



NEWSLETTER

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EDITORIAL

The campaign for 1983 by the Chairman of the Chartered Society of Physiotherapy encourages recognition of professional excellence and conduct by the public and other health professionals through consistent titling of oneself as a Chartered Physiotherapist.

It is noteworthy that many of our members are personally known, locally, nationally or some known internationally for their professional excellence and highly regarded for their knowledge and therapeutic skills specific to paediatrics.

Unstintingly, such therapists share their expertise with members and with colleagues from many other disciplines coupling this with provoking discussion on appropriate theory, research, reading and offering supervised practice.

These gifted persons are truly specialists or consultants in one or more of the various aspects of paediatric physiotherapeutic practice.

Not all of us are determined nor designed to be high flyers or leaders in this way but, it behoves all who aspire to be recognised as paediatric physiotherapists to constantly update their theory and evaluate their practice in this developing speciality at which ever level is personally appropriate.

Members of the Association of Paediatric Chartered Physiotherapists should identify such excellence as well as personal and local professional needs for their Regional Representatives to carry to and from the National Committee.

Ideas, requests for guidelines and such on postgraduate education, training or other professional needs will, when shared amongst our advisory or working groups for action, eventually benefit the children, families and profession which we serve.

Discussion and sharing through letters and articles written to this Journal will assist such interchange or dialogue.

For local or personal needs to be met, local and personal energies need to be expended. Too many members (and non members and lapsed subscribers!) rely constantly on the initiative, goodwill and dedication of one or two local concerned members of their Regional Representatives. It is needful and healthy that they should offer service to the Association and Physiotherapy as well as constantly taking from them.

This specific interest group within the Chartered Society of Physiotherapy evolved over ten years ago from a local (Midlands) group of therapists with a healthy professional self evaluation and search for knowledge and sharing of skills appropriate to the practice of physiotherapy in the speciality of Paediatrics. As members of the Association we cannot afford to ignore the need for personal and professional growth through acquisition of knowledge as well as theory and practice in application of appropriate therapeutic skills.

As members of this Association it behoves us to identify, demand and support, locally, regionally and nationally such introductory and advanced courses as may be offered for physiotherapists in paediatric practice.

One hopes, that in the future, to state that one is a Paediatric Chartered Physiotherapist shall be synonymous with high professional and ethical standards as well as excellent practice in therapeutics specific to Paediatrics.

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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
22, Whernside Road
Lancaster LA1 2TA
Lancs.

ARTHROGRYPOSIS MULTIPLEX CONGENITA

ORTHOPAEDIC MANAGEMENT

Arthrogryposis multiplex congenita literally means a child born with multiple curved joints. As such it is purely a descriptive term and not a diagnosis. A number of conditions such as sacral agenesis and congenital muscular dystrophy can produce an arthrogryptic appearance of the limbs in a child but should not be called true arthrogryposis. The condition was first described by Otto in 1841 and the first detailed description in the English literature was by Sir. Wilfred Sheldon in 1932. It is a rare disorder and in the Edinburgh birth register from 1964 - 1968 only one case occurred in 52 thousand births. However, a recent survey by Wynne-Davies in 1981 showed that there appears to have been an increased incidence of the condition in the late 1960's and it seems to be particularly common in Australia.

The aetiology is unknown and the condition is not progressive. In cattle and sheep a similar disease is caused by the Akabane virus which causes anterior horn cell degeneration in the spinal cord. Immobilization of the baby in utero may also be a feature. Mothers frequently say that the baby was unusually inert in utero and there is a case recorded in which a mother, who developed tetanus with severe muscle spasm was treated with the muscle paralyzing agent Curare, and gave birth to an arthrogryptic baby. The number of anterior horn cells in the spinal cord has been shown to be reduced in arthrogryposis. There does not appear to be any evidence to suggest that there is a familial tendency to this condition.

