ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

NEWSLETTER

MAY 1983 No. 27

CONTENTS

Editorial 2

Original Articles

Acute Viral Bronchiolitis 3

Embarking Upon Work with Profoundly Handicapped Children 5

Letters 6

Articles of Interest 7

Publications 13

Books 17

Safety Notes 19

Toy Notes 19

Product Notes 21

Equipment 22

Did You Know? 24

Audiovisual Aids 27

Courses Diary 28

APCP News 30

EDITORIAL

As you will read, one of the many changes in the National Committee is that Elizabeth Carrington retires as Public Relations Officer and Newsletter Editor. We, as the nucleus of what will become the editorial board, would like to express our appreciation of the enthusiasm and expertise which Liz brought to developing the Newsletter. We hope that we will be able to continue the high standards she has set for us. We also hope that Liz will enjoy her well deserved rest and send her every good wish for the future (which we know will include APCP!).

This is a time of change and it is thought that this should be reflected in the format of the Newsletter. It is one of our most important means of presenting the Association and of communicating, not only between members, but also with other professions and organisations who share our concern with children.

As our specific interest group matures so, perhaps, should the way we present ourselves mature and change also. We plan that the Newsletter will metamorphose into a professional Journal (which will have an Editorial Board), still keeping the high standard of content, but extending it to make it more of a forum for your news, views and interests and also for current topics which affect our practice (our November edition will be devoted to the Education Act 1981 - let us know your experiences). We hope to be thought-provoking and, perhaps, controversive. This can only happen if you enter the dialogue - so please communicate with us, we want to hear from you.

Gillian Riley
Marion Whyte

The Editorial Board welcomes contributions to the Newsletter. Original articles, abstracts from other journals, notes on new ideas/new products etc., and any other material for publication, should be sent to:

The Editor
APCP Newsletter
15 Tragail Mercier Road
LONDON SW15

ACUTE VIRAL BRONCHIOLITIS

R. Simon, Senior Physiotherapist, Respiratory Unit
E. Martin, Deputy Group Superintendent Physiotherapist
Hospitals for Sick Children, Great Ormond Street, London WC1.

This is one of the most common potentially serious acute lower respiratory infections in infants.

Incidence

This condition usually occurs in the winter months and the highest incidence is in infants between the age of one month and six months, but it has been known to occur at one week of life and up to two or three years of life. Boys are more predominantly affected, approximately 60% and it appears to be more common in families of lower socio-economic class. A high percentage of infants with acute viral bronchiolitis have first degree relatives with asthma.

Cause

The cause in about 80% of cases is thought to be the Respiratory Syncytial virus, but para influenza type 3, rhinovirus and influenza type A_2 cause a similar illness.

Pathology

There is inflammation of the walls of the bronchioles resulting in oedema and congestion of the tissues. There may be destruction of the ciliated epitheleal cells. The bronchioles become blocked with mucous and desquamated epitheleal cells resulting in atelectasis or hyperinflation.

Signs and Symptoms

The condition usually presents initially with cold-like symptoms and over the next few days the infant develops an irritating cough and becomes wheezy. The temperature may not be unduly elevated, but breathing becomes rapid, more than 60 minute, and respiratory distress increases; this may be associated with subcostal recession on inspiration and cyanosis. Excess bronchial secretions result in a low PO_2 and elevated PCO_2 depending on the severity of the illness. Due to the hyperinflation of the lungs, the chest becomes barrel shaped. Rhonchi and widespread crepitations are heard on auscultation towards the end of inspiration due to the opening of partially obstructed bronchioles. Chest X-ray shows hyperinflation with patchy areas of collapse and consolidation. The diaphragm is flattened and the liver may be pushed downwards due to the hyperinflation; prolonged coughing may cause vomiting and a few (1-2%) may become so physically exhausted that respiratory failure results. If the illness is prolonged the infant may become dehydrated and show considerable weight loss.

Lung function tests show an increase in Functional Residual Capacity. Pulmonary Resistance and decreased Dynamic Compliance.

Diagnosis

Diagnosis is usually made by clinical presentation and viral studies such as immunofluorescence which detects RSV in the respiratory secretions. Other conditions such as pneumonia, cystic fibrosis and severe immune deficiency may be present in this way.

Management

The best management of acutr viral bronchiolitis is through good general nursing care with minimal handling of the infant.

Medical care includes blood gas monitoring and, administration of oxygen if required. Careful attention is also paid to fluid balance which may be maintained

by the nasogastric or intravenous route. A few babies will require ventilation and full intensive care. Antibiotics are not usually indicated unless there is secondary bacterial infection. Bronchodilators are rarely successful and steroids are not indicated.

There is considerable discussion amongst the medical, physiotherapy and nursing profession as to the value of physiotherapy treatment. Very little research to resolve this problem has been carried out so we can only base our advice on clinical experience over a long period of time. It must always be remembered there are no set rules for each condition and that treatment must be modified depending on the age, and condition of the patient at any given time.

As already mentioned, the patient should be handled as little as possible. The smaller infant may be nursed lying in a cot with a head box and the larger infant on a chair in a croupette. Oxygen therapy, with good humidity, is given as required with oxygen levels being monitored by an analyser. Blood should be taken regularly for blood gas analysis. Naso-pharyngeal and oro-phanyngeal suction is given, hourly and as necessary, a sterile technique being used. Temperature, pulse and respiratory rate will be taken hourly, blood pressure four-hourly, and urine output and weight recorded daily.

The child should be given small, frequent feeds, often hourly, via a naso-gastric tube or they may be fed intravenously - this perhaps being preferrable in the tacypnocic child.

Resuscitation equipment (for intubation) must be available by the bed side or in close proximity. Ideally the child should be nursed in a cubicle and infectious precautions - ie., wearing gowns and masks - should be carried out.

Physiotherapy Management
Initial Stage

The Physiotherapist works closely with the medical and nursing team. She should observe the patient frequently and note the quantity and colour of the secretions, the observations recorded by the nursing staff and the results of X-ray and blood gases.

If the amount of suction the patient is receiving from the nursing staff is adequate then it is better for the physiotherapist to leave the patient alone. If the patient's condition deteriorates and there are more areas of atelectasis on X-ray than, after discussion with the medical staff, the physiotherapist may commence treatment.

She should treat the patient in the position she finds him, if he is sitting up in a chair, treat in sitting and alternate high side lying. Gentle clapping in preference to vibration for a short period is given, then rest and observe the patient's reaction and check the appropriate monitors. Continue gently if there are no adverse effects allowing plenty of rest periods. Suction the patient before turning to another position. The oxygen may need to be increased prior to physiotherapy treatment or suction. The physiotherapists must have the rebreathing equipment by her side during treatment and if the patient is in a croupette she must work from the inside and not leave the croupette open, to minimise the disturbance of oxygen levels. Treatment should be for short periods only, approximately five minutes, but may be given frequently, for example, at two hourly intervals, day and night. The physiotherapist must observe the patient continually and if he shows any deterioration with treatment, then treatment must stop.

If the patient is ventilated, then the physiotherapist should treat in alternate side lying and $\frac{1}{2}$ ml of sterile saline should be put down the endotracheal tube prior to suction. Again, the same care must be taken as mentioned above. Vibrations can be given but may be less well tolerated.

The length of treatment will vary depending on the patient's condition and response.

Recovery Stage

The physiotherapist should grade her treatment, introducing postural drainage as recovery occurs. Suction should be discontinued 3-4 days before discharge.

Prognosis

Most infants with acute bronchiolitis show an apparent complete recovery. A significant percentage go on to have recurrent wheezing episodes and later develop obvious asthmatic symptoms, especially if there is a history of allergy in other family members.

Further Reading

Hodges IGC (1982) Causes & management of Bronchiolitis with Chronic Obstructive Features Arch. Dis. Child 57: 495-499

With thanks to the Respiratory Team for their advice.

* * * * * * * * * * *

EMBARKING UPON WORK WITH PROFOUNDLY HANDICAPPED CHILDREN - A PERSONAL VIEW

Jennifer M. McKinlay, Senior Physiotherapist, Queen Mary Hospital, Carshalton, Surrey

The following are my personal thoughts and opinions formed during the last 9 months working with multiply and profoundly handicapped children. My experiences are limited to one hospital where there are approximately 100 mentally handicapped long stay patients. The title 'mentally handicapped' is very misleading for these children. While an accurate diagnosis, it is frequently an incomplete one as most children are multiply handicapped. For reasons which elude me, they come under the care of the psychiatrists first, not the paediatricians, and regrettably there still exists quite a dichotomy between the long stay and acute wards.

Since moving into this work, other people's reactions have been intriguing. After the odd frown, gasp or disparaging look, comments like "Did you want to work there, or were you pushed" and "why do you want that job" have been commonplace. Strangely enough, they frequently come from fellow physiotherapists and other medical professionals working the acutely ill. For many, the thought of working with such children is unsavoury and/or a waste of time. I remember these feelings as one who passed by the wards for 18 months hearing strange noises and I realised my previous dislike and apprehension was due to ignorance, 'fear of the unknown' and a misunderstanding of my motives in the treatment and management of patients.

As physiotherapists, we aim to improve the function of our patients and we flourish on the success of our treatments. To a degree, our ego is boosted by any praise we receive for successful treatment and morale is raised by visible achievement. Of course these are not the only reasons for being therapists, but they play a very important part in our job. To work with profoundly handicapped children is to accept that there may not be the rewards of success that we have with other patients, but rather we are motivated to change the circumstances of our patients, to give them some variety of experiences which they will never be able to give themselves. It is also necessary to come to grips with the fact that these children are members of our society, the very society which has dictated that they must live, but a society which regrettably finds it very difficult to relate to the type of life they have. Despite the

extent of their handicaps, I find it useful to rememver that most have very normal parents whose lives and marriages are frequently permanently disrupted because of the strains of having such a child, and that any one of these children could have been mine. Therefore, no matter how handicapped, and no matter how little they may be able to give back to society in terms of 'cost-effectiveness', they deserve as much attention and care as those with lesser problems. Once these hurdles are surmounted, the work can really begin. And when progress is seen and achieved, there is much joy and self-satisfaction.

