascotto A, et al. The insulin gene variable number of tandem repeats (INS VNTR) genotype and sleep disordered breathing in childhood obesity. *Journal of Endocrinological Investigation*. 2009;**32**(9):752-755
- [10] Deflandre E, Kempeneers D, Degey S, Poirrier R, Legros P, Brichant JF, et al. Risk factors for nocturnal hypoxemia in severe obstructive sleep apnea patients. *Minerva Anestesiologica*. 2017;**83**(5):449-456. DOI: 10.23736/S0375-9393.16.11491-9
- [11] Mitchell RB, Garetz S, Moore RH, Rosen CL, Marcus CL, Katz ES, et al. The use of clinical parameters to predict obstructive sleep apnea syndrome severity in children: The Childhood Adenotonsillectomy (CHAT) study randomized clinical trial. *JAMA Otolaryngology. Head & Neck Surgery*. 2015;**141**(2):130-136. DOI: 10.1001/jamaoto.2014.3049
- [12] Venekamp RP, Hearne BJ, Chandrasekharan D, Blackshaw H, Lim J, Schilder AG. Tonsillectomy or adenotonsillectomy versus non-surgical management for obstructive sleep-disordered breathing in children. *Cochrane Database of Systematic Reviews*. 2015;**10**:CD011165. DOI: 10.1002/14651858.CD011165.pub2
- [13] Marcuccio G, Di Bari M, Precenzano F, Operto FF, Bitetti I, Motta G, et al. Relationship between sleep quality and rhinitis in children: Role of medical treatment with isotonic and hypertonic salines. *Minerva*

Pediatrica. 2019. DOI: 10.23736/S0026-4946.19.05563-4

[14] Fu D, Pinto JM, Wang L, Chen G, Zhan X, Wei Y. The effect of nasal structure on olfactory function in patients with OSA. *European Archives of Oto-Rhino-Laryngology*. 2015;272(2):357-362. DOI: 10.1007/s00405-014-3096-1

[15] Rodrigues MM, Gabrielli MFR, Garcia Junior OA, Pereira Filho VA, Passeri LA. Nasal airway evaluation in obstructive sleep apnoea patients: Volumetric tomography and endoscopic findings. *International Journal of Oral and Maxillofacial Surgery*. 2017;46(10):1284-1290. DOI: 10.1016/j.ijom.2017.05.009

[16] Luzzi V, Di Carlo G, Saccucci M, Ierardo G, Guglielmo E, Fabbrizi M, et al. Craniofacial morphology and airflow in children with primary snoring. *European Review for Medical and Pharmacological Sciences*. 2016;20(19):3965-3971

[17] Cielo CM, Gungor A. Treatment options for pediatric obstructive sleep apnea. *Current Problems in Pediatric and Adolescent Health Care*. 2016;46(1):27-33. DOI: 10.1016/j.cppeds.2015.10.006

[18] Cielo CM, Konstantinopoulou S, Hoque R. OSAS in specific pediatric populations. *Current Problems in Pediatric and Adolescent Health Care*. 2016;46(1):11-18. DOI: 10.1016/j.cppeds.2015.10.008

[19] Guillemainault C, Huang YS. From oral facial dysfunction to dysmorphism and the onset of pediatric OSA. *Sleep Medicine Reviews*. 2018;40:203-214. DOI: 10.1016/j.smrv.2017.06.008

[20] Carotenuto M, Esposito M, Pascotto A. Facial patterns and primary nocturnal enuresis in children. *Sleep*

& Breathing. 2011;15(2):221-227. DOI: 10.1007/s11325-010-0388-6

[21] Kong DL, Qin Z, Shen H, Jin HY, Wang W, Wang ZF. Association of obstructive sleep apnea with asthma: A meta-analysis. *Scientific Reports*. 2017;7(1):4088. DOI: 10.1038/s41598-017-04446-6