Any child born with the characteristic stiff deformed joints, tubular limbs with a lack of skin creases at the joints and deep dimples over the bones should be thoroughly investigated for the other possible causes of an arthrogryptic appearance. Investigations should include x-ray of the whole spine, pelvis and involved limbs, chromosome studies, estimation of the creatine phosphokinase level to exclude muscular dystrophy, electromyography and if necessary muscle biopsy and a CT scan of the brain. In order to make the diagnosis most doctors would like to see the features of the disorder in all four limbs but sometimes it can be seen in only the upper or the lower limbs. These patients should be looked at particularly carefully for a differential diagnosis. Once the diagnosis has been established it is important to emphasize that the disorder is not curable but on the other hand it is not progressive. However, deformity tends to increase and recur with growth. It does not affect the sensory system but the motor system is defective and many muscles and tendons may be fused or even absent.

The aim of orthopaedic treatment is to help the child achieve maximum function from his limbs. It is most important that the joint deformities should be treated by passive stretching from birth. This is done by the Physiotherapist who can instruct the parents in the stretching exercises which should be done several times a day. Initially this often appears useless but it is surprising how some apparently rigid deformities can respond to this treatment. Splintage with plasters or moulded splints is also used, to maintain the correction once it has been achieved, and to prevent further deformity.

In the lower limbs the aim is to correct all the deformities which would prevent walking by the age of 12 - 18 months when the child would normally be expected to walk. These children are quite remarkable in their ability to cope with their handicap, and nearly always seem to be very well motivated both mentally and physically.

The deformities in the lower limbs are frequently multiple and have to be treated in the right order and in relation to each other. When stretching the feet in a small baby it is usually necessary to flex the knees to control the feet. Once the maximum correction in the feet has been obtained then attention can be paid to the knees. Usually the problem is one of fixed flexion although occasionally they can be fixed in extension. Stretching in serial plasters and lying prone to treat the associated hip flexion is very useful in the child under

the age of one. If the child has a hip dislocation it will rarely if ever respond to conservative measures. A unilateral dislocation should be treated by open reduction and femoral or pelvic osteotomy at the age of 12 - 18 months provided the child is otherwise developing normally. Almost invariably following reduction the hip remains stiff with limited movements. Therefore if the child has bilateral dislocation of the hips it is very much better to leave the hips in the dislocated position, and retain some movement, as operation will not improve the situation and will often make it substantially worse. In these children flexion deformity at the hips is the main problem. Initially this can be treated by prone lying and stretching. Often muscle release operations will be necessary and sometimes femoral extension osteotomy when the child is older. It is rare for the feet to correct completely with stretching. Soft tissue operations releasing the tendons behind the heel will sometimes produce correction for a period of time which then recurs. In these feet removal of the bone immediately below the ankle joint, so called talectomy, is very useful in producing a planti grade but stiff foot. Once the lower limbs are reasonably corrected it is vital to continue splintage if possible for the rest of the child's growing life. The problem is that the stiff unyielding muscles and tendons do not stretch normally with growth and all the deformities tend to recur. Repeat surgery is often necessary. Splints or orthoses are usually worn for support and to maintain correction. Night splints should be continued for as long as possible provided the child is comfortable in them and they are controlling the legs satisfactorily. Near maturity bony procedures are often necessary but great care should be taken to avoid correcting flexion deformities of the knee by a supracondylar osteotomy early in life as this can produce a severe and increasing deformity with growth.

In the upper limbs it is essential to consider the whole limb as a functional unit in relation to the activities of daily life and to the other limb before correcting any one deformity. For instance if there is fixed extension at both elbows one elbow should be left in extension so that the arm can still be used in extension for pushing out of a chair, using a crutch or to reach the anal region. The combination of one elbow which flexes to the mouth and one which extends strongly is a good one whereas the combination of two flexed elbows, neither of which can extend actively, is very bad. The shoulders are often weak and this may determine the whole pattern of upper limb movement. Commonly internal rotation develops at the shoulder and sometimes a simple external rotation osteotomy of the humerus can be very helpful in putting the forearm and hand in a much more useful position. Flexor power at the elbow can be increased by various muscle and tendon operations but this should always be planned in relation to the child's functions as previously stated. Fixed flexion of the wrist is very common and is often quite useful in bringing the hand nearer to the mouth when associated with limited elbow flexion.

