INTRODUCTION

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The great increase in sleep research during the 1950s and 1960s has resulted in recognition of normal sleep patterns, i.e rapid eye movement (REM) and non-rapid eye movement (non- REM) sleep with their characteristic EEG patterns. ***(Bailey and Croft, 1997).***

Sleep – disordered respiration is present when there are recurrent episodes of cessation of respiration (apnea) or decrements in airflow (hypopneas) during sleep.

Apnea is cessation of airflow for 10 seconds. An apnea can be obstructive (no airflow but continued respiratory effort), central (airflow and respiratory effort are both absent), or mixed ***(Richard J. et al., 1999).***

The sleep apnea syndrome (SAS) : 30 or more apneaic episodes during a 7-hour period of sleep or an apnea index of 10 ***(Fletcher et al., 1985)*** or an apnea + hypopnea index of 15 ***(Gould et al., 1988)*** should be present before diagnosing the sleep apnea syndrome.

The pathophysiology of snoring and obstructive sleep apnea is determined by a number of interrelated factors. One of which is obstruction at the level of soft palate. ***(Guilleminault C. et al., 1992).***

The most common cause of obstructive sleep apnea in children is undoubtedly non – inflammatory enlargement of the adenoids and / or tonsils. ***(Bailey and Croft, 1997).***

Management includes medical and surgical procedures, surgical procedures in obstructive sleep apnea syndrome depending on the site and level of obstruction ***(Bailey and Croft, 1997).***