Executive dysfunction in children affected by obstructive sleep apnea syndrome: an observational study

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Introduction: The role of sleep in cognitive processes can be considered clear and well established. Different reports have disclosed the association between sleep and cognition in adults and in children, as well as the impact of disturbed sleep on various aspects of neuropsychological functioning and behavior in children and adolescents. Behavioral and cognitive dysfunctions can also be considered as related to alterations in the executive functions (EF) system. In particular, the EF concept refers to self-regulatory cognitive processes that are associated with monitoring and controlling both thought and goal directed behaviors. The aim of the present study is to assess the impact of the obstructive sleep apnea syndrome (OSAS) on EF in a large sample of school aged children.

Materials and methods: The study population comprised 79 children (51 males and 28 females) aged 7–12 years (mean 9.14 ± 2.36 years) with OSAS and 92 healthy children (63 males and 29 females, mean age 9.08 ± 2.44 years). To identify the severity of OSAS, an overnight respiratory evaluation was performed. All subjects filled out the Italian version of the Modified Card Sorting Test to screen EFs. Moreover, to check the degree of subjective perceived daytime sleepiness, all subjects were administered the Pediatric Daytime Sleepiness Scale (PDSS).

Results: No significant differences between the two study groups were found for age (P = 0.871), gender (P = 0.704), z-score of body mass index (P = 0.656), total intelligence quotient (P = 0.358), and PDSS scores (P = 0.232). The OSAS children showed a significantly higher rate of total errors (P < 0.001), perseverative errors (P < 0.001), nonperseverative errors (P < 0.001), percentage of total errors (P < 0.001), percentage of perseverative errors (P < 0.001), and percentage of nonperseverative errors (P < 0.001). On the other hand, OSAS children showed a significant reduction in the number of completed categories (P = 0.036), total correct sorts (P = 0.001), and categorizing efficiency (P < 0.001). The Pearson’s correlation analysis revealed a significant positive relationship between all error parameters and apnea-hypopnea index, oxygen desaturation index, and percentage of mean desaturation of O₂ with a specular negative relationship between the error parameters and the mean oxygen saturation values, such as a significant negative relationship between apnea-hypopnea index, oxygen desaturation index, percent of mean desaturation of O₂, and the number of completed categories.

Conclusion: Our study identified differences in the executive functioning of children affected by OSAS and is the first to identify a correlation between alteration in respiratory nocturnal parameters and EF that has not yet been reported in developmental age. These findings can be considered as the strength and novelty of the present report in a large pediatric population.

Keywords: OSAS, polysomnography, executive functions, sleep, sleepiness, children

Introduction
The role of sleep in cognitive processes can be considered as clear and well established. In general, a good sleep may be considered as a strong predictor of

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Materials and methods
Participants
The study population comprised 79 children (51 males and 28 females) aged 7–12 years (mean 9.14 ± 2.36 years) with OSAS recruited to the Sleep Center for Developmental Age of Child and Adolescent Neuropsychiatry Department of Second University of Naples. Exclusion criteria were psychiatric illness (ie, schizophrenia, psychosis, attention deficit hyperactivity disorder, depressive symptoms), mental retardation (IQ < 75), neurological disorder (epilepsy, neuromuscular disorders, cerebral palsy), overweight (body mass index (BMI) ≥ 85th percentile) or obesity (BMI ≥ 95th percentile), and referral for sleep complaints other than OSAS. The control group consisted of 92 healthy children (63 males and 29 females, mean age 9.08 ± 2.44 years) enrolled in schools within the Campania region.

The subjects in both groups were recruited from the same urban area; participants were all Caucasian, and held a middle class socioeconomic status (between class 2 or class 3 corresponding to 28,000–55,000 Euros/year to 55,000–75,000 Euros/year, respectively, according to the current Italian economic legislation parameters) as previously reported. All evaluations were performed after informed parental consent was obtained for all the children enrolled, according to the World Medical Association criteria. The study was approved by the Departmental Ethics Committee at the Second University of Naples.

Cognitive assessment
Intellectual functioning was assessed by the Italian version of the Wechsler Intelligence Scale for Children (WISC)-III edition which is applicable for children ranging in age from 6 to 16 years. The WISC-III is composed of 13 distinct subtests divided into two scales, a verbal scale and a performance scale. The six verbal scale tests use language based items, whereas the seven performance scales use visual motor items that are less dependent on language. Five of the subtests in each scale produce scale-specific intelligence quotients (IQs) such as verbal IQ and performance IQ, and the ten subtest scores produce a total scale IQ (Total IQ), ranging from 85 to 115 in normal subjects.