[22] Trivedi M, ElMallah M, Bailey E, Kremer T, Rhein LM. Pediatric obstructive sleep apnea and asthma: Clinical implications. *Pediatric Annals*. 2017;46(9):e332-e335. DOI: 10.3928/19382359-20,170,815-03

[23] Albdewi MA, Liistro G, El Tahry R. Sleep-disordered breathing in patients with neuromuscular disease. *Sleep & Breathing*. 2018;22(2):277-286. DOI: 10.1007/s11325-017-1538-x

[24] Selvadurai S, Al-Saleh S, Amin R, Zweerink A, Drake J, Propst EJ, et al. Utility of brain MRI in children with sleep-disordered breathing. *The Laryngoscope*. 2017;127(2):513-519. DOI: 10.1002/lary.26042

[25] Tenconi R, Khirani S, Amaddeo A, Michot C, Baujat G, Couloigner V, et al. Sleep-disordered breathing and its management in children with achondroplasia. *American Journal of Medical Genetics. Part A*. 2017;173(4):868-878. DOI: 10.1002/ajmg.a.3813

[26] Nashed A, Al-Saleh S, Gibbons J, MacLusky I, MacFarlane J, Riekstins A, et al. Sleep-related breathing in children with mucopolysaccharidosis. *Journal of Inherited Metabolic Disease*. 2009;32(4):544-550. DOI: 10.1007/s10545-009-1170-4

[27] Andersen IG, Holm JC, Homøe P. Obstructive sleep apnea in children and adolescents with and without obesity. *European Archives of Oto-Rhino-Laryngology*.

2019;**276**(3):871-878. DOI: 10.1007/s00405-019-05290-2

[28] Martinelli EO, Haddad FLM, Stefanini R, Moreira GA, Rapoport PB, Gregório LC, et al. Clinicals and upper airway characteristics in obese children with obstructive sleep apnea. *Sleep Science*. 2017;**10**(1):1-6. DOI: 10.5935/1984-0063.20170001

[29] Toraldo DM, Di Michele L, Ralli M, Arigliani M, Passali GC, De Benedetto M, et al. Obstructive sleep apnea syndrome in the pediatric age: The role of the pneumologist. *European Review for Medical and Pharmacological Sciences*. 2019;**23**(1 Suppl):15-18. DOI: 10.26355/eurrev\_201903\_17342

[30] Unnikrishnan D, Jun J, Polotsky V. Inflammation in sleep apnea: An update. *Reviews in Endocrine & Metabolic Disorders*. 2015;**16**(1):25-34. DOI: 10.1007/s11154-014-9304-x

[31] Lavie L. Oxidative stress in obstructive sleep apnea and intermittent hypoxia—Revisited—The bad ugly and good: implications to the heart and brain. *Sleep Medicine Reviews*. 2015;**20**:27-45. DOI: 10.1016/j.smrv.2014.07.003

[32] Gul F, Muderris T, Yalciner G, Mise HI, Canan Y, Babademez MA, et al. A novel method for evaluation of oxidative stress in children with OSA. *International Journal of Pediatric Otorhinolaryngology*. 2016;**89**:76-80. DOI: 10.1016/j.ijporl.2016.07.035

[33] Donadio V, Liguori R, Vetrugno R, Contin M, Elam M, Wallin BG, et al. Daytime sympathetic hyperactivity in OSAS is related to excessive daytime sleepiness. *Journal of Sleep Research*. 2007;**16**(3):327-332

[34] Precenzano F, Ruberto M, Parisi L, Salerno M, Maltese A, D'Alessandro I,

et al. ADHD-Like symptoms in children affected by obstructive sleep apnea syndrome: A case-control study. *Acta Medica Mediterranea*. 2016;**32**:1755. DOI: 10.19193/0393-6384\_2016\_6\_159