To say that the work is sometimes a 'maintenance' rather than a 'construction' job may suggest that little expertise is required. Not so. Indeed, where children suffer from multiple handicaps, it is imperative to increase knowledge multifariously. That is, to look at 'the whole child' not just in terms of physical development and abilities from head to toe, but 'the whole child' as we relate to mankind – in mind, body and, dare I suggest, spirit. The latter, though hard to define, is surely of relevance. To combine our beliefs with our factual knowledge has never been a simple matter, but it requires serious deliberation. More difficult than accumulating knowledge is discerning how best we use that knowledge and translate it into practical reality. My vote has to be for an eclectiv approach to treatment as I have not yet found any one technique which embraces adequately all the needs of multiply handicapped children. I also wish to find out much more about the ways in which the mind influences movement.

Do I enjoy my work? As with most things in life, there are good days and bad. Undoubtably the challenge is great and there is a feeling of urgency because of severe understaffing. Because of that situation, a large part of my role is teaching and advising those who have the permanent responsibility for the care of the children. One stumbling block can be a reluctance by people to change their ways. The old argument that 'We've always done it that way' regrettably lingers on, but I too have to watch that problem!

* * * * * * * * * * * * *

LETTERS

From: Mrs Hilary Smith, Senior Paediatric Physiotherapist, Musgrove Park Branch, Taunton & Somerset Hospital, Taunton, Somerset TA1 5DA.

Have any Paediatric Physiotherapists, dealing with children with Downs or other syndromes, been able to solve the problems of children with chronically discharging noses ie., affecting breathing, eating, schooling as well as social acceptance?

I am sure that many physiotherapists, especially those working in Special Schools, must have met this problem and may have found a way of dealing with it. Paediatricians may prescribe drugs, ENT surgeons will talk about the problem, but they feel that nothing can be done.

Any helpful ideas would be welcomed eg., success with drugs, nasal sprays, surgery.

From: Mrs Christine Edwards, P.R.O., British Paraplegic Sports Society, 3 Roblin Close, Stoke Mandeville, Aylesbury, Bucks HP22 5XF

On Friday 7th January 1983, the BPSS launched an appeal for £100,000 to take 130 athletes and 30 staff to the 1984 Paralympics in the U.S.A. These games will take place between 19th June and 4th July 1984 at the University of Illinois, Urbana, USA. The Olympics for other disabled will be held in Nassau County, New York.

I am writing to ask if you will help through your publication to publicise this appeal. We need sponsorship, fund raising schemes and support fro m the public. The more money we raise the more world class athletes we can send. If you require more

ARTICLES OF INTEREST

REHABILITATION BULLETIN

Copies of the following articles can be ordered from: The Assistant Librarian, National Demonstration Centre, Pinderfields General Hospital, Wakefield, West Yorkshire WF1 4DG.

Please quote the Bulletin date, the number of the article and full details of the citation. You will be invoiced at 5p per page. Do not send money with order.

JANUARY 1983

34. Albrecht GL et al
Social distance from the stigmatized. A test of two theories
Soc Sci Med, 1982: 16(14): 1319-27

57. Sykanda AM: Levitt S
The physiotherapist in the developmental management of the visually impaired child
Child Health Care Dev, 1982 Sep-Oct; 8(5): 295-302

58. McGown MP
Guidance for parents of a handicapped child
Child Health Care Dev, 1982 Sept-Oct; 8(5): 295-302

60. Bernardo ML
A conceptual model of children's cognitive adaption to physical disability
J Adv Nurs, 1982 Nov; 7(6): 595-601

FEBRUARY 1983

3. Horvat MA
The implementation of a trampoline program for children with handicapping conditions
Am Correct Ther J, 1982 Jul-Aug; 36(4): 105-8

5. Frank LL Jr.
Organisation and support for handicapped ski program
Am J Sports Med, 1982 Sep-Oct; 10(5): 276-84

10. Giljohann A
Returning to school after burn injuries
Aust Fam Physician, 1982 Jul; 11(7): 570, 572, 574

11. Sensky T
Family stigma in congenital physical handicap
Br Med J (Clin Res), 1982 Oct 9; 285(6347): 1033-5

14. Pollak IV
Microprocessor-based communications system for the non-verbal person with serious motor handicaps: a preliminary report
Bull Prosthet Res 1982 Spring, 19(1): 7-17

20. Munton JS
An overview of research on seating
Eng Med 1982 Jul; 11(3): 107-10

26. Gross AM et al
Training parents to be physical therapists with their physically handicapped child
J Behav Med, 1982 Sep; 5(3): 321-7

29. Yung K
Physical exercise therapy in juvenile diabetes mellitus

47. Okamoto GA et al
Skin breakdown in patients with myelomeningocele
Arch Phys Med Rehabil, 1983 Jan; 64(1): 20-3

55. Sillanpaa M et al
The young adult with cerebral palsy and his chances of employment
Int J Rehabil Res, 1982 Dec; 5(4): 467-76

58. Goodman G et al
Application of learning theory to small group instruction: An innovative program for treatment of children with scoliosis
Int J Rehabil Res, 1982 Dec; 5(4): 524-7

MARCH 1983

26. Asher MI et al
The effects of inspiratory muscle training in patients with cystic fibrosis
Am Rev Respir Dis, 1982 Nov; 126(5): 855-9

39. Melnick ME; Shellenberger MK
Management of paediatric spasticity
Compr Ther, 1982 Oct; 8(10): 20-6

45. Holdsworth BJ; Sloan JP
Proximal forearm fractures in children: residual **disability**
Injury, 1982 Sep; 14(2): 174-9

53. Jaffe DL
An ultrasonic head position interface for wheelchair control
J Med Syst, 1982 Aug; 6(4): 337-42

54. Kun LE et al
Quality of life in children treated for brain tumours. Intellectual, emotional and academic function
J Neurosurg, 1983 Jan; 58(1): 1-6

55. Filipe G; Carlioz H
Use of the Pavlik harne ss in treating congenital dislocation of the hip
J Paediatr Orthop, 1982 Oct; 2(4): 357-62

69. Elegbe I et al
Pupils and teachers attitudes toward handicapping children
R Soc Health J, 1982 Oct; 102(5): 216-7

75. Ingolia P et al
The effect of choreoathetoid movements on the quick neurological screening test
Am J Occup Ther, 1982 Dec; 36(12): 801-7

76. Hinojosa J et al
Occupational Therapy for Sensory Integrative Dysfunction (ACTA official position paper)
Am J Occup Ther, 1982 Dec; 36(12): 831-2

77. Hinojosa J et al
Roles and Functions of the Occupational Therapist in the treatment of Sensory Integrative Dysfunction (AOTA official postion paper)
Am J Occup Ther, 1982 Dec; 36(12): 832-4

The February and March Bulletins also give a selection of papers from the proceedings of the IXth WCPT Conference in Stockholm (1982). Copies of individual papers may be obtained from the authors. The entire proceedings (two vols) may be obtained from:

LSR
Apelbergsgaten 50
S - 11137 Stockholm
SWEDEN   Price 150 Swkr.

ABSTRACTS

Counselling Parents of the Handicapped Child

Parents decide to have a child for many reasons. These may include satisfaction of social expectation, satisfaction of the parent's need to show their capacity for love and care to reporesent the synthesis of two persons. Before a child is born, the parents fantasis about the child, and a handicapped child is inevitably a disappointment. The handicapped child does not replace the 'fantasised child' and stands in the way of grief. The parents often recognise that it would be easier to come to terms with a dead child than a diminished one.

The person who tells the parents that their child is handicapped has a heavy burden and is often the person on whom they vent their powerful emotions Although the information should be passed on as soon after it is available as possible, finding a figure of trust soon after the birth is not always easy. The news should be given to both parents at the same time in private; full information should be given, and if necessary, ignorance admitted. The parents should be given the opportunity to talk things over until they understand everything. The counsellor must be prepared to repeat things over and over again and must retain contact with the parents even in the face of rejection.

The birth of a handicapped child may have a profound effect on the marriage and the parents' relationship. Counselling should give them the opportunity to face those issues within themselves which the trauma has brought into prominence.

When handicap develops as the child grows older, counselling should be continuous, and in-patient care of the child gives the opportunity for counselling. Through counselling, the parents can learn to accept the handicapped child as a complete person rather than as a failing or partially failing normal person.

Taylor DC. British Medical Journal 1982: 284(6321): 1027-8

Infantile Myositis

Three cases have been described of infantile myositis which had been misdiagnosed as congenital muscular dystrophy. All three cases responded well to steroid (prednisone) treatment. Infantile myositis, a rare but treatable condition, may often be missed, and should be considered separately from the disease known as adult polymyositis.

The general criteria to establish a diagnosis of pure polymyositis appear to be: proximal progressive muscle weakness or diffuse weakness at birth, specific bippsy changes, raised levels of serum enzymes and a response to treatment with steroids.

Thompson CE, Infantile myositis. Developmental Medicine and Child Neurology 1982; 24(3): 307-13.

The Problems of Club Feet

How effective are the present methods of treating club foot? Research in Sweden has shown that 88 per cent of 106 patients aged 27-33 did not look normal, and 20 per cent experienced some discomfort.

According to research findings there are genetic and neurogenic factors in the development of club foot, and treatment cannot begin too early. After the child has reached the age of one, successful treatment for club foot is unlikely.

Children with easily corrected club foot can be treated shortly after birth by gentle stretching without anaesthetic. Full correction can be produced rapidly by frequent manipulations supplemented by strapping or a plaster cast. Severe and resistant club foot requires an operation at four to six weeks after preliminary stretching and strapping.

For both types of club foot regular and careful supervision is necessary during the period of growth. Few studies have followed the development of children from infancy to the end of growth, so an evaluation of treatment procedures is not possible.

Klenerman L. The problems of club feet. British Medical Journal 1982; 284(6327): 1427-8.

Managing Limb Deficient Children

Limb malformations are caused by developmental arrest, and when the mother gives birth to a malformed baby, the experience can be very traumatic. Allowing the mother to see and hold the baby as soon as possible after the birth will lessen the chances of rejection. Early referral to one of the 36 artificial limb and appliance centres in England, Scotland and Wales is to be strongly recommended. The doctors at these centres are able to allay any doubts about hereditary factors being responsible for the malformation, in the vast majority of cases the cause appears to be viral in origin.

At the centre the parents are given an approximate date for the fitting of a prosthesis and the programme for the future. After the fitting of a prosthesis children are seen every three months, and the same doctor is seen whenever possible from infancy to adulthood. Consequently, any psychological problems can be foreseen and hopefully avoided. Counselling of both the parents and children is frequently necessary.