Executive functions evaluation
To assess the EF in the entire sample group, the Italian version of the Modified Card Sorting Test (MCST) was administered according to the validation criteria for developmental age. Therefore, the aim of the present study is to assess the impact of OSAS on EF in a large sample of school aged children.
maintenance and has been found to be efficacious for use with young children.\textsuperscript{35} After each MCST administration, we calculated all subscores that were identified across MCST literature. We first determined if a participant’s errors were perseverative or nonperseverative. As recommended by Nelson,\textsuperscript{36} we classified perseverative errors when participants persisted to sort according to previous criteria after receiving feedback that a sort was incorrect. All other errors were classified as non-perseverative.

Once errors were classified, we calculated the following scores for each participant: the number of completed categories (CAT), total errors (TE), perseverative errors (PE), nonperseverative errors (NPE), total correct sorts (CS), the percentage of total errors that were perseverative (%PE), the percentage of total errors that were nonperseverative (%NPE), and failures to maintain set (FMS), which were defined as instances when participants make at least three consecutive correct responses (ie, 50\%) needed to complete a category but make an error before successful completion. According to the criteria for developmental age, supplementary scores were derived,\textsuperscript{35} such as the percentage of TE (%TE) and the categorizing efficiency (CE), by taking into account the number of cards used by the subject to complete a maximum of six categories. This score ranges from 0 to 48. For each item, the age related T scores were considered for the analyses.

In summary, according to the MCST scoring criteria, higher scores demonstrate better performances for the following parameters: CAT, CS, CE; lower scores show better performances for the following parameters: TE, %TE, PE, %PE, NPE, %NPE, and failures to maintain set.

**Pediatric daytime sleepiness evaluation**

As reported in a study,\textsuperscript{37} to check the degree of subjective perceived daytime sleepiness, all subjects were administered the Pediatric Daytime Sleepiness Scale (PDSS).\textsuperscript{38} The PDSS is an eight item, self-reported Likert-type questionnaire that measures daytime sleepiness in school age populations, with possible scores ranging from 0 to 32. Higher PDSS scores indicate greater daytime sleepiness. Along with being easy to administer, score, and interpret, the PDSS has a high internal consistency (\(\alpha\)) of at least 0.80 in split-half samples and acceptable factor loadings (0.4).\textsuperscript{38}

**Sleep evaluation**

In all children (with or without OSAS) a cardiorespiratory device (Embletta X10; Embletta PDS, MedCare Flaga, Iceland) was used to perform an overnight respiratory evaluation.\textsuperscript{39,40} The Embletta device is used to specifically detect the presence of OSAS and to assess its severity, is suitable for use both in a sleep laboratory and at home,\textsuperscript{41} has been validated against full polysomnography for the evaluation of nocturnal breathing disorders,\textsuperscript{42} and is largely used in the pediatric age group.\textsuperscript{39,40} All evaluations were performed overnight in the sleep laboratory at the Sleep Center for Developmental Age of Child and Adolescent Neuropsychiatry at the Second University of Naples. All recordings started at the subjects’ usual bedtime and continued until spontaneous morning awakening.

The parameters measured were: nasal airflow using two appropriately placed thermistors (one thermistor for oral breath and the other for nasal breath), thoracoabdominal movements via two piezoelectric bands, pulse oximetry using a finger probe, snoring episodes detected via a vibration sensor placed anterior to the sternocleidomastoid muscle, and continuous actigraphy to monitor and record body position. Recordings were analyzed manually using the device-specific software (Somnologica for Embletta 3.3; Embla, Broomfield, CO, USA). Sleep onset was estimated as the beginning of the first 10-minute period not containing any changes in body position and morning awakening was estimated as the end of the last such 10-minute period.\textsuperscript{43} Estimated sleep time was calculated as the time between sleep onset and morning awakening. Recordings were analyzed for artefactual or uninterpretable periods of nasal flow, thoracic effort, abdominal effort, or oximetry. Movement periods and artefactual or uninterpretable periods were excluded from the estimated sleep time if they lasted for more than 5 minutes, and the corrected estimated sleep time was calculated.\textsuperscript{43} A minimum of 5 hours of corrected estimated sleep time was required.