[35] Wu J, Gu M, Chen S, Chen W, Ni K, Xu H, et al. Factors related to pediatric obstructive sleep apnea-hypopnea syndrome in children with attention deficit hyperactivity disorder in different age groups. *Medicine (Baltimore)*. 2017;**96**(42):e8281. DOI: 10.1097/MD.00000000000008281

[36] Luzzi V, Ierardo G, Di Carlo G, Saccucci M, Polimeni A. Obstructive sleep apnea syndrome in the pediatric age: The role of the dentist. *European Review for Medical and Pharmacological Sciences*. 2019;**23**(1 Suppl):9-14. DOI: 10.26355/eurrev\_201903\_17341

[37] Chang SJ, Chae KY. Obstructive sleep apnea syndrome in children: Epidemiology, pathophysiology, diagnosis and sequelae. *Korean Journal of Pediatrics*. 2010;**53**(10):863-871. DOI: 10.3345/kjp.2010.53.10.863

[38] Carotenuto M, Gimigliano F, Fiordelisi G, Ruberto M, Esposito M. Positional abnormalities during sleep in children affected by obstructive sleep apnea syndrome: The putative role of kinetic muscular chains. *Medical Hypotheses*. 2013;**81**(2):306-308. DOI: 10.1016/j.mehy.2013.04.023

[39] Constantin E, Low NC, Dugas E, Karp I, O'Loughlin J. Association between childhood sleep-disordered breathing and disruptive behavior disorders in childhood and adolescence. *Behavioral Sleep Medicine*. 2015;**13**(6):442-454. DOI: 10.1080/15402002.2014.940106

[40] Uema SF, Vidal MV, Fujita R, Moreira G, Pignatari SS. Behavioral evaluation in children with obstructive sleep disorders. *Brazilian*

Journal of Otorhinolaryngology. 2006;**72**(1):120-122

[41] Khassawneh BY, Alkhatib LL, Ibnian AM, Khader YS. The association of snoring and risk of obstructive sleep apnea with poor academic performance among university students. *Sleep & Breathing*. 2018;**22**(3):831-836. DOI: 10.1007/s11325-018-1665-z

[42] Ding H, Wang M, Hu K, Kang J, Tang S, Lu W, et al. Adenotonsillectomy can decrease enuresis and sympathetic nervous activity in children with obstructive sleep apnea syndrome. *Journal of Pediatric Urology*. 2017;**13**(1):41.e1-41.e8. DOI: 10.1016/j.jpuro.2016.10.009

[43] Arslan B, Gezmis CT, Çetin B, Gönültas S, Gökmen E, Gürkan O, et al. Is obstructive sleep apnea syndrome related to nocturia? Lower Urinary Tract Symptoms. 2019;**11**(3):139-142. DOI: 10.1111/luts.12250

[44] Perez C. Obstructive sleep apnea syndrome in children. *General Dentistry*. 2018;**66**(6):46-50

[45] Krzeski A, Burghard M. Obstructive sleep disordered breathing in children—An important problem in the light of current European guidelines. *Otolaryngologia Polska*. 2018;**72**(5):9-16. DOI: 10.5604/01.3001.0012.1570

[46] Villa MP, Brunetti L, Bruni O, Cirignotta F, Cozza P, Donzelli G, et al. Guidelines for the diagnosis of childhood obstructive sleep apnea syndrome. *Minerva Pediatrica*. 2004;**56**(3):239-253

[47] Yu Y, Chen YX, Liu L, Yu ZY, Luo X. Neuropsychological functioning after adenotonsillectomy in children with obstructive sleep apnea: A meta-analysis. *Journal of Huazhong University of Science and Technology. Medical Sciences*. 2017;**37**(3):453-461. DOI: 10.1007/s11596-017-1756-2

[48] Taylor HG, Bowen SR, Beebe DW, Hodges E, Amin R, Arens R, et al. Cognitive effects of adenotonsillectomy for obstructive sleep apnea. *Pediatrics*. 2016;**138**(2):pii: e20154458. DOI: 10.1542/peds.2015-4458

