During the past 25 years, development of Pediatric and Adolescent Sleep Medicine (PASM) has become an imperative child health care discipline. During the past decade, the American Academy of Sleep Medicine (AASM) prepared a modern path for certification in competency in the practice of Sleep Medicine by the American Board of Medical Specialties (ABMS) by applying for recognition of sleep medicine training programs by the Accreditation Council for Graduate Medical Education (ACGME) and pursuing ABMS approval of the certification process.¹

In addition, the American Board of Pediatrics (ABPeds) joined together with the American Board of Family Medicine (ABFM), American Board of Otolaryngology (ABOto), the American Board of Psychiatry and Neurology (ABPN), and the American Board of Internal Medicine (ABIM). ABIM was designated as the administrative board. Accreditation requirements were established for post-graduate fellowship training in sleep medicine in 2004. ABMS approved sleep medicine certification in 2005. The first certification examination in Sleep Medicine was administered in 2007. Medical content areas often overlapped (for example, obstructive sleep apnea, hypersomnolence, sleep-related movement disorders), but only 2% of the examination focused on considerations and disorders unique to childhood.² Nonetheless, a cross-disciplinary approach was utilized in development of the certification examination to ensure appropriate balance among disciplines represented, and a new, unmistakably recognizable subspecialty of sleep medicine was born.

Pediatric sleep medicine has been at the forefront of diagnosis, management, research and advocacy for infants, children, and adolescents. However, there is much work to be done. In a 2012 survey of specific pediatric sleep medicine services in the United States,³ fewer than 20% of children’s hospitals had sleep medicine centers accredited by the American Academy of Sleep Medicine; only 2% of all accredited centers were based in children’s hospitals. Six percent of accredited centers reported competency in evaluating children younger than 5 years of age, and only 4% reported competency in evaluating and managing sleep disorders in children younger than 3 years of age.

These statistics are remarkable in that the primary care pediatrician will be called upon as a resource for identification, management, and referral of the majority of children who present to the office with disordered sleep. Therefore, this issue of Pediatric Annals is timely.

Controversy exists in when a polysomnogram (comprehensive sleep study) is needed prior to referral for adenotonsillectomy. In 2011, the American Academy of Otolaryngology and Head and Neck Surgery published clinical practice guidelines. Review of these guidelines is clearly presented in this issue. In 2002, the American Academy of Pediatrics first published clinical practice guidelines for the diagnosis and management of obstructive sleep apnea in the child. This
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was updated in 2012 and is reviewed in this issue. Prader-Willi Syndrome, when associated with pediatric obstructive sleep apnea and growth hormone initiation, has been reported to be associated with sudden unexpected death at night, which has led to delays in or avoidance of management for this disorder. There has been intense focus on sleep-disordered breathing, obesity and the development of metabolic syndrome, a perplexing problem for both pediatricians and the medical community at large. Also reviewed in this issue are unusual disorders of arousal from sleep that often present to the child health care practitioner as “nightmares” or unusual behaviors during sleep.

Everyone requires sleep to maintain good physical and emotional health, and it is essential that all child health care practitioners recognize sleep-related disorders. There is treatment available. Intervention in the management of sleep-related disorders in children may be more important than we have ever dreamed.

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REFERENCES


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About the Guest Editor