All the recordings were visually scored by one of the investigators (MC) according to pediatric criteria.\textsuperscript{44-47} Specifically, obstructive apnea was defined as cessation of airflow, lasting for at least two breaths, in the presence of paradoxical ribcage and abdominal movements. The hypopnea index was defined as a reduction in the nasal flow curve signal by more than 50\% that was accompanied by either oxygen desaturation or arousal. Central apnea was defined as the absence of airflow at both the nose and mouth with absent inspiratory effort throughout the duration of the event, lasting 20 seconds or longer, or two missed breaths accompanied by at least 3\% oxygen desaturation, an arousal, or an awakening. The apnea-hypopnea index (AHI) was defined as the number of obstructive apneas and hypopneas per hour of sleep,\textsuperscript{44,45,46} and the lowest oxygen saturation value and number of desaturation events by 4\% and to 90\%
were counted. The oxygen desaturation index (ODI), defined as events per hour, was also calculated. An AHI and ODI ≤1 per hour were considered as normal according to American Thoracic Society criteria.44,45

Statistical analysis
Comparisons between age, gender, z-score of BMI (z-BMI), intellectual abilities, MCST, PDSS, and respiratory parameters obtained in OSAS children and typical developing individuals were carried out by the $t$-test. To verify the matching sex ratio (M/F), the Chi-squared test was performed. $P < 0.05$ was considered statistically significant. The Pearson’s correlation test was computed to analyze the relationship among MCST scores with respiratory indices (AHI and ODI). The commercially available data analysis software STATISTICA version 6 (StatSoft, Inc, Tulsa, OK, USA) was used for all statistical tests.

Results
No significant differences between the two study groups were found for age ($P = 0.871$), gender ($P = 0.704$), z-BMI ($P = 0.656$), Total IQ ($P = 0.358$), and PDSS scores ($P = 0.232$) (Table 1). Table 2 shows the differences in nocturnal respiratory parameters and MCST scores between the two groups. The OSAS children showed a significantly higher quota of TE ($P < 0.001$), PE ($P < 0.001$), NPE ($P < 0.001$), %TE ($P < 0.001$), %PE ($P < 0.001$), and %NPE ($P < 0.001$). On the other hand, OSAS children showed a significant reduction in the number of CAT ($P = 0.036$), total CS ($P = 0.001$), and CE ($P < 0.001$) (Table 2). Moreover, the Pearson’s correlation analysis revealed a significant positive relationship between all error parameters and AHI, ODI, and percentage of mean desaturation of $O_2$, with a specular negative relationship between the error parameters and the mean oxygen saturation values, such as a significant negative relationship between AHI, ODI, percentage of mean desaturation of $O_2$, and the number of CAT (Table 3).

Discussion
The main findings of our study can be summarized in that children affected by OSAS presented a lower executive functioning, as showed by the MCST evaluation, with a significant correlation with the severity of nocturnal respiratory impairment. In general, the most common documented cause of sleep related breathing disorders in children can be considered as upper airway obstruction, with prevalence for OSAS of about 1%–3%, and a peak prevalence between 2 and 8 years of age.49 The symptoms of OSAS include abnormal position during sleep,50–52 mood disorders,49,53–56 reduced quality of life, and cognitive problems57 at all ages. Moreover, considering the increasing prevalence of OSAS and neuropsychological and cardiovascular consequences, an objective evaluation with nocturnal monitoring for children with suspected OSAS has been recommended.58,59

Cognitive impairment in subjects affected by OSAS has been studied since the 1980s,60 and the most common cognitive deficits reported in most adults were in attention or concentration, vigilance, memory and learning abilities, motor

Table 2 Comparison of nocturnal respiratory indexes and MCST scores between the children affected by Obstructive Sleep Apnea Syndrome (OSAS) and typical developing children (Control)

