Parasomnia in children and adolescents

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Parasomnias are defined as unpleasant or undesirable behavioral or experiential phenomena that occur predominately or exclusively during the sleep period.The international classification of sleep disoirS stated that ” The parasomnia consist of clinical disorders that are not abnormalitieS of the processes responsible for sleep and awake states per se but, rather, are undesirable physical phenomena that occur predominantly during sleep .”Parasomnias in children include most commonly: sleepwalking(sonmainbulisin), night terrors, sleep talking (soninilociuy), enuresis, sleep bruxism, and body rocking.The parasomnias are divided into two major categories: primary — those disorders that are the manifestations of the sleep state per se and secondary disorder that are symptoms originating in other organ systems and occur in or are precipitated by the sleeping state.Parasomnias are common disturbances of sleep that may significantly affect the patient’s quality of life and that of the bed partner. Most parasomnias can be diagnosed with careful history taking and polysomnography, and management is usually safe and effective.The category of common sleep disorders known as parasomnias includes disorders of arousal, rapid eye movement (REM) sleep behavior disorder (RBD), nocturnal seizures, rhythmic movement disorder, and tooth grinding or ’bruxism’. Parasomnias are all characterized as undesirable physical or behavioral phenomena occurring during the sleep period. Although these conditions can be distressing and, in some cases, hazardous to the sleeper and his or her bed partner, it is important to recognise that parasomnias are diagnosable and treatable in the vast majority of patients. Evaluation begins with a careful clinical interview with the sleeper and a family member to elucidate the frequency, duration, description and timing after sleep onset of these behavioral events. Disorders of arousal are the most common type of parasomnia and cover a spectrum from calm sleepwalking to emotionally agitated or complex behaviors, such as dressing or driving, for which the patient usually has no memory upon awaking. ’Sleep terrors’ are quite common in young children and are often outgrown. Disorders of arousal represent a partial, as opposed to a full, awakening from deep non-REM sleep, typically occurring within the first 60 to 90 minutes after sleep onset. RBD is characterized clinically by a history of dream-enacting behaviour, and the patient may recall dream content. REM sleep periods typically occur infthe latter half of the night. Physiologically, RBD results from a lack of the normal muscle atonia that is associated with REM sleep. RBD has been linked to a number of other neurological conditions; thus, a careful review of systems and a physical examination are crucial. A formal laboratory sleep study or polysomnogram with an expanded electroencephalographic montage can

help distinguish among non-REM and REM parasomnias and nocturnal seizures. The latter may manifest clinically as arousals from sleep associated with vocalisation and/or complex behaviours. Rhythmic movement disorder can include head banging or body rocking at sleep onset or during the night. Tooth grinding is a common sleep-related behaviour that, when severe, can result in dental injury. Hypnagogic hallucinations (experience of dream imagery at sleep onset) and sleep-onset paralysis (experience of muscle/body paralysis as one is falling asleep) are symptoms rather than diagnOstic categories. These phenomena classically Occur in many individuals with narcolepsy.