Children with limb deficiencies can manage well at normal schools unless the handicap is very severe. Ian Fletcher, writing in Maternal and Child Health, has described the most common causes of upper and lower limb deficiency, and the types of prosthesis available. In certain types of limb deficiency, for example the absence of a hand or a whole arm, no prosthesis is required and the child can learn to be very independent without artificial aids. However, a prosthesis is required for lower limb deficiency, but even children with the complete absence of legs can move around on their own.

Fletcher I. The management of limb deficient children. Maternal and Child Health 1982: 7(12); 490-98.

The above first appeared in Health Visitor Vol. 56:3 Feb. and March.

AUTHORS SUMMARIES

Early Social Interactions between Infants with Down's Syndrome and their parents

Parents now take an active part in early intervention programmes with their handicapped children and it is important for them to develop positive interactions with their young babies. However, the interactions between a mother and her handicapped baby differ in some respects from those between a mother and her non-handicapped child, and the mother may need help to understand this.

Concentrating mainly on Down's syndrome babies, the authors describe in detail the main mother-infant interactions during the first six months of life and discuss how specific difficulties may be prevented or overcome. Guidelines are suggested to help parents.

Berger J. & Cunningham C. Health Visitor 1983; 56: 58-60

Who Holds the Purse Strings?

When money is scarce in the health service the finance officer may all to easily assume undue influence, not always to the benefit of the patient. To stand up for their clients and their profession, health visitors need to communicate effectively with treasurers and this involves an understanding of what the treasurer's job and responsibilities are.

This article explains the treasurer's role and how it has expanded. Traditionally the treasurer looked after paying the wages and the internal auditing of the accounts, but nowadays is increasingly involved in the general management of services, management accounting and providing financial advice.

The role of audit is also explained, including the growing use of management audit which aims to ensure that value for money is obtained in the NHS.

In all these expanded functions, the treasurer has a special but not exclusive responsibility. Health visitors, too, need to become involved in these areas since they have ideas to contribute which can improve the quality of services, and data which can improve the quality of the financial and statistical information on which many NHS decisions are based.

Vintern G. Health Visitor 1983; 56: 58-60

Dermatoglyphic and Palmar-crease Alterations as Indicators of Early Intra-Uterine Insult in Mental Retardation

A comparative study of unusual dermatoglyphic and palmar patterns revealed significant differences between the frequencies of certain patterns amount 200 congenitally affected mentally retarded children and 500 normal controls. A scoring method demonstrating the significance of eight unusual patterns as non-specific indicators of early intra-uterine fetal insult was devised. 10 per cent of the children previously classified as idipathically mentally retarded were shown to have been exposed to early intra-uterine insult. Dermatoglyphic and palmar-crease analysis should be included as a routine investigation for children with mental retardation of unknown cause.

Dav H. & Jaffe M. Develop. Med Child Neurol. 1983; 25: 53-59

Scoliosis in the Community

Screening for scoliosis at schools has become more and more popular despite the lack of knowledge concerning the clinical course of idiopathic scoliosis. An epidemiological study of 5303 school children showed three types of scoliosis in the community: (1) pelvic tilt scoliosis (an inconsequential deformity caused by an inequality in the length of the legs but accounting for almost 40% of curves detected); (2) spinal scoliosis (a minor asymmetry of the spine in the coronal place that tends to remain static or to resolve and which may be normal in growing children, accounting for the remaining 60%); and (3) progressive scoliosis (10% of the spinal scolioses measuring 10° or more that progress by 5° or more a year). Progressive scoliosis resembles idiopathic scoliosis because in girls with right thoracic curves the potential for progression is appreciable. Until the natural history is better established growing awareness in the community of spinal deformity should help earlier detection, and screening should be directed towards providing subjects for further epidemiological work.

Dickson RA. Brit Med J 1983; 286: 615-618

Diagnosis of Duchenne muscular dystrophy: experiences of parents of sufferers

Sixty nin parents of boys suffering from Duchenne muscular dystrophy were interviewed at home. The interview explored the parents' experiences at the time of their son's diagnosis. Many families had experienced distressing delays (average 2.5 years) between the time they first became aware of symptoms

and the time of the diagnosis. On only 18 occasions were both parents told of the diagnosis together. One third of the parents were "not satisfied" with the way the diagnosis had been communicated. Parents want to know as soon as possible if there is something wrong with their child. They should be told the diagnosis together and in private. Full information should be given and a series of contacts should be arranged.

Firth MA. Brit Med J, 1983; 286: 700-701

Continuous electroencephalographic recording to detect seizures in paralysed newborn babies

A muscle relaxant is often given to abolish spontaneous respiratory activity in babies who require artificial ventilation. Paralysis abolishes the clinical signs of neurological complications, particularly seizure activity, which may follow hypoxic brain damage, hypercapnia, or other biochemical abnormality. Some studies have suggested that repeated seizures lead to permanent neurological sequelae. We report seizure activity, detected by a new method of continuous electroencephalographic monitoring, in three babies paralysed while receiving intensive care. This technique permitted prompt diagnosis and rapid assessment of anticonvulsant treatment.

Eyre JA. Oozeer RC. Wilkinson AR. Brit Med J 1983; 286: 1017-18

The physiotherapist in the developmental management of the visually impaired child

The role of the developmental physiotherapist, rather than the general physiotherapist, in a developmental vision team is described. Physiotherapy can contribute to both the assessment and intervention programmes. Motor development and associated postural reactions will be trained, abnormal postures prevented or decreased, and body image and use of residual vision developed. Selection and supervision of aids and play equipment, as well as decreasing of physical handicap are also included in the physiotherapist's role in helping the child and his family.

Sykanda AH. Levitt A. Child: care, health & development 1982; 8: 261-270

Learning through play: the evaluation of a videocourse for parents of mentally handicapped children

Although studies have shown that parents can be effective teachers for their mentally handicapped children, the majority have been prescriptive and this may inhibit parents' own intuitive style of inter-acting with thier child. By centring intervention around parents' play with their child, such disadvantages may be overcome. This study investigates the feasibility of an instructional videocourse for parents on furthering the play of mentally handicapped children. Course components included six videoprogrammes of mentally handicapped children at play, practical activities for parents to carry out at home, a handbook, instructions on simple toy making, and books and information at play. Evaluation of the course found that the majority of parents described the course as enjoyable and useful; most gained new ideas about play and appreciated the discussions with tutors and other parents. A three-month follow-up interview indicated that parents' positive attitudes to the course were maintained and changes in their child's play behaviour were reported. Suggestions for improving the course are discussed along with some of the difficulties encountered in offering parents opportunities to nurture their child's development.

McConkey R. McEvoy J & Gallagher F. Child: care, health & development 1982; 8: 345-359

Psychosocial dwarfism

Psychosocial dwarfism (PSD) or the syndrome of deprivation is one of the many forms of child abuse and neglect. Although very short stature is the most striking feature, signs of maltreatment are commonly found in these children and

vice versa, a follow-up of abused children has shown growth failure in a third. A history of failure to thrive in infancy is always obtainable. Although hospital care restores the weight loss temporarily, under-nutrition continues at home in the hands of a mother who is neglecting, lacking concern, coldly rejecting or cruel and hostile, and who avoids the normal sources of help and advice.

MacCarthy D. Update (General Practice) 1983; 26(1); 91-103

Paediatric Oncology

Practical points:

Cancer is now the principal disease causing death between 1 and 15 years of age.

Advances in treatment have come from a multidisciplinary approach in specialized centres.

Genetic counselling is vital in those tumours produced by a defective gene.

Environmental carcinogens include ionizing radiation, viruses, hormones and possibly anticancer drugs.

For many childhood tumours about 50 per cent five-year relapse-free survival is expected.

Chickenpox and measles are major hazards for a child being treated for acute lymphoblastic leukaemia.

Accurate staging, precise pathological diagnosis and careful manipulation of the three modalities of treatment (surgery, radiotherapy and chemotherapy) have transformed the outlook in childhood malignancy.

Eden OB. Update (General Practice) 1983; 26(5): 779-788

* * * * * * * * * * * *

PUBLICATIONS

1. Mechanical and Manual Handling in the Swimming Pool Environment

   Brief guidelines on how to approach the problem, the need for effective training and practice and what solutions are available.

   Available from - Sara R. Green
   Harold Fern House
   Derby Square
   Loughborough
   LE11 OAL

   Price free

2. Oops! My Crutch is Slipping (1982)

   Subtitled "Practical Hints for the Physically Handicapped" are based on the experience of disabled people.

   Available from - The secretary
   Disabled Motorists (Victoria)
   7/42 Northcote Avenue
   Balwyn
   Vic 3103
   Australia

   Price free but SAE appreciated

3. International Year of Disabled People 1981

A guide - including illustrations of aids and self invented gadgets for those who advise and help the visually handicapped.

Available from - Jewish Blind Society
1 Craven Hill
London W2 3EW

Price on application

4. Vocational Rehabilitation of Leprosy Patients (1982)

A report on the Int. Labour Office/Danish Int. Development Agency regional seminar which aimed in 1981 to stimulate action in the field of vocational rehabilitation and social integration of leprosy patients.

Published by - International Labour Office
Geneva
Switzerland

Price - 15 Swiss Francs

5. Physical Education and Physically Handicapped Pupils in Day Schools

Produced by a working party of Kent County Councils Education Departments Inspectorate who spent two years visiting schools, initiating discussions with teachers and physiotherapists and working with children.

Published by - Kent County Council
Education Department
Springfield
Maidstone ME14 2LT

Price on application

This publication will be of special interest to members of the APCP.

6. Play Aids for the Handicapped Child (May 1982)

A catalogue of many types of playthings and aids suitable for handicapped children.

Published by - Handicapped Person's Research Unit
Newcastle Upon Tyne Polytechnic
No. 1 Coach Lane
Coach Lane Campus
Newcastle Upon Tyne NE7 7TW

Price - £1.50

7. The Health Education Council Publication:

The Best Way to Feed your Baby

How to Survive the First Week of Breast Feeding

Immunisation

An Important Message for Women of Childbearing Age

Measles is Misery

Play and Things to Play With

Hello Baby

The Baby Blues and Post Natal Depression

All these leaflets are available from the:-

Health Education Council
78 New Oxford Street
London WC1A 1AH

8. Five Ways to Fold Your Baby's Nappy

Available free from - Sylvia Meredith Health Education Advisory Service
3 Elgin Road
Sutton
Surrey

9. Access at the Channel Ports

This publication give information on each cross channel ferry operator and port facilities as well as a good deal of other general information.