Attempts to straighten the wrist during the growing period tend to fail unless combined with vigorous splintage which often gets in the way of function. Near, or at maturity fusion of the wrist can be done, particularly for cosmetic reasons. Operations on the fingers are usually useless. The fingers tend to be curved, hypo-plastic and there is little, if any, chance of improving function unless one finger is grossly deformed or getting in the way of others. Occasionally the thumb is fixed in adduction into the palm and release of this adduction contracture can be helpful. Many of the children will need to use crutches and calipers or orthoses. Despite this they are usually very rewarding to treat and make the best of any procedure which they find is of benefit to them. It is most important that their deformities are looked at as a whole, and not separately in relation to function, and not specific movements. Finally, prolonged splintage after correction of deformities seems to be necessary during growth because of the persistent tendency to relapse with growth.

* * * * *

THE OXFORD PAEDIATRIC COMMUNITY PHYSIOTHERAPY SERVICE

Selena Furth, Superintendent Paediatric Community Physiotherapist

The purpose of this paper, which is based on a report covering 1981/82, is to provide information on the work of the Paediatric Community Physiotherapy Service which has been evolving to cope with changes over the past few years. These changes include alteration in ages and conditions of patients referred, alteration in educational policy for handicapped pupils and increasing team work among the professions working with chronically disabled children. The paper also shows why there is still a priority scheme for allocation of physiotherapy time.

EXPLANATION AND ANALYSIS OF ACTIVITIES CARRIED OUT WITH PATIENTS

The eventual aim of physiotherapy is for the child to become as functionally independent as possible. Table A shows the various activities carried out with the patients and the number of sessions for each activity.

TABLE A

NUMBERS OF PERIODS SPENT ON VARIOUS PHYSIOTHERAPY ACTIVITIES 1.4.81 - 31.3.82

	<u>No. of sessions</u>
Assessment	192
Treatment	4584
Assessing and adapting equipment	272
Advising	594
Riding for disabled	187
Hydrotherapy and swimming for disabled	126
Visits with child to special clinic (e.g.London)	8
Visits to a local hospital or clinic re a child	17
Case conferences	62
Reports on a child	190

Assessment and periodic reassessment is carried out for every patient referred to the service and if required, for the patients at the two assessment centres. Assessment is necessary to decide if physiotherapy could be useful and if so, what form the treatment should take.

The majority of sessions (4584) were spent in specific treatment which could involve a variety of activities as appropriate to encourage the child to use his abilities at the developmental level he has reached as normally as possible and to prepare for more advanced activities.

Many sessions were spent on teaching and advising teachers, parents and other therapists on the handling of a specific child. The "equipment" sessions were spent designing or trying out various pieces of equipment for use at school or home. Children with neurological disorders have very individual problems and standard equipment frequently requires to be adapted.

As can be seen, from Table A, the treatment of some children was carried out in water. Swimming and riding for the disabled sessions have a value both as therapy and education for leisure.

Seventeen clinic visits were made with individual children. A few children were accompanied to the Bobath Centre for physiotherapy advice and to the Hammersmith Hospital. Clinic and special centre visits are time consuming but valuable for the management of a specific child as well as improving the therapists general understanding and treatment skills.

CONDITIONS TREATED

The majority of patients had neurological conditions of muscle diseases. These conditions are liable to severely affect the child's function. Several professionals, medical and educational, community and hospital based, may be involved with each child. It is important for the physiotherapist to retain contact with the rest of the team helping the child. This involves meetings and report writing (Table A). The present type of case load requires more physiotherapy time than the treatment of postural problems which are more likely to improve with maturity and normal school activities. Some of the physiotherapists were originally employed to treat mainly postural problems but these now only account for 2% of the case load.

TABLE B

Ages of Children Being Treated (1.4.81 - 31.3.82)

	<u>No. of children</u>	<u>%</u>
Aged above 5 years on March 31st 1982	206	71%
Aged below 5 years on March 31st 1982	84	29%
Total children	290	

AGES OF CHILDREN TREATED

Table B shows that the case load now includes 29% of children below the age of five years. It is encouraging that young children and babies are now being referred. The severely handicapped can be more helped by physiotherapy before they become habituated to their abnormal movement patterns and before deformities become fixed. In general this age group requires more treatment time than the older child. Also the families and playgroup leaders and teachers require more help and advice while they are learning how to manage the child.