<table>
<thead>
<tr>
<th></th>
<th>OSAS (N = 79)</th>
<th>Control (N = 92)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHI</td>
<td>9.91 ± 3.216</td>
<td>0.48 ± 3.02</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ODI</td>
<td>5.04 ± 1.762</td>
<td>0.48 ± 3.72</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mean SpO$_2$ (%)</td>
<td>94.06 ± 1.243</td>
<td>98.73 ± 0.69</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mean SpO$_2$ desaturation (%)</td>
<td>5.918 ± 1.087</td>
<td>0.948 ± 0.651</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CAT</td>
<td>53.94 ± 9.349</td>
<td>56.38 ± 5.16</td>
<td>0.036</td>
</tr>
<tr>
<td>CS</td>
<td>48.82 ± 8.718</td>
<td>52.97 ± 8.04</td>
<td>0.001</td>
</tr>
<tr>
<td>CE</td>
<td>46.16 ± 8.036</td>
<td>50.90 ± 5.73</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>TE</td>
<td>42.06 ± 8.162</td>
<td>36.08 ± 2.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% TE</td>
<td>43.32 ± 8.912</td>
<td>34.91 ± 4.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PE</td>
<td>47.43 ± 13.208</td>
<td>36.02 ± 2.73</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% PE</td>
<td>47.91 ± 13.895</td>
<td>38.76 ± 5.41</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>NPE</td>
<td>41.09 ± 7.086</td>
<td>37.48 ± 3.24</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>% NPE</td>
<td>31.18 ± 13.053</td>
<td>23.04 ± 4.73</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>FMS</td>
<td>47.07 ± 13.992</td>
<td>45.19 ± 3.71</td>
<td>0.216</td>
</tr>
</tbody>
</table>

Note: $t$-Test was applied and $P$ values ≤0.05 were considered statistically significant. AHI/hypopnea index-AHI; Oxygen desaturation index-OID; percentage of SpO$_2$ mean saturation-Mean SpO$_2$ [%]; percentage of SpO$_2$ mean desaturation-Mean SpO$_2$ desaturation [%]; number of completed categories-CAT; total correct sorts-CS; categorizing efficiency-CE; total errors-TE; percentage of total errors-TE; perseverative errors-PE; percentage of total errors that were perseverative-%PE; non-perseverative errors-NPE; percentage of total errors that were non-perseverative-%NPE; failures to maintain set-FMS.
Table 3 Correlation between nocturnal respiratory indexes and MCST scores in our study sample

<table>
<thead>
<tr>
<th>AHI</th>
<th>ODI</th>
<th>Mean (\text{SpO}_2) (%)</th>
<th>Mean (\text{SpO}_2) desaturation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT</td>
<td>-0.3528</td>
<td>-0.1850</td>
<td>0.2122</td>
</tr>
<tr>
<td>CS</td>
<td>0.0753</td>
<td>0.0339</td>
<td>-0.0193</td>
</tr>
<tr>
<td>CE</td>
<td>0.0325</td>
<td>0.1230</td>
<td>-0.0620</td>
</tr>
<tr>
<td>TE</td>
<td>0.4745</td>
<td>0.1374</td>
<td>-0.2602</td>
</tr>
<tr>
<td>% TE</td>
<td>0.5167</td>
<td>0.2517</td>
<td>-0.2485</td>
</tr>
<tr>
<td>PE</td>
<td>0.4183</td>
<td>0.2100</td>
<td>-0.3603</td>
</tr>
<tr>
<td>% PE</td>
<td>0.3787</td>
<td>0.1880</td>
<td>-0.3123</td>
</tr>
<tr>
<td>NPE</td>
<td>0.3529</td>
<td>0.1910</td>
<td>-0.0176</td>
</tr>
<tr>
<td>% NPE</td>
<td>0.4199</td>
<td>0.2198</td>
<td>-0.1636</td>
</tr>
<tr>
<td>FMS</td>
<td>0.2086</td>
<td>0.0353</td>
<td>-0.1620</td>
</tr>
</tbody>
</table>

Notes: Pearson’s correlation test was computed. \(P\) values \(< 0.05\) are reported in bold characters. Apnea/hypopnea index-AHI; Oxygen desaturation index-ODI; percentage of \(\text{SpO}_2\) mean saturation-Mean \(\text{SpO}_2\); percentage of \(\text{SpO}_2\) mean desaturation-Mean \(\text{SpO}_2\) desaturation [%]; number of completed categories-CAT; total correct sorts-CS; categorizing efficiency-CE; total errors-TE; perseverative errors-PE; percentage of total errors that were perseverative-%PE; non-perseverative errors-NPE; percentage of total errors that were non-perseverative-%NPE; failures to maintain set-FMS.