Cost - 25p to cover postage costs from RADAR
25 Mortimer Street
London W1N 8AB

Tel. No. 01-637 5400

10. Elements of a Comprehensive Local Service for People with Mental Handicap

Written particularly for members of Local and Health Authorities. It's guide identifies the principles upon which a comprehensive local service should be based and described how the individual needs of people with mental handicap can be met appropriately throughout their own communities.

Available from - Independent Development Council for
People with Mental Handicap
126 Albert Street
London NW1 7NF

Tel. No. 01-267 6111

Price - £1.25 incl. post and package
Bulk Orders - 11-50 copies 10% discount
51 copies and over 15%

11. Notes for Teachers of Visually Handicapped Children (Not in Special Schools)

Compiled by Agnes T. Cameron ALCM. Cert. Ed.

Teachers should be able to recognise the signs of visual impairment even when masked by some other disability. The defect needs to be identified and teaching methods adapted to enable such children to help them achieve their full potential.

These notes are intended to give teachers some brief basic non medical advice and reading lists on the different problems they may face.

They may be obtained from - Mrs Valerie Scar
Advisor on Visual Handicap
Disabled Living Foundation
346 Kensington High Street
London W14 8NS

Price - £2.50 per copy incl. p & p
£2.00 over the counter

12. Start Rite Shoes for Children

have printed a leaflet outlinging some of the points extracted from the START RITE DIPLOMA COURSE.

This leaflet is directed to footwear retailers and others interested in child welfare and contains some useful basic advice about shoes and how they should be fitted.

Obtainable from - Start-rite Shoes Ltd.,
Crome Road
Norwich, Norfolk NR3 4RD

Tel. No. Norwich 43841

13. Facts about Hay Fever - and other allergies

This booklet contains answers to some of the most frequently asked questions about allergic conditions. They are not intended to act as a guide to treatment. The information given is intended to explain the basic facts about allergy, and to broaden public knowledge and awareness of the condition.

It states clearly that those of any age who suffer an allergic complaint can best help themselves by seeking medical advice.

It has been produced by - Dame/Hollister-Stier
Division of Miles Laboratories Ltd.
Stoke Court
Stoke P
Slough SL2 4LY

14. Holidays for the Physically Handicapped - 1983

Comprehensive, annual guide to holiday accommodation.

Published by - Radar
25 Mortimer Street
London W1N 8AB

Price - £1.00 + £1.35 p & p

15. Integrating Disabled Children in Play

A practical guide to organising an integrated play scheme or junior youth club, written from 7 years experience by A. J. Leicester.

Published by - Sheffield Childrens Integrated Play Association
124 Devonshire Street
Sheffield S3 7SF

Price - free to groups in Sheffield otherwise
£1.00 + 35p p & p

16. NAHPS Pamphlets - No. 1 "Babies in Hospital" and No. 2 "Toddlers in Hospital"

Illustrated pamphlets giving play ideas for the two age groups.

From - The Honorary Secretary
National Association for Hospital Play Staff
Thomas Coran Foundation for Children
40 Brunswick Square
London WC1N 1AZ

Price - 20p each

BOOKS

1. **Footwear and Footcare for Disabled Children by Janet Hughes, MCSP**

This easily read and useful guide is the result of the concern felt by the DLF about the foot wear problems of people with a disability.

It is designed for parents, professionals and non professionals and being simply written and clearly illustrated will prove very useful to all involved and concerned with the care of children's feet.

Available from - DLF (Sales) Ltd
43 East Hill
London SW18 2QZ

Price £5.25 incl. postage and package

2. **Parents and the Handicapped Child - A Guide for Families by Margaret R. Marshall**

Discovering your child is handicapped is a shock for all parents. Expert advice is given here in a straight forward but sympathetic way dealing with all the practical and emotional problems for all those involved.

It succeeds well in outlinging organisations which can offer help and support as well as suggesting books and toys for the child.

Published by Julia MacRae Books.

Price £6.95

3. **No Handicap to Dance by Gina Levete**

Human Horizon Series

Paperback	£4.95
Casebound	£6.95

This book tells how dance teachers can use improvisation, mime and dance with handicapped people. It includes the story of how Gina Levete started the development of Shape which is now a wide ranging organisation of artists performing and developing creative activities for the disabled and disadvantaged.

Much of the book is a prodical guide to creative movement sessions with many ideas of varying activities for different age groups.

4. **Sexuality and the Physically Disabled - an Introduction for Counsellors**

Available from SPOD
The Diorama
14 Peto Place
London NW1 4DT

Tel. 01 486 9823

Cost £1.70 including postage

The aim of this book is to give counsellors information about various disabilities and outline possible implications for sexual and personal relationships.

5. **Ask the Children**

Experience of Physically Handicapped Children in the School Years by Nicola Madge & Meg Fasson

Published by Batsford Academic Cost £5.95

This is a sensitive study of the result of questioning children aged between 7 and 16 from special and ordinary schools in London about their understanding of others. It makes a valuable contribution to the current debate on the merits of integrated versus segregated education for handicapped children.

6. Disability in Adolescence by Elizabeth M. Anderson and Lynda Clarke with Bernie Spain

This book published posthumously looks at the social and psychological needs of disabled adolescents. The findings of a study in which two groups of disabled teenagers took part, one with cerebral palsy and one with spina bifida and hydrocephalus underline the need for a counselling service whilst the teenagers are still at school and the need to rationalise the overlapping provision of help for disabled school leavers.

Published by Methuen and Co. Ltd., Price on application.

7. Independence Training for Visually Handicapped Children by Doris Tooze

Published by Groom Helm Special Education Series

Edited by Bill Gillham

Cost £6.95, Croom Helm Ltd.
2-10 St Johns Road
London Sw11

This gives specific information about orientation and mobility as part and parcel of Mobility for Independence. It emphasises the importance of starting in the early pre-school years.

8. Orientation and Mobility Techniques - A Guide for the Practitioner Everett Hill - Puruis Ponder

9. Concept Development for Visually Handicapped Children by T. Lydon

A useful book relevant for those working with children with mental handicap and visual problems.

Both these books are from the USA - they are available from:-

The American Foundation for the Blind
15 West 16th Street
New York
NY 10011

The RNIB library may also be able to help you - address 338/346 Goswell Road, London, EC1U 7JE

10. When Pregnancy Fails by Susan Borg and Judith Lasker

A comprehensive source book of what to expect at a time of infant loss, for parents, their families and friends and medical professions. Practical guidance for the decisions to be faced is given to help cope with such a tragic event.

Published by Routledge and Kegan Paul

Price £3.95 paperback

SAFETY NOTES

MISUSING BOUNCING CRADLES

A report in "Which" April 1983, points out the dangers of misusing bouncing cradles. Department of Trade surveys show that of the 1000 babies injured in accidents involving these cradles, most of the accidents happen because, instead of being placed on the floor, the cradles are rested on tables etc., and slip or get knocked off. The report goes on to note a number of things which could make bouncing cradles safer.

ORTHOKINETIC TRAVEL CHAIR - SEAT BELTS

Recent legislation allows the Orthokinetic chair to be used in the front seat of a car but it must be securely fastened in.

Two methods of anchorage are used:

1. A special safety strap, supplied by the manufacturers - Price: £13.50 +VAT
2. The existing seat belt place completely round child and chair.

Detailed instructions for fitting from:

Orthokinetic (UK) Ltd.
24 South Hampshire Industrial Park
Totton, Southampton

CHILDREN IN CARS

Get hold of a booklet called "Child Safety in Cars" from the Road Safety Officer at your local Town Hall or from your DHSS office.

INTRAMUSCULAR INJECTIONS

Children run a higher risk of complications eg., nerve injuries and muscular contractions, than adults when given intramuscular injections. A review in "Paediatrics (1982; 70: 944-7)" suggests that the upper lateral thigh is the safest site and that when multiple injections are needed the site should be varied.

HAZARD NOTICE: DLF Sheet 23, January 1983

The PLUG AID included in the D.L.F.s "Ideas for one-off Aids" sheet has been described as potentially dangerous by the Electricity Council Applicance Testing Laboratory. The aid is described as "shaped leather placed in between the plug and socket. Join handles and pull to extract plug". Please delete from information sheets. The D.L.F. apologise for including this aid.

* * * * * * * * * * * * *

TOY NOTES

1. From SAVILLE TOYS
   132 Chapel Lane
   Thornhill
   Dewsbury
   West Yorkshire WF12 ODH

   Amongst other things this company do a very nice range of 3D puzzles. Comprising of a farm, harbour, village and town, which can all be used separately or put together to make one large layout. Model care, houses, trees and boats etc., fit into a raised "formboard" which doubles as a storage box. 17" x 14" £8.90 each.

2. From ARTUR FISCHER (UK) LTD.
   25 Newton Road
   GB Marlow
   Bucks. SL7 1BY

   This company has introduced a nice range of rattle blocks, lots of different shapes in an array of bright colours. The beads inside act as a stabiliser when building, and the rattle may be used too as a locator for visually handicapped children.

3. From LEGO UK LTD.
   Wrexham
   Clwyd LL13 7TQ

   The Lego Duplo range has been extended down the age scale to include rattles/teethers that fit into the existing Duplo bricks. The bath activity set is useful for two handed play but the actual activities are rather disappointing.

4. From WELLS-KELO
   Progress Works
   Kingsland
   Holy Head
   Anglesey
   Gwynedd, North Wales LL65 2SN

   Among the growing number of bath activity toys on the market, apart from Lego, Fisher Price (always first and usually best) and Berwick this firm have a range. They are:-

   Macbath which is a Loch Ness monster musical bath activity toy. (What more could anyone ask for!) Very good for two handed activities in water.

   The animals A Noah's Ark with squirting animals in it. Again good for two handed activities (and target practice).

   Ship Ahoy, a shape fitting toy with a fishing rod to hook the shapes out of the boat. This can also be used as a pull along toy (nothing if not versatile).