[49] Pietropaoli N, Supino MC, Vitelli O, Rabasco J, Evangelisti M, Forlani M, et al. Cognitive function in preschool children with sleep-disordered breathing. *Sleep & Breathing*. 2015;**19**(4):1431-1437. DOI: 10.1007/s11325-015-1157-3

[50] Gaines J, Vgontzas AN, Fernandez-Mendoza J, He F, Calhoun SL, Liao D, et al. Increased inflammation from childhood to adolescence predicts sleep apnea in boys: A preliminary study. *Brain, Behavior, and Immunity*. 2017;**64**:259-265. DOI: 10.1016/j.bbi.2017.04.011

[51] Ryan S. Adipose tissue inflammation by intermittent hypoxia: Mechanistic link between obstructive sleep apnoea and metabolic dysfunction. *The Journal of Physiology*. 2017;**595**(8):2423-2430. DOI: 10.1113/JP273312

[52] Kheirandish-Gozal L, Bhattacharjee R, Kim J, Clair HB, Gozal D. Endothelial progenitor cells and vascular dysfunction in children with obstructive sleep apnea. *American Journal of Respiratory and Critical Care Medicine*. 2010;**182**(1):92-97. DOI: 10.1164/rccm.200912-1845OC

[53] Kheirandish-Gozal L, Gozal D. Obstructive sleep apnea and inflammation: Proof of concept based on two illustrative cytokines. *International Journal of Molecular Sciences*. 2019;**20**(3):pii: E459. DOI: 10.3390/ijms20030459

[54] Sozer V, Kutnu M, Atahan E, Caliskaner Ozturk B, Hysi E, Cabuk C, et al. Changes in inflammatory mediators as a result of intermittent hypoxia in obstructive sleep apnea

syndrome. *The Clinical Respiratory Journal*. 2018;**12**(4):1615-1622. DOI: 10.1111/crj.12718

[55] Münzer T, Hegglin A, Stannek T, Schoch OD, Korte W, Büche D, et al. Effects of long-term continuous positive airway pressure on body composition and IGF1. *European Journal of Endocrinology*. 2010;**162**(4):695-704. DOI: 10.1530/EJE-09-0919

[56] Kanbay A, Demir NC, Tutar N, Köstek O, Özer Şimşek Z, Buyukoglan H, et al. The effect of CPAP therapy on insulin-like growth factor and cognitive functions in obstructive sleep apnea patients. *The Clinical Respiratory Journal*. 2017;**11**(4):506-513. DOI: 10.1111/crj.12365

[57] Operto FF, Precenzano F, Bitetti I, Lanzara V, Fontana ML, Pastorino GMG, et al. Emotional intelligence in children with severe sleep-related breathing disorders. *Behavioural Neurology*. 2019;**2019**:6530539. DOI: 10.1155/2019/6530539

[58] Uyrum E, Balbay O, Annakkaya AN, Gulec Balbay E, Silan F, Arbak P. The relationship between obstructive sleep apnea syndrome and apolipoprotein E genetic variants. *Respiration*. 2015;**89**(3):195-200. DOI: 10.1159/000369560

[59] Lal C, Strange C, Bachman D. Neurocognitive impairment in obstructive sleep apnea. *Chest*. 2012;**141**(6):1601-1610. DOI: 10.1378/chest.11-2214

[60] Dusak A, Ursavas A, Hakyemez B, Gokalp G, Taskapilioglu O, Parlak M. Correlation between hippocampal volume and excessive daytime sleepiness in obstructive sleep apnea syndrome. *European Review for Medical and Pharmacological Sciences*. 2013;**17**(9):1198-1204

[61] Koren D, Chirinos JA, Katz LE, Mohler ER, Gallagher PR, Mitchell GF, et al. Interrelationships between obesity, obstructive sleep apnea syndrome and cardiovascular risk in obese adolescents. *International Journal of Obesity*. 2015;**39**(7):1086-1093. DOI: 10.1038/ijo.2015.67