TABLE C

Site of Treatment (1.4.81 - 31.3.82)

	<u>No. of children</u>	<u>%</u>
Special school or playgroup	140	48%
Normal school or playgroup	72	25%
Home	66	23%
Bradwell Grove Hospital	7	2%
Park Hospital	3	1%
Clinic	2	1%
Total children	290	

SITE OF TREATMENT

Oxfordshire Education Authority has been implementing some of the recommendations of the Warnock Report for some time: Table C shows that 25% of the case load now attend normal schools or playgroup. Presumably this proportion will be maintained or possibly increased after October 1982, when the 1981 Education Act comes into force. It requires more physiotherapy time to make arrangements for individual children at scattered normal schools than for a group of children at one special school. It is usually necessary to teach school staff with little experience of handicap how to handle the child and his equipment and to recommend and provide the equipment. It is especially useful when the physiotherapist knows the child before he starts at the school so that she can ensure the school and the child are prepared for each other. It may involve adaptations to the school in conjunction with the occupational therapist.

Most children treated at school also receive periodic home visits and treatment during the holidays when necessary. Table C shows that 23% of the case load are treated only at home. With chronically disabled children it is important to teach the family how to handle the child and the child how to function to his maximum in his own surroundings.

TRAINING PROVIDED BY THE SERVICE

- a) The service continues to provide a speaker for the regular Handicap Awareness Courses run by the Oxfordshire Education Authority for teachers in normal schools (4 lectures this year).
- b) Other lectures include those to teachers aides in normal schools as part of the course at Mary Marlborough Lodge, to C.S.P. Oxford branch The Radcliffe Infirmary physiotherapy staff.
- c) Introduction to physiotherapy for children for community physicians employed at HEPAC on rotation basis. This includes discussion and visits to schools and homes to illustrate the work.
- d) More specific help with the treatment of paediatric patients for the basic grade physiotherapists rotating from the Churchill Hospital.
- e) Talks to helpers at Riding for Disabled groups.

STAFF HOURS AND TRAINING

There are normally 9 people employed, which represents 4.8 W.T.E. during school term-time and 3.0 W.T.E. during school holidays. Two of the full-time staff are chiefly employed by the Churchill Hospital Sector and the rest by the Community Sector.

Staff training is particularly important in a service where the nature of the case load is altering and at a time when approaches to the treatment of paediatric patients are developing and expanding.

SUMMARY

Physiotherapy for paediatric patients involves a variety of activities including specific treatment, advice to families and schools, assessment for and provision of equipment, hydrotherapy and riding for disabled. Total number of sessions for each activity are included.

The majority of children being referred have neurological or muscle conditions requiring extensive and long-term help. Younger children and babies are being referred. This is welcomed as these children can be most helped.

More children are treated at home. Severely disabled children are treated at special schools but more of these children are treated at normal schools. Physiotherapists are important members of the team, helping disabled children at ordinary schools and often form a link between educational and health and community and hospital authorities.

Members of the service are involved in training other professionals working with handicapped children. Education of the physiotherapists is considered especially important at this time when there is alteration in the ages and conditions of patients referred and progress in the treatment approaches currently employed by paediatric physiotherapists.

INSTRUMENTATION - THE POLYGON

In a recent article A. Minford and others used the Polygon to monitor the gait of 46 normal children aged 4 - 15 years. Although the gait appeared normal on observation, asymmetry was found, predominantly more flexion of the right leg in 50% of the children under 10. Flexion of both limbs during all phases of the gait cycle was significantly greater in the children under 10 years, but becomes progressively less marked as the child matures.

Clinical examination showed asymmetry in several tests in one third of the whole group, but this did not correlate with the gait asymmetry. Although the findings suggest a possible relationship with dominance was small and so this possibility remains to be tested. The parents of only 4 children could remember persistent head turning to one side in infancy, and there was no relationship demonstrated. The relationship between this factor and asymmetry of gait was previously shown to disappear by the age of 3 in other studies. Recent investigation on anatomical and developmental asymmetry is discussed well and the authors present this paper as part of the evidence that maturation occurs asymmetrically.