5. A growing number of fantasy role playing games are becoming available. Two of the marketers being:-

CAMES WORKSHOP 27-29 Sunbeam Road London NW10 6JP	and	TSR HOBBIES (UK) LTD. The Mill Rathmare Road Cambridge CB1 4AD

   A great opportunity for the older physically handicapped child/adolescent to play games on a par with their peers. No great physical ability or co-ordination is required just lots of imagination. All tastes are catered for including science fiction, western, historical, spy, cops and robbers etc.

PRODUCT NOTES

Nomeq - Canvas Corner Seats

Nomeq are planning modifications to this seat. They intend replacing the canvas with porous, washable terylene (also stronger than canvas) as well as strengthening the frame. These modifications should not add appreciably to the cost.

If you have any comments on this, or any other of their products OR IF YOU HAVE ANY NEW IDEAS WHICH COULD BE MARKETABLE, Nomeq would be delighted to hear from you. Contact: The Marketing Director, Nomeq, Washford Mills, Ipsley Street, Redditch, Worcs. B98 7AB.

M.S.W.

The Maclaren-Burnett Porta Buggy System

Buggy - bigger wheels to make the buggy easier to push, more comfortable to ride in and easier to steer. However, the brakes which are not (and never have been) linked are still a cause for concern. The new footrest, although a good idea in principle is suitable only for the smallest children (or those with very short legs!).

Shell Seat - this is t he systems most disappointing feature. The body - head - legs proportions are totally wrong as is the seat angle. The valve operation for the moulded seat is a great improvement though the operating instructions are unclear. Body moulding cushion is only suitable for the smallest children. The whole chair is awkward and heavy and again the footrest height is wrong. The harness is also unsuitable in its present form.

Reclining chair - this has a number of good features - folding ability, stability, good size and removal of canvas seat is very simple. However, again the seat angle is poor when the chair is upright, the footrest again. A different locking system in the reclining position may be needed for heavier children. The front legs of the frame are also hazardous when in the reclining position.

A.B.

The Sarah Stallard Playchair

This laminated beech chair has nine seat heights and is suitable for 3 to 10 year olds.

We have tried out two of these chairs at a school for ESN 'S' children in York. They are very attractive and very easy to adjust. The seat slides in and out of the slots in the chair sides if lifted slightly. There is a holding groove on the underside of the seat to keep it firm when the child is sitting on it. The chair is useful for children who have fairly good sitting balance and have symmetrical posture. A mobile scoliosis could be dealt with by the addition of a wedged seat cushion. Anyone with poor balance would have difficulty because the chair is wide enough to allow an adult to fit into it. However, for those with developing sitting ability, the chair offers some support and the possibility of grasping the sides with the hands. If the child is very small and requires the seat to be positioned in a low slot, the head and shoulder are then afforded some support which could be useful.

The chair can also be used as a crawling tunnel or a rocker when turned over. A second chair can be used as a desk. Toys can be posted through the slots.

In my school the chair fitted underneath several school tables, provided they had no bars below. The curving sides of the chiar prevented more active children from escaping or sitting sideways on to the table. The degree of adjustablity allowed several children to be at the correct height for writing, for the first time.

The relative heights of school tables and chairs are so often incorrect and are order ed without reference to the class teacher or the physiotherapy staff. If you have problems in the school in which you work, these chairs may provide a solution.

Price - £85 (approx.) Contact: Stallard & Walker, 17 Back Lane, Bilbrough, York YO2 3PL

M.E.C.

Jenx Infant Prone Standing Board

This attractive prone-board fills a gap, in that it caters for the very young child (under 2 years) and can cope with a height variation from 440mm (17.5") to 760mm (30") from feet to axilla. The adjustable foot plates tilt to give a 60° range of dorsi/plantorflexion.

The board has been designed in conjection with therapists, to gain maximum efficiency and adaptability. In addition there is an optional abduction block, a base (with or without wheels) which allows 3 positions of tilt and a play tray. The board folds flat for storage and is portable.

Prices:	Infant Prone Standing Board	£114.00
	Free Standing Frame	£ 28.00
	Free Standing Frame on locking castors	£ 45.00
	Play Tray	£ 27.00

The workshop also produces wobble boards of various sizes and a junior standing board will shortly be available.

Prices:	Large wobble board	1800mm x 600mm	£ 38.00
	Medium " "	1200mm x 500mm	£ 35.00

Contact: Clive Jenkins, Sheffield Enterprise Workshop, Workshop 6, Oakes Green, Attercliffe, Sheffield S9 3MR. Tel. 0742 443878.

M.E.C.

* * * * * * * * * * * * *

EQUIPMENT

Unbreakable Mirrors

Lizard Designs are now stocking stainless steel mirrors in two sizes 9" x 18" and 12" x 36". The prices of £4.75 and £10.80 include p & p. pf £1.25 and £1.50 but are sent carriage free if ordered with other items.

Lizard Designs
35 Sunderland Street, Tickhill, Doncaster DN11 9PT

Game Time

Park and Playground equipment 1983 catalogue, also their newsletter.
Available from:

Roddinglaw Works
Roddinglaw, Edinburgh EH12 9DB, Scotland

Tel. No. 031 333 2222

No More Flats

A puncture proof tube for wheelchaird and bicycles has been manufactured by a firm in Horsham. The tube replaces the inner tube of a pneumatic wheel and is easily fitted into a standard tyre mounted on to the wheel rim, and is made of a special rubber compound. It costs £9.

Availabe from: Proudline Associates Ltd.
2 Percy Road, Horsham, West Sussex RH12 2JN

Tel. No. Horsham 0403 53652

Special Garments

From: Jo Thompson
56 Larkspur Terrace, Jesmond, Newcastle-upon-Tyne NE2 2DU

Jo Thompson, having studies fashion design at Newcastle-upon-Tyne Polytechnic, specialises in designing and making garments for problem figures. She has designed a range of garments specifically as play clothes for a spastic child which are especially recommended.

Scratch Me and Smell

Produced by Triman Ltd. Silice Road, Amington Industrial Estate, Tamworth, Surrey B77 4DT.

Tel. No. 0827 52131-2-3

This company produces a number of educational items and their catalogues contain interesting items to help develop the sense of smell especially in mentally handicapped children with visual problems.

Paperchase

A variety of defractive material is available from this shop. You can write to their Mail Order Dept., 213 Tottenham Court Road, London W1., enclosing 50p and ask for samples of:

Diffraction foil 6" wide - £1.06 per ft
$\frac{1}{8}$" squares, $\frac{1}{4}$" squares, $\frac{1}{2}$" squares - Wavey lines
fish scales, 1" circles
flourescent board 20" x 25" - 36p
foil board 20" x 30" - 45p

Melinex - makes a superb safety mirror
24" wide 100 gauge 64p per metre
24" wide 400 gauge £2.24 per metre
48" wide 400 gauge £4.47 per metre
48" wide 100 gauge £1.17 per metre

DID YOU KNOW

ABOUT - The Human Touch Information Leaflets

These leaflets are by and for workers concerned in the education of mentally handicapped children with little or no sight. They contain many excellent ideas for helping these children, book lists and helpful articles.

Back issues can be obtained from the RNIB - donations of £1 will go to help cover the cost of producing the sheets which are sent out three times a year.

ABOUT - A new car sticker - I USE A WHEELCHAIR - designed and produced by The Rev. Patrick Ralton and Michael Bishop a 21 year old ex police constable who was paralysed from the waist down after an accident. There has been general widespread concern about the excessive use and abuse of the Orange Badge Disabled Persons Parking Scheme. This has meant that Wheelchair users are sometimes denied facilities of access and parking. The aim of this new sticker is to create enough publicity to correct the misuse of the wheelchair motif.

The new badges are available for £1.00 from the Rev. P. H. Ralton, 2 St James Way, North Gray, Kent.

ABOUT - The Clinical Trial of Vitamin Supplementation organised by the Medica Research Council which starts on 1st April. The aim of the trial is to find out whether giving certain vitamins to women 'at risk' prevents their babies from developing neural tube defect. ASBAH is compiling a pamphlet of questions and answers about the trial which should be available soon.

If anyone wishes to discuss the Trial or find out more about it, please contact Miss Rosie Harstall, Disabled Living Foundation.

ABOUT - Motor Show for the Disabled

The Department of Transport is organising the first ever Motor Show especially designed to be of interest to disabled people. It is being held at the Transport and Road Research Laboratory at Crowthorne in Berkshire, May 19-21 1983. Disabled people will have the opportunity of seeing and test driving a wide variety of cars. Powered wheelchairs, vans, minibuses, hoists, hand controls and other equipment will be on show.

For more information contact

Yolandi Rizzi
Department of Transport
N19-14, 2 Marsham Street
London SW1 3EB

Tel.No. 01 212 5257

ABOUT - The Folk School's Material and Aids Research Centre

This centre (MARC) was established in Denmark in 1965 with the support of their Ministry of Education. The aim of the centre is to make materials and aids for special education which cannot be obtained through the usual channels for severely disabled children. The Centre issues regular information sheets on new materials and aids within the field of special education - there is now an English edition of this catalogue.

Further information can be obtained from Folkeskolens Materialelaboratorium
Ostre Kirkjeuj 4
DK 7400 Herning
Denmark

ABOUT - Centre for Studies on Integration in Education

The 1981 Education Act is coming into force in 1983 - this recommends the integration of handicapped children into mainstream education. The Spastics Society has established a Centre to promote good practice and to conduct research into and provide information on the process of integration. It plans to run projects, produce leaflets, hand books and information sheets.

For further information contact

Mark Vaughan
Centre for Studies on Integration in Education
The Spastics Society
12 Park Crescent
London W1N 4BQ

ABOUT - Chair Design

Two students on a one year course are examining the seating problems of children with spinal or head injuries following road traffic accidents. Their aim is to research and manufacture a chair which provides good body and head support and is adjustable for children aged 5-12 years.

They are requiring information from those working with such children to assess:-

1. What needs exist for this type of chair?

2. How is the problem being currently handled?

3. Is there any other research in this area?

All comments gratefully received by

J. Corderoy
M. Jersky
London College of Furniture
41 Commercial Road
London E1 1LA

ABOUT - The Association of Continence Advisors

This group was inaugurated in September 1981 - it is a multi-disciplinary group of health care professionals with a special interest in the promotion of continence and management of continence.

The Association welcomes therapists into membership and it is hoped many will join - at present the Association has predominantly nursing membership, but also includes doctors, bio-engineers, and clinical psychologists.