performance, constructional abilities, and EF. Both excessive daytime sleepiness and nocturnal hypoxemia seem to equally contribute to cognitive deficits.\(^{60-62}\) Moreover, excessive daytime sleepiness has been mostly related to impairment in attention, vigilance, and memory function, while hypoxemia tends to correlate with deficits in EF.\(^{57,61}\) In this light, our findings are suggestive for a causative role of nocturnal hypoxemia in executive impairment, considering that the levels of subjective perceived daytime sleepiness are comparable with the normal control subjects (\(P = 0.232\)). Only about 7% of children affected by OSAS present with symptoms that are compatible with excessive daytime sleepiness.\(^{63}\)

Alternatively, several studies have reported a nonlinear worsening in cognitive impairment related to the severity of OSAS,\(^{64,65}\) different from our report of the positive and significant relationships between executive functioning and nocturnal respiratory parameters (AHI, ODI, and mean oxygen desaturation levels) and a negative correlation with the mean oxygen saturation level (Table 3).

With respect to the other few studies in a pediatric population, our results can be considered quite different. In fact, Archbold et al in 2004\(^{25}\) and Kohler et al in 2009\(^{29}\) both reported the effect of adenotonsillectomy on executive functioning, with no significant correlation with nocturnal respiratory parameters. On the other hand, Beebe et al failed to indicate any clear relationship between neuropsychological functioning and objective indices of hypoxia or sleep disruption in a small sample of children,\(^{26}\) similar to a report by O’Brien et al.\(^{27}\) This report cannot be considered as properly focused on executive functioning evaluation in children affected by sleep related breathing disorders (SRBD) because the authors considered the effect of the sleep pressure score linked and due to the SRBD on behavior and on generic neuropsychological functioning. Finally, according to Calhoun et al in 2009\(^{28}\) no clear relationship between neuropsychological functioning and objective indices of hypoxia or sleep disruption was identified.

Furthermore, as reported in a study, the MCST evaluation results may be considered to be related to changes in blood flow levels, particularly in the frontal cortex and in the hippocampus regions.\(^{66}\) In this perspective, our results suggest a putative relationship between the executive efficiency of the frontal lobes and the severity of night breathing alterations as shown by the correlation between high AHI and ODI values and the increase in MCST error rates (PE and NPE). On the other hand, gray matter reduction level in the frontal-parietal and in the hippocampus regions\(^{67,68}\) may explain the perseveration tendency in our OSAS children that is related to their respiratory nocturnal abnormalities.

Alternatively, our results also support the hypothesis that the deficit in executive functioning may be related primarily to the severity of nocturnal hypoxemia rather than daytime sleepiness\(^{69,70}\) in children, although further studies are needed. Moreover, the neurocognitive deficits in domains such as manual skills, planning abilities, and in particular, executive functioning, do not seem to improve after continuous positive airway pressure (CPAP) treatment\(^{71,72}\) in adults, suggesting that OSAS related hypoxemia resulted in permanent brain injury leading to enduring cognitive deficits. In fact, studies\(^{71,72}\) evaluating cognitive functioning in OSAS patients seem to suggest that CPAP improves only some cognitive functions, with long-term cognitive deficits most pronounced for executive functioning. On the other hand, in adult patients with untreated OSAS, the impact on verbal and intellectual functioning was minimal, irrespective of vigilance and executive functioning impairment.\(^{73}\) In this light, our finding would suggest the importance of EF assessment in children affected by OSAS, and the need for an early rehabilitation and ventilatory therapy to avoid establishment of permanent executive functioning damage.

In conclusion, the following limitations of this study need to be taken into account: (1) subjects were recruited from a specific region in southern Italy (and cannot be considered as derived by the whole Italian pediatric population), (2) our data was derived from a nocturnal cardiorespiratory evaluation and not from full polysomnography (with a lack of correlation with the sleep stages percentages), (3) assessment of the excessive daytime sleepiness was not performed using objective methods such as...
the Multiple Latency Sleep Test, (4) this can be considered as an observational resting study on a small sample of children affected by OSAS, (5) follow-up data was not available, and (6) neuroimaging evaluations were not performed.

However, our study does identify differences in executive functioning in children affected by OSAS and is the first to identify a correlation between alteration in respiratory nocturnal parameters and EF not yet reported in the developmental age group, and these findings can be considered as the strength and novelty of the present report in a large pediatric population.

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Disclosure

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