The Polygon has been used to assess limb angles during gait for several years. Light weight optical sensors are attached to the subjects' leg, above and below a joint. The d.c. voltage from each sensor is proportional to the angular displacement as the subject works across a beam of polarised light. These outputs drive a pen recorder, and it can be used in several ways. This particular study monitored the angle of the thigh and calf, and the knee angle being the difference between the two, but the hip and ankle could also be assessed, though with more difficulty. The graphical representation is recorded on squared paper, so that a statistical analysis can be made of the angles during the gait cycle. It is possible to compare the two limbs, by recording simultaneously. There is a recognisable and reliable pattern of recording for each joint, especially at a slow speed and any deviation from the normal is easily seen. Whilst this equipment is not available in most Physiotherapy departments, the potential use for assessment before and after specific treatment regimes, or before and after surgical intervention, can be readily appreciated. Orthopaedic departments and medical schools often have Polygons and sometimes can be persuaded to cooperate in investigations; with a little training the results are reliable and Physiotherapists will find that the Polygon is a useful evaluative tool.

1. MINFORD A., MINNS, R & BROWN J.

Asymmetry of gait in normal children demonstrated by polarised light goniometry. Child: care, health and development 2 97-108.

2. GRIEVE D. (1969) THE ASSESSMENT OF GAIT. PHYSIOTHERAPY 6 55 452-60

MARGARET SCHOLEY MSc MCSPT DipTP.

CYCLES FOR CHILDREN WITH HANDICAPS

When working in a Toy Library I was frequently asked about bikes and trikes for handicapped children. Since I knew very little about the subject I looked for information and couldn't find much. Eventually I collected a file of information and a little experience, then realised with astonishment that I was becoming regarded as a bit of an expert. Here is the article that I wish I had found in those early days so you too can become an expert!

Most children have the use of some toy to push and ride on from their first birthday or Christmas. Mostly they play with them indoors at first, propelling them by pushing their feet on the ground and using them to learn all sorts of ways of movement.

Peddalling is not usually mastered until a child is nearly three years old. Some can do it earlier but it takes practice, strength and good co-ordination. It is easier to pedal with a fixed gear - when the pedals are turned the wheels turn. Trikes for this stage usually have the cranks and pedals mounted on the front wheel itself, can be pedalled in reverse too, and braked by the feet on the pedals. Children at this stage can become very expert at manoeuvring and enjoy exploring their environment on wheels. They range round in a fairly small territory and often involve the cycle in various kinds of imaginative play.

Chain driven cycles usually free wheel. The pedals can stay still while the wheels are moving and may have gears which alter the distance the wheels go round for each turn of the pedals. Low gears move the wheels a shorter distance for each turn while high gears move them further, need more effort and give more speed. Free wheel cycles need separate brakes which are usually hand operated. These more sophisticated 2,3 or 4 wheeled vehicles are used more as a means of transport and need a safe large area in which to be ridden. A child should not be allowed on a road that carries traffic until they are aware of the danger and trained to deal with it. The Royal Society for the Prevention of Accidents does not allow children to train for and take its Cycling Proficiency Test until they are ten years old. They are not considered capable of proper judgement until then.

The point I wish to emphasise is that at different stages of development cycling for children has different aspects. For exploring movement, for exploring space and as a means of transport - each one requiring more space. If the appropriate safe space is not available it is frustrating for everyone and it may be better if a cycle is not provided. This may sound harsh but it applies to all children. In fact the mentally handicapped resident of an institution, riding a cycle round the grounds could be much better off than an able city child with heavy traffic growling past the garden gate. Some housing estates are safe for any child but most are not.

Since pedalling ability comes quite late in a child's development it is not just children with physical handicaps who have problems. Children and adults with developmental delay may need "feet on the ground" cycles like the WRK Pedalong, big versions of toddlers' trundle toys, or easy to pedal cycles like Searles' Maxi cycle or the WRK low-g geared Supa bikes rather than chain driven free wheel cycles.

Vehicles come in many shapes and sizes and can have so many means of propulsion that it is worth gathering as much up-to-date information as possible. A good starting point is the Disabled Living Foundation's Index. List 15 gives Children's Equipment and Sections 6 and 7 cover Tricycles and other mobility aids. Occupational therapy departments and aids centres should have the lists available for reference.

Exhibitions are another good source of information and give you a chance to try the goods, gather the brochures and best of all talk to the suppliers. Harrogate Cycle Show (July), the Toy Fair (London - January) and Naidex are all good but local exhibitions, study days and conferences are useful too. I met Mr. Searle of Searles Tuffa Toys, Mr. Clark of WRK and Mr. Hayes with his Jay

bikes in this way. They all give outstandingly good personal service if you contact them to discuss your needs. I find them preferable to deal with to the big general supply companies.