Further details from

Dorothy Mandelstom MCSP Dip. Soc.Sc.
Incontinence Advisor, Disabled Living Foundation
346 Kensington High Street
London W14 8NS

ABOUT - Conductive Education Interest Group

Newsletter No. 1 came out in September 1982. The group was formed on 10th July. 20 people attended a meeting at Castle Priory Collge. The aim is to promote knowledge, practice and quality of Conductive Education. Membership is open to individuals concerned with children or adults for whom C.E. might be of benefit.

Membership fee £5.00

The first AGM will be held in July 1983 in conjunction with a Conference/ Course. Steering committee includes Ester Cottong, Dorothy Seglow, Rowena Kinsman, Ann Smith. Also 2 headmasters, a teacher and an Ed Psych.

The group would like to know which schools/therapists are using CE for inclusion in the next Newsletter - Patterns of CE in the UK. They hope to produce three Newsletter per year. Membership fee £5.00.

Further information, publications list and copies or articles will soon be available from - Ingfield Manor School, Five Oaks, Billingshurst, West Sussex RH14 9AX.

ABOUT - Airborne Lead

90% of airborne lead is omitted at pram level, just where the most vulnerable age group is taking the air.

ABOUT - Cost to the DHSS of Mobility and Attendance Allowances

In 1981-82 the cost was £5 million and £12½ million respectively. Of these amounts £1¼ million and £4 million, respectively were paid to the examining doctors. (Figures given by Hugh Rossi in reply to a question from Alf Morris).

ABOUT - Free Toys!

Fisher Price have 3,00 toys to give away - mainly discontinued lines. Apply in writing, giving a few details to:-

Denise Doran
Fisher Price Toys
50 Upper Brook Street
London W1Y 1PG

ABOUT - Major Sporting Events for the Disabled 1983

Details can be obtained from:

Christine Edwards
3 Roblin Close
Stoke Mandeville
Aylesbury
BUCKS.

ABOUT - In the Spring 1983 edition of ARK - The Journal of the Toy Libraries Association, there is a very useful list of Toys recommended by their Advisory Panel. Especially to be recommended is the Number Turner produced by Susan Wynter Toys, price £3.75.

However, all the toys on this list would be helpful additions to any departmental toy cupboard.

HELP WANTED

1. We have received a letter from the Austrian Association of Bobath Therapists - it is in German. Could anyone offer to translate it?

2. From a letter of "Health Visitor" March 1983:

   A mother of a child with Downs Syndrome and Spastic Quadriplegia would like to contact another mother whose child has this particular combination of handicaps. If you can help please contact: The Editor, Health Visitor, 26 Eccleston Squire, London SW1 1FF

* * * * * * * * * * * *

AUDIO-VISUAL AIDS

NEW TITLES AUDIOVISUAL LIBARY

1. Sexual Counselling for Mentally Handicapped People, Their Parents and Care Staff - by Mrs. Ann Croft. Cat. Ref: 81-57

2. Music for Severely Mentally Handicapped Adults by Mrs M. Wood. Cat. Ref: 80-55

3. Needs of Disabled People by Prof. Cairns, Aitkin and Mrs Loreen Mackenzie. Cat. Ref: 81-52

Further information from :

Graves Medical Audiovisual Library
220 New London Road
CHELMSFORD
Essex CM2 9BT

1. Building Bridges : Movement for the Mentally Handicapped
   Veronica Sherbourne
   (shows movement sessions in an ATC and Subnormality Hospital)

From : Concord Films Council
201 Felixstowe Road
IPSWICH

COURSES DIARY

DATE		SUBJECT	ORGANISER/VENUE
JUNE 22	WED	Management of Duchenne Muscular Dystrophy	Mary Marlborough Lodge Nuffield Orthopaedic Centre OXFORD OX3
JUNE 22	WED	The Education Act:1981 Implications for Social Services Depts and Primary Health Care Teams	Conference Organiser National Childrens Bureau 8 Watney Street LONDON EC1
JUNE 23	THUR	Muscular Dystrophy	Demonstration Centre Sec. National Demonstration Centre Pinderfields Hospital WAKEFIELD
JULY 2-3		Movement and Arts in Therapy - Movement (led by Wolfgang Stange)	The Place The Sec 16 Flaxman Tee LONDON WC1
JULY 4-6	MON - WED	Growing Older as a Person with Cerebral Palsy	Course Organiser Castle Priory College Thames Street, Wallingford OXON OX10 OHE
JULY 7	THUR	Early Intervention for Handicapped Children: Medical Ethical, Social & Practical Issues	Conference Organiser National Childrens Bureau a/a
JULY 11-20	MON - WED	Current Trends in the care of Handicapped People in the U.K.	Castle Priory College a/a
JULY 12-15	TUES - FRI	Association of Professions for the Mentally Handicapped 10th Annual Congress: People first - living and learning together	Digby Stuart College London SW15 Details from: APMH 126 Allient Street, London NW1 7NF 01-256 6111
JULY 4 or 15	THUR or FRI	Childrens Equipment	D.L.F. 346 Kingsington High St. London W14 8NS
JULY 16	SAT	Activity Day	Castle Priory College
JULY 19-22	TUES - FRI	Learning, Loving and Living SPOD's 2nd International Congress	Christine Taylor 33 Grantham Road Chiswich, London W4 2RT
JULY 23-31		Laban Guild - Summer Workshop for Therapists	Therapy Workshop Ivy Cottage, Clockhouse Lane East Egham, Surrey

DATE		SUBJECT	ORGANISER/VENUE
AUGUST 19-21	FRI - MON	Teaching the Child with Cerebral Palsy to Use the Hands	Castle Priory College a/a
AUGUST 30 SEPTEMBER 2	TUES FRI	International Federation of Adapted Physical Therapy	Mr J. Biddle West London Institute of Higher Education, Borough Road, ISLEWORTH, MIDDLESEX TW7 5DU 01-568 8741
SEPTEMBER 11-13		National Rubella Association International Conference on Provision for the Deaf and Blind	NADBRH Centre 86 Cleveland Road EALING, LONDON W13 01-991 0513
OCTOBER 30	SUN	Active Autumn Conferenece & Exhibition: Communication not just aids	ACTIVE Toy Libraries Assoc. Seabrook House Willgotts Manor Darkes Lane POTTERS BAR, EN6 2HL

LATE ADDITIONS

DATE		SUBJECT	ORGANISER/VENUE
JUNE 15-18		International Symposium by International Cerebral Palsy Society	Centre Paul Dottin ASE1 Avenue Tolosane 31520 Ramonville St Agne, FRANCE
JULY 7	THUR	Parents and the Education Act	ACE/Spastics Society ACE 18 Victoria Park Square LONDON E2 9PB
JULY 18-22		Annual Refresher Course for Nurses and Physiotherapists especially 21st July - day on Cerebral Palsy in Children Exeter University	The Secretary J.E.B. 25 Mortimer Street LONDON W1N 8AB

A.P.C.P. NEWS

MISS ROSE DAWSON MCSP - RETIRING CHAIRMAN

An Appreciation

Rose, during her 3 years as Chairman (and also as Midlands Regional Representative) has lead the Association to its present strength. Among the changes that have occured during her time in office she has been especially involved in encouraging the developments in Post-Registration Education and (a great triumph) seeing the finalisation of our Constitution.

The children, patients and colleagues who have benefitted from Rose's concerned and devoted service to Paediatrics (both as a clinician and an educator) will surely wish to join with all Association members in wishing her a long, blissfully peaceful and happy retirement.

A.G.

CONFERENCE PROCEEDINGS

The 10th ARCP Annual Conference was held this year over the weekend of the 8th to the 10th of April amid the congenial surroundings of St Martin's College, Lancaster.

Dr Ian McKinlay, Consultant Paediatric Neurologist at Booth Hall Childrens Hospital, Manchester, and an honorary member of APCP, opened the conference by welcoming the delegates to Lancaster, and chaired the first session.

The first lecture, on Adverse Factors In Brain Development, was given by Dr W M L Turner MD, FRCP, DCH, DLO

He gave a resume of the many factors that can cause a baby's brain to fail to develop properly, particularly in the vital first 20 weeks when most of the neuronal development takes place.
Prenatal factors, both genetic and evnironmental, include alcohol, where as little as 2 drinks a day can cause foetal alcohol syndrome and severe damage. Maternal infections are still a major problem. Despite the energetic vaccination programme, the numbers of babies affected by Rubella syndrome have not dropped by very much.
Perinatal factors are numerous and well known - low birth weight, birth anoxia, haemorrhage etc.
Postnatal factors include accidental brain damage, anoxia from various causes and the well publicised and controversial pertussis vaccination damage.
Dr Turner posed the question of whether the modern habit of glue sniffing would in the future be proved to have an adverse influence on normal brain development. The lecture led to a discussion on the future of the very small 750 gram babies who are now surviving.

Dr J Sills, MB, BChir, MRCP, DCH, gave the second lecture entitled Non Accidental Head Injury

Awareness of nonaccidental injury has been steadily increasing since the 1940's when it was first brought to public notice.
Over the years attention has been focused on a widening spectrum of child abuse. Early concern over severe injuries - fractures and head injuries, has developed into concern for all kinds of child abuse including sexual and psychological abuse.

Brain development is very rapid from birth to 4 years old when the brain attains almost its adult weight. An injury in the early years can therefore have grave consequences.
Skull fractures and brain haemorrhages can obviously cause severe damage and it is very easy to damage a baby's brain. Before the neck is fully under the child's control, shaking can cause the head to oscillate wildly through 180 degrees and cause tearing of blood vessels and bleeding.
There is definite evidence that failure to thrive has a lasting effect on brain development. Such children are nearly always significantly delayed in their development and present such lasting problems as mental handicap and speech and language disorders.

Dr Sills concluded his talk by reminding us that the danger to the child is not necessarily in direct proportion to the severity of the injury. The minor bruise of today can be the major brain injury of tomorrow.