[62] Ievers-Landis CE, Redline S. Pediatric sleep apnea: Implications of the epidemic of childhood overweight. *American Journal of Respiratory and Critical Care Medicine*. 2007;**175**(5):436-441

[63] Lezak MD, Howieson DB, Bigler ED, Tranel D. *Neuropsychological Assessment*. 5th ed. Oxford University Press; 2012

[64] Chavez-Arana C, Catroppa C, Carranza-Escárcega E, Godfrey C, Yáñez-Téllez G, Prieto-Corona B, et al. A systematic review of interventions for hot and cold executive functions in children and adolescents with acquired brain injury. *Journal of Pediatric Psychology*. 2018;**43**(8):928-942. DOI: 10.1093/jpepsy/jsy013

[65] Igazság B, Demetrovics Z, Cserjési R. The developmental trajectory of executive functions and their stress sensitivity in adolescence. *Psychiatria Hungarica*. 2019;**34**(3):300-310

[66] Floden D, Stuss DT. Inhibitory control is slowed in patients with right superior medial frontal damage. *Journal of Cognitive Neuroscience*. 2006;**18**(11):1843-1849

[67] Wolfe KR, Madan-Swain A, Kana RK. Executive dysfunction in pediatric posterior fossa tumor survivors: A systematic literature review of neurocognitive deficits and interventions. *Developmental Neuropsychology*. 2012;**37**:153-175

[68] Stuss DT. Traumatic brain injury: Relation to executive dysfunction and



the frontal lobes. *Current Opinion in Neurology*. 2011;**24**:584-589

[69] Ko JH, Antonelli F, Monchi O, et al. Prefrontal dopaminergic receptor abnormalities and executive functions in Parkinson's disease. *Human Brain Mapping*. 2012

[70] Smits LL, Pijnenburg YA, Koedam EL, et al. Early onset Alzheimer's disease is associated with a distinct neuropsychological profile. *Journal of Alzheimer's Disease*. 2012;**1**(30):101-108

[71] Calviere L, Ssi Yan Kai G, Catalaa I, et al. Executive dysfunction in adults with moyamoya disease is associated with increased diffusion in frontal white matter. *Journal of Neurology, Neurosurgery, and Psychiatry*. 2012;**83**:591-593

[72] Schoemaker K, Bunte T, Wiebe SA, et al. Executive function deficits in preschool children with ADHD and DBD. *Journal of Child Psychology and Psychiatry*. 2012;**53**:111-119

[73] Salorio CF, White DA, Piccirillo J, et al. Learning, memory, and executive control in individuals with obstructive sleep apnea syndrome. *Journal of Clinical and Experimental Neuropsychology*. 2002;**24**(1):93-100

[74] Gozal D, Pope DW Jr. Snoring during early childhood and academic performance at ages thirteen to fourteen years. *Pediatrics*. 2001;**107**:1394-1399

[75] Blunden S, Lushington K, Kennedy D, et al. Behavior and neurocognitive performance in children aged 5-10 years who snore compared to controls. *Journal of Clinical and Experimental Neuropsychology*. 2000;**22**:554-568

[76] O'Brien LM, Mervis CB, Holbrook CR, et al. Neurobehavioral correlates of sleep-disordered breathing

in children. *Journal of Sleep Research*. 2004;**13**:165-172

[77] Bourke R, Anderson V, Yang JS, et al. Cognitive and academic functions are impaired in children with all severities of sleep-disordered breathing. *Sleep Medicine*. 2011;**12**:489-496

[78] Sarchielli P, Presciutti O, Alberti A, et al. A 1H magnetic resonance spectroscopy study in patients with obstructive sleep apnea. *European Journal of Neurology*. 2008;**15**:1058-1064

