

# SINGAPORE MEDICAL COUNCIL CATEGORY 3B CME PROGRAMME

(Code SMJ 202004A)

	True	False
1. Snoring is any sound produced from the nose and the pharynx during breathing in sleep.	<input type="checkbox"/>	<input type="checkbox"/>
2. Up to 28% of healthy children snore occasionally, while habitual snoring affects 3%–12% of children.	<input type="checkbox"/>	<input type="checkbox"/>
3. Habitual snoring, which is defined as snoring for two or more nights in a week, may be a manifestation of underlying sleep-disordered breathing.	<input type="checkbox"/>	<input type="checkbox"/>
4. Upper airway resistance syndrome, obstructive hypoventilation and obstructive sleep apnoea (OSA) are difficult to differentiate and diagnose from a structured history or clinical examination.	<input type="checkbox"/>	<input type="checkbox"/>
5. Snoring observed in children during an acute illness is a strong suggestion of obstructive sleep-disordered breathing.	<input type="checkbox"/>	<input type="checkbox"/>
6. Awareness about sleep and snoring is increasing in the general population, and most parents today know that snoring is benign and a reflection of good sleep.	<input type="checkbox"/>	<input type="checkbox"/>
7. Primary care providers are in the best position to screen and intervene early to reduce increased work of breathing, sleep fragmentation and consequences of undiagnosed OSA.	<input type="checkbox"/>	<input type="checkbox"/>
8. A previous study demonstrated OSA in 18% of six-year-old children performing in the lowest 10% of their cohort and a subsequent improvement in their performance after adenotonsillectomy.	<input type="checkbox"/>	<input type="checkbox"/>
9. OSA in children, unlike in adults, is not associated with significant cardiovascular and metabolic comorbidities.	<input type="checkbox"/>	<input type="checkbox"/>
10. The prevalence of OSA is 1.2%–5.7% in children, with the peak incidence occurring between the ages of two and eight years.	<input type="checkbox"/>	<input type="checkbox"/>
11. With increasing societal affluence and the resultant rising prevalence of obesity, there is now a second peak in OSA incidence in children, especially in girls aged above eight years.	<input type="checkbox"/>	<input type="checkbox"/>
12. OSA is more common in children with allergic rhinitis or chronic nasal congestion.	<input type="checkbox"/>	<input type="checkbox"/>
13. The 'BEARS' sleep screening tool is a structured tool to detect habitual snoring or excessive daytime sleepiness, such that a more detailed history and targeted physical examination can be performed to evaluate for OSA.	<input type="checkbox"/>	<input type="checkbox"/>
14. The symptoms of paediatric OSA may be difficult to elicit, as they are all nocturnal symptoms such as witnessed apnoea, snoring or gasping during sleep, restless sleep, primary nocturnal enuresis and, in severe cases, observed cyanosis.	<input type="checkbox"/>	<input type="checkbox"/>
15. Many parents may not have paid attention to their child's sleep and can be informed of the symptoms and signs to look out for, or can consider taking a video recording of their child's sleep for review at the next clinic consult.	<input type="checkbox"/>	<input type="checkbox"/>
16. As OSA is usually worse during REM (rapid eye movement) sleep, which predominates in the later half of the night, parents should be advised to check for symptoms at both the onset of sleep and in the later half of the night.	<input type="checkbox"/>	<input type="checkbox"/>
17. Primary care providers can consider a trial of intranasal corticosteroids and/or leukotriene antagonists in paediatric patients with habitual snoring only or habitual snoring with few symptoms/signs of OSA.	<input type="checkbox"/>	<input type="checkbox"/>
18. Treatment of OSA needs to be individualised, with surgical removal of enlarged tonsils and/or adenoids being a common first-line treatment after failure of a trial of medical treatment.	<input type="checkbox"/>	<input type="checkbox"/>
19. The greatest risk for children with a normal immune system and moderate to severe OSA after adenotonsillectomy is impaired immunity.	<input type="checkbox"/>	<input type="checkbox"/>
20. While adenotonsillectomy is effective in resolving OSA for most children, OSA may recur later from adenoidal regrowth, neglect of allergic rhinitis management or development/worsening of obesity.	<input type="checkbox"/>	<input type="checkbox"/>

### Doctor's particulars:

Name in full: \_\_\_\_\_ MCR no.: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Email: \_\_\_\_\_

#### SUBMISSION INSTRUCTIONS:

Visit the SMJ website: <http://www.smj.org.sg/current-issue> and select the appropriate quiz. You will be redirected to the SMA login page.

**For SMA member:** (1) Log in with your username and password (if you do not know your password, please click on 'Forgot your password?'). (2) Select your answers for each quiz and click 'Submit'.

**For non-SMA member:** (1) Create an SMJ CME account, or log in with your SMJ CME username and password (for returning users). (2) Make payment of SGD 21.40 (inclusive of 7% GST) via PayPal to access this month's quizzes. (3) Select your answers for each quiz and click 'Submit'.

#### RESULTS:

(1) Answers will be published online in the SMJ June 2020 issue. (2) The MCR numbers of successful candidates will be posted online at the SMJ website by 9 June 2020. (3) Passing mark is 60%. No mark will be deducted for incorrect answers. (4) The SMJ editorial office will submit the list of successful candidates to the Singapore Medical Council. (5) One CME point is awarded for successful candidates. (6) SMC credits CME points according to the month of publication of the CME article (i.e. points awarded for a quiz published in the April 2020 issue will be credited for the month of April 2020, even if the deadline is in June 2020).

**Deadline for submission (April 2020 SMJ 3B CME programme): 12 noon, 2 June 2020.**