Computers for Communication - Mr R Bates, a teacher at the Lancasterian School in Manchester, closed the first session with a talk on the work being done with computers in his school.
Since the development of the microchip, advances in the microcomputer field have been very rapid.
Small individual microcomputers eg., The Commodore Pet, are easy to use in the classroom. They can be programmed so that the child can select up to 15 pages of work (or games) at will and can be left to work alone. As it is the teacher who provides the programmes, they can be tailored exactly to the child's and the teacher's requirements.
Both work and games are available to the child at all times to give him the chance to opt out of work and plan the use of his available time himself in the same way that a non handicapped child would do using conventional books, pen, and paper.
Work is going ahead to develop different types of input switches and print-out facilities are available so that children normally incapable of producing legible writing can arrange their work on the television screen and then print it onto paper by operating a single switch, producing neat presentable work often for the first time ever.
The emphasis must be on using commercially available equipment which is cheaper and therefore accessible to more people than expensive equipment specially developed for the disabled at great cost.
The future probably lies in battery operated portable microcomputers which are now being commercially developed and remote control input switches which would eliminate dependence on another person to set up the machinery.

Provision of computers at home and in F.E. Colleges must now keep pace with demand from young people leaving school and leaving their computers behind them.

Dr McKinlay closed the session with a call for computers to be available on prescription as wheelchairs and other equipment already are.

The second session, on Saturday morning, was chaired by Dr J V Dyer, Community Physician, Lancaster Health Authority.

Dr K P Murphy MA PhD, opened the session with a talk on audiology

Dr Murphy identified 3 aspects of response to sound,

Reflex
Hearing
Listening, which is the rarest and most prone to malfunction

Listening also has 3 components - hearing, attention and though, therefore anything which affects attention affects listening.

Often the children we deal with, particularly the profoundly multiply handicapped do not hear because they do not listen, their attention being totally focussed on other stimuli eg., smell, touch.

It was salutary to be reminded of the very high proportion of the children we see who have some kind of hearing difficulty.

75% of children receiving remedial teaching in normal schools have been found to have middle ear disorders.

Many children, although they have hearing in both ears, are functionally monaural because of imbalance and therefore incapable of distinguishing speech from background noise and the child who always hears badly ceases to listen.

A high tone hearing loss is very common in cerebral palsied children and even a small loss can cause great confusion in speech.

Dr Murphy concluded his talk with a review of the work he has been doing using vibration to train response in deaf/blind children. Seemingly deaf children have been taught to respond to sound and apparently to hear quite well once they have been taught to respond using vibration.

Miss M Howard M.Ed, MBAOT, spoke on Visual Perception in Children with Developmental Problems

Miss Howard defined perception as the meaning we give to sensation, our interpretation of our environment.

She gave a resume of all the factors influencing perception and stressed that it is a learned skill and highly subjective in nature. This makes it very difficult to test accurately and means that we can only judge perception difficulties by behaviour.

She went on to detail some of the problems experienced by children who have difficulties with perception. These can be as basic as finding different types of foot on a plate, and to give suggestions as to what we as therapists can do to help them, by careful analysis of their problems and our handling of them.

The third session was chaired by Miss Ann Grimley, Superintendent Physiotherapist at The Royal Manchester Childrens Hospital.

Dr K P Mogford LCST, B.Sc, spoke on The Effect of Being Handicapped on Developing Communication

Over the last 10 to 15 years there have been several detailed studies of communication between mother and child. These studies have tended to cast doubt on the effectiveness of using parents as therapists which has been the practice of most therapists and specialist teachers recently.

These studies have suggested that perhaps the least efficient way of dealing with parents of handicapped children is to give them specific tasks to perform with their child at home.

Perhaps we should be more concerned with training parents to understand and interpret their child's own attempts at communication or movement and to respond to them, rather than teaching them to intervene.

Dr Ian McKinlay closed the afternoon session with a talk on Family Counselling He stressed the need to find out exactly what people want to know and then tell them the answer as honestly as possible.

He also reminded his audience that families do not only consist of handicapped children and their parents, but that brothers and sisters often have just as many problems and worries about the situation, and need equally sympathetic handling.

An excellent conference dinner on Saturday evening, when we were reminded by the speaker Mr Geoffrey Barnes of Lions International, of the fellowship to be found at gatherings such as ours, was followed by the Kingston Marionettes, led by Mr Phillip Barton, District Physiotherapist, for Burnley, Pendle and Rossendale.

As their finale they performed a piece called "Hands" reflecting the work of physiotherapists particularly in paediatrics. If formed a most fitting end to the evening.

After the A.G.M. on Sunday Morning, the conference was brought to a close by a lively talk by Miss Cynthia Mason MCSP, GRSM, ARCM entitled "Heads for Rhythm". Miss Mason is a professional musician as well as a trained physiotherapist, and brings her love of music very much to bear in her physiotherapy work.

She impressed on her audience the importance of rhythm in all aspects of life and the ways in which we can all use rhythm and music in our work regardless of whether we consider ourselves "Musical" or not.

She concluded her talk by reminding us that every one of us has a flexible internal metronome, the heart.

M.S.

ANNUAL GENERAL MEETING - 10th APRIL 1983

ST. MARTIN'S COLLEGE, LANCASTER

1. The Minutes of the last A.G.M. were approved.

2. REPORT ON THE ADDRESS OF THE CHAIRMAN OF APCP

   Welcoming the Association's members, Miss Rose Dawson stated her pride in the honour she had presenting the Chairman's Annual Report at this, the tenth AGM of the Association. It marked a particular milestone in the development of the specific interest group within the Chartered Society of Physiotherapy.

   Miss Dawson reviewed the formation and progress of the Association from its inception by an interested group in Birmingham in 1972, through the election of a Steering Committee by 100 members at the Hospital for Sick Children, Great Ormond Street in 1973, to the first annual general meeting and conference at Salford in 1974. Then followed an illustrated review on the themes and venues of all subsequent annual conferences.

   Miss Dawson continued her report by stating that the traditionally high standards of the Association's conferences were being upheld in Lancaster. This weekend being, as in previous years, a credit to the Regional Committees who design and mount such events.

   Miss Dawson then reviewed the work of the Association. In past years it had commented, for the CSP, on the Jay Committee Report on Mental Handicap, the Warnock Commission on Special Education, the Court Report

on Child Health Care and, more recently, the Education Act 1981. Many members have, in some way or another, become involved with the Open University. Miss Dawson reported that, this year, the Executive had met with DHSS Officers to discuss and clarify the role of the Paediatric Physiotherapist and this Association.

Miss Dawson was sad to report that, because of ill-health the Vice-Chairman Mrs Anne Murdoch, had had to retire from office. On behalf of the Association, Miss Dawson wished to thank Mrs Murdoch most sincerely for her services and able support not only as Vice-Chairman but also when, as Regional Representative she worked so hard to establish the Association in Scotland.

Miss Dawson paid tribute to the enthusiastic and unstinted services given to the Association by the retiring PRO, Miss Elizabeth Carrington, stating that we will continue to benefit from the many contacts, nationally, inernationally and interdisciplinary, that she has established. In addition to this, Miss Carrington has, almost single-handedly, produced our admirable newsletter since 1979. This has become established as a reliable and excellent reference for appliances, aids and equipment and also information exchange. Members were urged to put pen to paper and let others know of particular aspects of their work via the newsletter. (The members present gave long and loud applause in tribute to Miss Carrington).

Miss Dawson commented on other changes in the National Committee. The secretarial difficulties of the past year were reported. Thanks and good wishes were expressed to Mrs Pamela Nichols (who succeeded Miss Cynthia Mason as Hon. Sec. in 1982) as, unfortunately, she had had to resign office because of ill-health; and also to Mrs Pamela Charon who, not only temporarily stepped into the breech, but upheld the splendid traditions and excellent practices established and maintained by previous Hon. Secs. The comprehensive procedures book compiled by Miss Mason continues to prove invaluable.

Mr Jerry Harris retires from the Committee this year. The Chairman congratulated him on the work he has done for APCP Publications and thanked him for his commitment to this important part of our function. The latest publication is "Serial Splinting in Hemiplegia". In looking to the future, Miss Dawson commented on the need continually to review our publishing policy so that we are meeting th e needs of the membership. A working party of 3 committee members was convened to prepare a feasibility study on changing the format of our present newsletter (see February newsletter). Members comments are welcomed.

Mrs Pauline Kay retires as a committee member and Membership Secretary. She was thanked for her services in these capacities.

The work of the Education Sub-Committee was commented on and the members of the Sub-Committee and others co-opted to help and advise, were thanked for their hard work in this area.

Mrs Penny Robinson, a committee member, was congratulated on her appointment as Professional Adviser at CSP. She was also thanked for the work she had don in revising the Constitution of the Association.

Mrs Sandra Hold, the Hon. Treasurer, was thanked for her efficiency and fiscal skills in keeping our affairs in order. The Chairman noted the importance making the Teasurer's task less onerous by paying membership fees on time.

As retiring Chairman, Miss Dawson thanked the Committee and the membership for their support and offered every good wish to her successor.

3. TREASURER'S REPORT

There are now 5 regional accounts all of which go for audit with the main accounts. The balance sheet is derived from all of these.

You will see from the balance sheet that the income of £14,725 was approx. £2,000 less than last year.

There were 758 paid up members of 1982, 141 of whom were new members. We hope that these people who did now renew their membership in 1982 will do so in 1983.

All regions made a profit on courses held throughout the year. I would like to thank all those involved with course organisation for their hard work. It should be noted that income from subscriptions did not even cover administration costs so we are still relying heavily on profit from courses.

Expenses for the year actually fell even though there was a rise in administration costs. You will see that this is accounted for by the drop of £4,000 in lecture fees and accommodation expenses. Income from courses also dropped by about £4,000 so these 2 figures cancel one another out (there were obviously less people attending residential courses therefore accommodation expenses were less).

Net profit of £2,517 was only £500 less than last year so we have had 2 good financial years.

The Building Society balance is now £8,470 and we have on the basis of this decided to finance 2 new ventures:

A year book of conference proceedings. The first of these containing last year's conference lectures will be circulated to members within the next 2 months.

Secondly a sub-committee have considered the feasibility of producing a journal to replace the existing newsletter. This will obviously cost more than the present format and we have decided to finance this without an increase in the subscription rates.

