

RECOMMENDATIONS FOR EVALUATION OF BREATHING ABNORMALITIES ASSOCIATED WITH SLEEP IN PRADER-WILLI SYNDROME

PWSA (USA) Clinical Advisory Board Consensus Statement - 12/2003

Problems with sleep and sleep disordered breathing have been long known to affect individuals with Prader-Willi syndrome (PWS). The problems have been frequently diagnosed as sleep apnea (obstructive [OSA], central or mixed) or hypoventilation with hypoxia. Disturbances in sleep architecture (delayed sleep onset, frequent arousals and increased time of wakefulness after sleep onset) are also frequently common. Although prior studies have shown that many patients with PWS have relatively mild abnormalities in ventilation during sleep, it has been known for some time that certain individuals may experience severe obstructive events that may be unpredictable.

Factors that seem to increase the risk of sleep disordered breathing include young age, severe hypotonia, narrow airway, morbid obesity and prior respiratory problems requiring intervention such as respiratory failure, reactive airway disease and hypoventilation with hypoxia. Due to a few recent fatalities reported in individuals with PWS who were on growth hormone therapy (GH) some physicians have also added this as an additional risk factor. One possibility (that is currently unproven) is that GH could increase the growth of lymphoid tissue in the airway thus worsening already existing hypoventilation or OSA. Nonetheless, it must be emphasized that there are currently no definitive data demonstrating GH causes or worsens sleep disordered breathing. However, to address this new concern, as well as the historically well documented increased risk of sleep-related breathing abnormalities in PWS, the Clinical Advisory Board of the PWSA (USA) makes the following recommendations:

1. A sleep study or a polysomnogram that includes measurement of oxygen saturation and carbon dioxide for evaluation of hypoventilation, upper airway obstruction, obstructive sleep apnea and central apnea should be contemplated for all individuals with Prader-Willi syndrome. These studies should include sleep staging and be evaluated by experts with sufficient expertise for the age of the patient being studied.
2. Risk factors that should be considered to expedite the scheduling of a sleep study should include:
 - Severe obesity - weight over 200% of ideal body weight (IBW).
 - History of chronic respiratory infections or reactive airway disease (asthma).
 - History of snoring, sleep apnea or frequent awakenings from sleep.
 - History of excessive daytime sleepiness, especially if this is getting worse.
 - Before major surgery including tonsillectomy and adenoidectomy.
 - Prior to sedation for procedures, imaging scans and dental work.
 - Prior to starting growth hormone or if currently receiving growth hormone therapy.

Additional sleep studies should be considered if patients have the onset of one of these risk factors, especially a sudden increase in weight or change in exercise tolerance. If a patient is being treated with growth hormone, it is not necessary to stop the growth hormone before obtaining a sleep study unless there has been a new onset of significant respiratory problems.

Any abnormalities in sleep studies should be discussed with the ordering physician and a pulmonary specialist knowledgeable about treating sleep disturbances to ensure that a detailed plan for treatment and management is made.

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Referral to a pediatric or adult pulmonologist with experience in treating sleep apnea is strongly encouraged for management of the respiratory care.

In addition to a calorically restricted diet to ensure weight loss or maintenance of an appropriate weight, a management plan may include modalities such as:

- Supplemental oxygen
- Continuous positive airway pressure (CPAP) or BiPAP
- Oxygen should be used with care as some individuals may have hypoxemia as their only ventilatory drive and oxygen therapy may actually worsen their breathing at night.
- Behavior training is sometimes needed to gain acceptance of CPAP or BiPAP.
- Medications to treat behavior may be required to ensure adherence to the treatment plan.

If sleep studies are abnormal in the morbidly obese child or adult (IBW > 200%) the primary problem of weight should be addressed with an intensive intervention – specifically, an increase in exercise and dietary restriction. Both are far preferable to surgical interventions of all kinds. Techniques for achieving this are available from clinics and centers that provide care for PWS and from the national parent support organization (PWSA-USA). Behavioral problems interfering with diet and exercise may need to be addressed simultaneously by persons experienced with PWS.

If airway related surgery is considered, the treating surgeon and anesthesiologist should be knowledgeable about the unique pre- and postoperative problems found in individuals affected by Prader-Willi syndrome (see “Medical News” article regarding “Anesthesia and PWS” written by Drs. Loker and Rosenfeld in the *Gathered View*, vol. 26, Nov. – Dec., 2001 or visit www.pwsausa.org). Tracheostomy surgery and management presents unique problems for people with PWS and should be avoided in all but the most extreme cases. Tracheostomy is typically not warranted in the compromised, morbidly obese individual because the fundamental defect is virtually always hypoventilation, not obstruction. Self endangerment and injury to the site are common in individuals with PWS who have tracheostomies placed.

At this time there is no direct evidence of a causative link between growth hormone and the respiratory problems seen in PWS. Growth hormone has been shown to have many beneficial effects in most individuals with PWS including improvement in the respiratory system. Decisions in the management of abnormal sleep studies should include a risk/benefit ratio of growth hormone therapy. It may be reassuring for the family and the treating physician to obtain a sleep study prior to the initiation of growth hormone therapy and after 6-8 weeks of therapy to assess the difference that growth hormone therapy may make. A follow-up study after one year of treatment with growth hormone may also be indicated.

Members of the Clinical Advisory Board are available for consultation with physicians and families through the Prader-Willi Syndrome Association (USA).