### Indications for PSG

Before performing tonsillectomy, the clinician should refer children with SDB for PSG if they exhibit any of the following: obesity, Down syndrome, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidoses.

**Recommendation based on observational studies with a preponderance of benefit over harm.**

### Advocating for PSG

The clinician should advocate for PSG prior to tonsillectomy for SDB in children without any of the comorbidities listed in statement I for whom the need for surgery is uncertain or when there is discordance between tonsillar size on physical examination and the reported severity of SDB.

**Recommendation based on observational and case-control studies with a preponderance of benefit over harm.**

### Communication with anesthesiologist

Clinicians should communicate PSG results to the anesthesiologist prior to the induction of anesthesia for tonsillectomy in a child with SDB.

**Recommendation based on observational studies with a preponderance of benefit over harm.**

### Inpatient admission for children with OSA documented in results of PSG

Clinicians should admit children with OSA documented in results of PSG for inpatient, overnight monitoring after tonsillectomy if they are younger than age 3 or have severe OSA (apnea-hypopnea index of 10 or more obstructive events/hour; oxygen saturation nadir less than 80%, or both).

**Recommendation based on observational studies with a preponderance of benefit over harm.**

### Unattended PSG with portable monitoring device

In children for whom PSG is indicated to assess SDB prior to tonsillectomy, clinicians should obtain laboratory-based PSG, when available.

**Recommendation based on diagnostic studies with limitations and a preponderance of benefit over harm.**