[79] Zhang X, Ma L, Li S, et al. A functional MRI evaluation of frontal dysfunction in patients with severe obstructive sleep apnea. *Sleep Medicine*. 2011;**12**:335-340

[80] Nagahama Y, Fukuyama H, Yamauchi H, et al. Age-related changes in cerebral blood flow activation during a Card Sorting Test. *Experimental Brain Research*. 1997;**114**:571-577

[81] Torelli F, Moscufo N, Garreffa G, et al. Cognitive profile and brain morphological changes in obstructive sleep apnea. *NeuroImage*. 2011;**54**:787-793

[82] Canessa N, Castronovo V, Cappa SF, et al. Obstructive sleep apnea: Brain structural changes and neurocognitive function before and after treatment. *American Journal of Respiratory and Critical Care Medicine*. 2011;**15**(183):1419-1426

[83] Osler W. *The Principles and Practice of Medicine*. New York: Appleton; 1906. p. 431

[84] Hill W. On some causes of backwardness and stupidity in children: And the relief of these symptoms in some instances by naso-pharyngeal scarifications. *British Medical Journal*. 1889;**2**(1500):711-712

- [85] Montgomery-Downs HE, Crabtree VM, Gozal D. Cognition, sleep and respiration in at-risk children treated for obstructive sleep apnoea. *The European Respiratory Journal*. 2005;**25**(2):336-342
- [86] Gozal D, Daniel JM, Dohanich GP. Behavioral and anatomical correlates of chronic episodic hypoxia during sleep in the rat. *The Journal of Neuroscience*. 2001;**21**:2442e50
- [87] Macey PM, Henderson LA, Macey KE, et al. Brain morphology associated with obstructive sleep apnea. *American Journal of Respiratory and Critical Care Medicine*. 2002;**166**:1382e7
- [88] Morrell MJ, McRobbie DW, Quest RA, et al. Changes in brain morphology associated with obstructive sleep apnea. *Sleep Medicine*. 2003;**4**:451e4
- [89] Yaouhi K, Bertran F, Clochon P, et al. A combined neuropsychological and brain imaging study of obstructive sleep apnea. *Journal of Sleep Research*. 2009;**18**:36e48
- [90] Yaouhi K, Bertran F, Clochon P, et al. A combined neuropsychological and brain imaging study of obstructive sleep apnea. *Journal of Sleep Research*. 2009;**18**:36-48
- [91] Carotenuto M, Esposito M, Cortese S, Laino D, Verrotti A. Children with developmental dyslexia showed greater sleep disturbances than controls, including problems initiating and maintaining sleep. *Acta Paediatrica*. 2016;**105**(9):1079-1082. DOI: 10.1111/apa.13472
- [92] Perillo L, Esposito M, Contiello M, Lucchese A, Santini AC, Carotenuto M. Occlusal traits in developmental dyslexia: A preliminary study. *Neuropsychiatric Disease and Treatment*. 2013;**9**:1231-1237. DOI: 10.2147/NDT.S49985
- [93] Carotenuto M, Roccella M, Pisani F, Matricardi S, Verrotti A, Farello G, et al. Polysomnographic findings in fragile X syndrome children with EEG abnormalities. *Behavioural Neurology*. 2019;**2019**:5202808. DOI: 10.1155/2019/5202808
- [94] Carotenuto M, Parisi P, Esposito M, Cortese S, Elia M. Sleep alterations in children with refractory epileptic encephalopathies: A polysomnographic study. *Epilepsy & Behavior*. 2014;**35**: 50-53. DOI: 10.1016/j.yebeh.2014.03.009
- [95] Miano S, Bachiller C, Gutiérrez M, Salcedo A, Villa MP, Peraita-Adrados R. Paroxysmal activity and seizures associated with sleep breathing disorder in children: A possible overlap between diurnal and nocturnal symptoms. *Seizure*. 2010;**19**(9):547-552. DOI: 10.1016/j.seizure.2010.07.015