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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Pediatric Narcolepsy: Physical Comorbidities

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Maski:
This is CME on ReachMD, and I'm Kiran Maski. We will discuss the psychological and social components of pediatric narcolepsy

Precocious puberty can occur in children, and we're not exactly sure why, but maybe there's some local endocrine, changes that occur within the hypothalamus, but that occurs in roughly 16 to 40% of children, maybe because of obesity. Obstructive sleep apnea is quite common in children with narcolepsy and has been reported in a range of nine to 25%. And certainly this is a red flag because this could potentially lead to a misdiagnosis. If the obstructive sleep apnea is noted and people aren't aware of that, this can be a comorbid condition.

And generally, for me, I look for the severity of sleepiness to differentiate that. Generally mild sleep apnea does not cause severe daytime sleepiness. So if it's just mild sleep apnea we're finding, and the child is very sleepy and certainly has cataplexy, we'll pursue further testing. Hypertension has been reported in 41%of adults with untreated, narcolepsy symptoms, and that number goes up if they are treated 58% on stimulants and medications such as venlafaxine used to control cataplexy. And then there's a host of other, comorbidities including GI symptoms, dysmotility, constipation, headache, including migraines and other endocrinopathies including thyroid disease.

There's a pediatric daytime severity scale, and then we have developed a pediatric hypersomnolence survey, which will be linked to this, content for further evaluation of both narcolepsy and idiopathic hypersomnia in the pediatric population. Once we are able to identify that we're talking about sleepiness and not say fatigue or just tiredness, then we wanna rule out other causes of daytime sleepiness with sleep logs, sleep diary, actigraphy. Any validated wake sleep devices is useful for this purpose, essentially to ensure that we're ruling out insufficient sleep or other circadian rhythm problems. we have sort of feedback with patients, if they are problems, can they correct their sleep problems return, and can we reassess the severity of sleepiness if they're still sleepy. Then we'll move on to diagnostic tests, which include the polysomnogram and multiple sleep latency tests, which are sleep studies that are looking for objective daytime sleepiness, as well as inappropriate REM periods, to be occurring.

We also look for other features such as disrupted nighttime sleep, and for cataplexy, if a polysomnogram and MSLT is not useful, then we will essentially consider doing a lumbar puncture to directly test for CSF orexin.

Well, this was brief, but I'm glad we had the opportunity to talk about the physical components and comorbidities of narcolepsy. Thank you for listening.

Announcer:
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