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Delayed Sleep Phase Syndrome: A common sleep disorder in adolescents, with important quality of life repercussions

Síndrome de fase de sueño retrasada: un trastorno del sueño frecuente en adolescentes, con importante repercusión en su calidad de vida

Dear Editor:

We have read the article about how sleeping difficulties can be a predictor of worse health-related quality of life.[1] Sleep disorders and delayed sleep phase syndrome (DSPS), are frequently overlooked in adolescents presenting with poor school performance or mood disorders. Primary care doctors should routinely screen for DSPS in adolescents by specifically inquiring about difficulties awakening, late bedtimes, excessive daytime sleepiness, and late weekend wake times.

DSPS is one of the most frequently diagnosed sleep disorders in adolescents. It is defined by the International Classification of Sleep Disorders (ICSD) as a circadian rhythm disorder including a delay in the onset of sleep and a great difficulty getting up at conventional hours, (affecting school performance in children, and work, social or family-life in older patients). DSPS is not secondary to pathology or drug intake and it affects patients with normal quantity and quality of sleep when allowed to follow his preferred schedule.[2] Patients with DSPS have a delayed circadian rhythm, which regulates our preferred sleep-wake times, relative to clock time. Consequently, they have difficulty falling asleep at night and waking up in the morning, at the conventional hours, but if allowed to sleep on their preferred schedule, there would be no perceived abnormalities of sleep time or sleep quality.[3] DSPS is different from insomnia in which patients have difficulty initiating sleep at any time and often report poor quality sleep, and therefore should be managed and treated diferently.[2,4] They have a feeling similar to ''Jet-Lag,'' as if every weekend they are crossing multiple time zones. A person with DSPS, could be quite comfortable going to bed at 3–4 in the morning and getting up at noon. The problem with this schedule is that it interferes with schooling and employment.[4,5]

DSPS is common in adolescents, but it can occur at any age. The etiology of this syndrome is complex and multifactorial, including behavioral, psychological and biological factors, and the prevalence between 5 and 10%, is increasing in the last decade.[3,5] Technology use, including screen activity and excessive exposure to artificial light in the evening exacerbates DSPS and caffeine use and napping further dis-regulate the sleep-wake cycle.

Recent studies propose as a causal factor a delay in the circadian rhythm due to inadequate melatonin secretion, others propose that the circadian rhythm length is greater than 24 h, or that patients present a diminished neuronal sensitivity to light, but without doubt, an important predisposing factor is when trying to sleep on two different schedules (week and weekends).[3] In these cases, the internal clock will adjust with the latest schedule, the weekend, producing a major problem on week days. Adolescents with DSPS usually have lack of sleep during the week and try to recover it by sleeping until later on weekends, actually worsening the problem.[4,5]

The initial treatment is based on adequate sleep hygiene and progressively adjusting the internal clock to social needs, following these basic guidelines[4]:

- Get up at the same time every day (no differences greater than one hour between week-days and weekend).

- Be exposed to daylight and have breakfast, just when you get up.
- Maintain a quiet routine at bedtime, such as reading in dim light.
- Avoid bright lights and turn off TV, computer and in general any screen one hour before bedtime.
- Avoid drinks with caffeine after noon (coffee, tea, chocolate, cola or energy drinks).
- Avoid naps during the day.
- Adjust the sleep schedule progresively: determining the time at which patient falls asleep naturally and progressively going to bed 10–15 min earlier every night, keeping every day the same get-up time.

When these means are not effective, patient should be referred to the sleep specialist to associate chronotherapy with a lightbox or pharmacotherapy with melatonin or other drugs.[4–6]

Psychosomatic symptoms, frequent in adolescents, can significantly worsen health-related quality of life (HRQoL) in this population, and sleep is an independent risk factor of worse HRQoL.[1] Primary care doctors must know how to recognize DSPS to prevent school failure, adverse mood disorders and its negative effects on HRQoL.

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Funcionamiento familiar y depresión en madres e hijos con dermatitis atópica

Family functioning and depression in mothers and children with atopic dermatitis

Sr. Editor:

La dermatitis atópica (DA) es una enfermedad de etiología multifactorial en la que intervienen factores genéticos, inmunológicos, medioambientales y psicológicos.

Este estudio se realizó con el objetivo de determinar la frecuencia de depresión en niños con DA y en sus madres y averiguar si hay asociación entre la percepción del funcionamiento familiar por parte de las madres y la depresión tanto en ellas como en sus hijos.

Es un estudio transversal en el que participaron niños de entre 7 y 15 años de edad con diagnóstico confirmado de DA, captados entre enero y diciembre del año 2010 en la Unidad de Medicina Familiar N.º 80 del Instituto Mexicano del Seguro Social en la ciudad de Morelia, México. El tamaño muestral se calculó con la fórmula para población finita. Se partió de 339 niños y el error de estimación asignado del 17%. Se incluyeron finalmente 18 niños y 16 niñas con edades de $9{,}97 \pm 2{,}4$ años y sus madres, con edades de $35{,}88 \pm 6{,}5$ años.

Para evaluar la depresión en niños se aplicó el inventario CDI[1] y el inventario BECK[2] para estimar la depresión en madres. Las madres completaron el cuestionario FF-SIL para medir su percepción del funcionamiento familiar[3].

Respecto a las familias, fueron percibidas por las madres como disfuncionales 4 (11,8%), funcionales 11 (32,4%) y 19 (55,8%) como moderadamente funcionales. Entre los niños se encontró depresión grave en el 11,8%, moderada en el 17,6% y ligera en el 35,3%. En las madres, el 5,8% tuvo depresión moderada y el 47,1% depresión leve. Se encontró algún grado de depresión en el 44,4% de los niños (8/18) y en el 87,5% de las niñas (14/16). Se ha demostrado mayor riesgo de padecer depresión en niños con DA que en controles [OR ajustado 1,81 (IC 95%: 1,33, 2,46)][4], y por otro lado, los hijos de madres con depresión suelen padecer depresión con más frecuencia que los hijos de madres sin depresión[5].

En este estudio, mayores grados de depresión materna tendieron a asociarse a peor percepción por parte de estas del funcionamiento familiar ($p < 0{,}001$), y las áreas más