Sandra Holt
Hon. Treasurer

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

SUMMARY OF ACCOUNTS for the year ended 31 December 1982

INCOME	1982	1981	EXPENSES	1982	1981
Courses	7,278	11,156	Lecture fees & Accommodation	4,198	8,269
Book Sales & 1982 Stock	4,011	2,509	Book Production & 1981 Stock	3,020	2,758
Subscriptions	2,274	2,294	Committee Expenses	1,240	1,184
Building Society Interest	659	382	Administration	3,437	1,481
Sponsors & Sundry	503	454	Corporation Tax	313	78
			Surplus	2,517	3,025
	14,725	16,795		14,725	16,795

ASSETS	1982	1981	LIABILITIES	1982	1981
Office Equipment	26	31	Creditors	195	185
Stock of Books	2,539	1,594	Corporation Tax	-	78
Banks & Cash	1,829	1,104	Balance from 1981	10,152	7,127
Building Society	8,470	7,686	Surplus for 1982	2,517	3,025
	12,864	10,415		12,864	10,415

4. POST REGISTRATION EDUCATION REPORT

We are pleased to be able to report developments and would like to thank those people who have worked so hard to ensure progress in this area.

The "Introduction to Paediatrics" course pilot scheme, based in the North East, has now reached the stage of arranging for speakers timings and, possibly, Regional funding.

The Post-graduate Diploma development team are now working on the basis that the objective of the diploma course will be to provide an academic background to support and enhance the practice of those physiotherapists taking the course. It is envisaged that the greater part of the 150 hours available for the paediatric module will include normal child development patho physiology and the communications skills appropriate to paediatric physiotherapists practice. In common with the neurology module, we do not feel that the teaching of practical skills is a necessary part of this particular course.

We are pleased to see that other groups are helping the development of the paediatric physiotherapist eg., the recent course at Great Ormond Street and the forthcoming one at Charing Cross.

We ought to restate our commitment to the Regional Study Day Programmes - we cannot overestimate their value in maintaining interest in our field and also the part they play in one's personal continuing education process. Linked with this is, of course, the newsletter as a major educational, as well as informational, input. Individuals may find it even more valuable if they investigate the many avenues it presents for broadening and deepening one's knowledge by, for example, using local medical library resources to follow up the references given.

I would like to end with what is, we hope, a starting point. The Report of the Review Committee published in Physiotherapy - March 1983, does, despite caveats, give us validation for our striving to be recognised by our parent body as specialists. Of the 1439 questionnaires received, 486 ie., 33% considered that Paediatrics were already an established speciality; that is a patient orientated specialisation concerning special approaches in assessment and, by extension, management of our particular client group.

In Paediatrics the massive growth in medical research and related sciences, including behavioural sciences implies that, as we are concerned with the clinical expression of such phenomena we will need a strong educational foundation that will enable us to assimilate and exploit these insights.

I think that we ought to consider carefully and foster our relationships with the generalists, other specialist groups and our colleagues in the pre-graduate field. At the same time we should be standing out strongly for a belief that Paediatrics <u>is</u> a specialist field and as such, practitioners once committed to it, should not be expected to maintain their generalist skills to any great degree.

Finally should we <u>always</u> look to organised courses as a way of developing within our speciality. There are many other models of specialist training which we will be examining in the coming year to assess their relevance to our needs.

Marion S. Whyte
Chairman - Education Sub-Committee

5. CONSTITUTION

The Hon. Treasurer presented the third draft of the Constitution to the meeting. After an amendment so that associate members would be ineligible for election to the National Committee the Meeting approved the adoption of the Constitution. (The Hon. Sec. holds a copy of the Constitution whic is available to members on application).

6. The following members were elected to the National Committee:

Mary Clegg
Maggie Diffey
Ann Grimley
Linda Haanrads
Noreen Hare
Jeanne Lamond

NATIONAL COMMITTEE APRIL 1983

CHAIRMAN:	*Miss Ann Grimley	Royal Manchester Childrens Hospital Pendlebury, Manchester
HON. SEC:	Mrs Maggie Soper	Northfield School Beckfield Lane, Acomb, York
HON. TREAS:	Mrs Sandra Holt	Elizabeth Fry School Suffolk Road, London E13
P.R.O:	*Miss Noreen Hare	Cheyne Centre for Spastic Children 61 Cheyne Walk, London SW13
CHAIRMAN ED. SUB-COMM:	Mrs Marion Whyte	Community Health Services 97-99 Bow Road, London E3
VICE-CHAIRMAN ED. SUB-COMM:	Mrs Pam Eckersley	Lancasterian School, Elizabeth Singer Road, Didsbury, Manchester
NEWSLETTER EDITOR:	Miss Gill Riley	15 Tragail Mercier Road, London SW15
PUBLICATIONS SECRETARY:	Miss Morag Booth	Raeden Centre Midstocket Road, Aberdeen
COMMITTEE MEMBERS:	Mrs Celia Ball	Brockhall Hospital Old Langho, Nr Blackburn, Lancs
	*Mrs Mary Clegg	Childrens Unit - Wordsley Hospital Stourbridge, West Midlands
	*Ms Maggie Diffy	Jenny Lind Unit Norfolk & Norwich Hospital, Norwich
	*Ms Linda Haanrads	Child Development Unit - Peterborough District Hospital, Thorpe Road, Peterborough
	*Mrs Jeanne Lamond	Physiotherapy Department, Royal Albert Hospital, Lancaster
	Mrs Penny Robinson	46 Heathfields, Eight Ash Green, Colchester, Essex

REGIONAL REPRESENTATIVES:

SCOTLAND:	Miss Morag Booth	Raeden Centre Midstocket Road, Aberdeen
NORTH-WEST:	Mrs Maureen Down	Lancasterian School, Elizabeth Singer Rd. Didsbury, Manchester
NORTH-EAST:	Mrs Maggie Soper	Northfield School Beckfield Lane, Acomb, York
MIDLANDS:	*Mrs Minnie Tarry	Paediatric Assessment Unit, Leicester Royal Infirmary, Leicester

* - new Committee member

WALES:	Mrs Wendy Williams	The Childrens Centre University Hospital of Wales, Cardiff
LONDON:	Miss Gill Riley	15 Tragail Mercier Road London SW15
EAST ANGLIA:	Mrs Patricia White	Richard Cloudesley School Golden Lane, London EC1Y
SOUTH-EAST:	Miss Shirley Raymond	Coney Hill School, Croydon Road, Hayes, Kent
SOUTH-WEST: (acting)	Miss Tess James	Child Development Unit, Damers Road, Dorchester, Dorset

REGIONAL REPORTS

Scotland

Reg.Rep. Miss M. Booth, 210 Union Grove, Aberdeen AB1 6SS.

The Halliwick Course was very successful and the "Paediatric Intensive Care" Course in Edinburgh is fully booked.

The February Newsletter carried an inclusion with the names of the new Regional Committee members.

North East

Reg.Rep. Mrs M. Soper, 29 Garth Terrace, Buston Stone Lane, York

A very successful day course was held on Saturday 10th April when Miss Sophie Levitt presented a day on assessment (approximately 100 people attended). The Regional A.G.M. was held on the same day and 1 new member was elected to the regional committee.

The next evening meeting will be held on 13th June at York District Hospital, Wiggington Road, York.

Miss M. C. Carrington, Superintendent Paedistrict Physiotherapist, York District Hospital, will speak on the use of vibration in treatment.

North West

Reg. Rep. Mrs M. Down, 62 Swann Lane, Cheadle Holme, Cheshire

The Regional A.G.M. was held at Whiston Hospital, Liverpool and over 50 people attended (much higher than in previous years). Many ideas for future meetings were received for which we are grateful. The members felt that the present Newsletter content was excellent and queried the need for change. The present nine Regional Committee Members continue in post as there were no proposals for new members received.

The A.G.M. was preceeded by a very interesting lecture on various aspects of Congenital Talipes Equino Varus presented by Mr Dorgan, Orthopaedic Surgeon and Mrs Raffle, Physiotherapist.

We have 119 people booked to attend the National Conference in Lancaster and look forward to a stimulating weekend.

South West

Reg.Rep. (acting) Miss T. James, 10 Frome Terrace, Dorchester, DT1 1JQ

The next meeting and A.G.M. is to be held at Poole on Friday 8th July. The topic for the day is "Childrens Hips and Feet".

Details from: Mrs J. Foley MCSP
Physiotherapy Department
Poole General Hospital
Poole
Dorset

South East

Reg.Rep. Mrs S. Raymond, 53 Gates Green Road, West Wickham, Kent

There have been 2 very well supported study days this year - those attending found them very helpful and interesting. The first, at Canterbury, considered different techniques for the treatment of children with C.P. Four speakers gave an outline of their particular technique which led to a lively discussion time. The second, at Brighton, considered the may aspects of the Clumsy Child and how the Physiotherapist can help.

October 15th 1983 - Dr J. Martin will demonstrate Halliwick Swimming at Thos-de-la-Rue School, Tonbridge, Kent.

Details from Mrs Raymond.

London

Reg.Rep. Miss G. Riley, 15 Tragail Mercier Road, London SW15

Much interest was raised from our March Study Day on Sensory Deficit - a further day is being planned on Sensory Integration.

The Regional Committee are very concerned to introduce a wider coverage of Paediatric Care as is possible; also about communications between the large membership and the committees. A Regional Newsletter had been introduced and discussion is encouraged and facilitated by planning our Study Days so that all those attending have lunch togethor.

Next Study Day: Childhood Asthma - June 18th 1983
Hemsworth Hall, Northwick Park Hospital

Course Organiser - Grace Borg

Programme in brieg:-

a.m.	Childhood Allergy The Wheezy Child	Dr John Warner, Consultant Paediatrician, Brompton Hospital
Lunch	Trade Exhibition	
p.m.	The Role of the Physiotherapist in Childhood Asthma Miss D Gaskell, Superintendent Physiotherapist, Brompton Hospital A Trial into Movement and Exercise with Asthmatic Children - Miss D Coggins, Queen Elizabeth Hospital, Hackney	

Application forms from:

Mrs M Gilbert
105 Swinderby Road
Wembley
Middlsex

East Anglia   Reg.Rep. Mrs P. White, 24 Maltings Drive, Wheathampstead, Herts.

We had a successful evening meeting on 15th March, at Harperbury Hospital, when Miss Mehta, Consultant Orthopaedic Surgeon at The Royal National Hospital, Stanmore, gave a most interesting talk on Infantile Idiopathic Scoliosis - prevention and treatment. It is hoped that Miss Mehta will be able to talk to us again in March 1984, perhaps on surgery for scoliosis and aftercare. We hope to have a talk from David Scrutton in the Autumn 1983, perhaps on Hip Surgery and aftercare.