Extreme measures can be taken to make a child self-propelled and some cycles look more like surgical appliances than fun vehicles. This is not inevitable. Meyra playmobiles manage to look elegant and desirable while catering for many types of severe handicap.

Lateral thinking helps. A three year old with one leg shorter than the other who couldn't pedal an ordinary trike came to me once. Possible solutions are:

- 1) A vehicle where odd length legs are a positive advantage (a scooter)
- 2) A trike with a block on one pedal (DIY)
- 3) A trike with a chain wheel crank extension (Hasi)
- 4) A trike with a floating pedal (WRK)
- 5) Almost any hand propelled trike or go kart

At the time I knew very little and introduced the family to a student who wanted to make a bike for a handicapped child. There were problems of delay, the student's desire to impose his solution on the child's problem, payment and the need to keep the bike for end-of-year assessment rather than the child's need for play.

Some children need more support than an ordinary saddle, but look around! Some cycles come with supporting seats already fitted. Some Puky trikes from Mr. Searle have them with safety belts too, as well as optional driving wheel steering for possible one-handed operation. Some have a detachable push or pull handle for an adult to help (so does the Hayes Tow Trike) with a free wheel, so the child's feet can rest while the adult is pushing. One of these did very well for a four year old child I knew who could not walk yet and had less than perfect balance. All that needed adding were skate pedals (made and fitted through North East ACTIVE). The result was an attractive and appropriate cycle.

A child with spasms, poor balance or epilepsy who might need a back support and belt on a high cycle could perhaps do without it on a low pedal go kart such as the Puky or the Preston Lo Boy.

Feet can be held onto pedals with toeclips and straps from cycle shops, if the pedals are the normal adult type. Skate pedals can be made from roller skate soles or a spare pair of shoes bolted onto the pedals. Chailey Engineering sell pedal plates with an optional side iron attachment to keep the ankle bent. Hasi bike suppliers have pedal shoes with leg splints available, and the Hayes bikes use a unique clip fitted to the child's boot sole which fits onto the pedal spindle. Your local ACTIVE group might be able to help if something special needs making, or your friendly neighbourhood surgical appliance maker could be consulted. They have the most amazing workshops!

Handlebar holding problems may be helped with strapped on gloves, elbow splints, Rifton upright handlebar handles, the Hasi handlebar extension, fitting a tiller handle in place of the handlebars (DIY) or, strangest of all, the Opal Skatebike steered like a skateboard by leaning sideways.

Hand propulsion comes in many forms:

- 1) Sit-in trolleys with side wheels pushed directly by hand (Chailey, Shasbah, WRK, Aremco, Rifton)
- 2) Sit-in trolleys with handles or rims on the wheels (Meyra, Preston)
- 3) Tricycles with hand cranked pedals (Thistle, Hayes, Rifton, Meyra)
- 4) Tricycles with up and down pump action (Flying Dutchman, Meyra)
- 5) Tricycles with fore and aft pump action (Leeds & District ACTIVE, Rowcar, Hobcart, Irish Mail, Meyra, Indicycle)
- 6) Buggy Car (Byrd) - two hand levers control direction, speed and braking

Adaptations, when necessary, should be done on cycles of reasonable quality or the effort could be wasted. There is a lot of flashy junk on the children's

cycle market. In their report on "Bikes and Trikes for Little Children" in December 1982, 'Which?' named the Raleigh Budgie as best buy. This model is also the basis of the Hayes Jay Bike and is available with adaptations on prescription. The Raleigh Little Lamb (pedals on front wheel) and Pashley Pickle (chain driven) tricycles are also recommended by 'Which?' and are available from ALAC on prescription.

"A disabled person who has limited walking ability and whose need for a wheelchair is permanent may be supplied with one by the DHSS on the recommendation of any NHS doctor. Recommendation on form AOF 5G should be sent to the appropriate Artificial Limb and Appliance Centre." For "wheelchair" also read "cycle, go kart or trolley." A very good case needs to be made before a child is provided with one. Their ability to move around must be shown to be improved; they cannot be lent one to see if they can manage it first. It helps to involve the child's therapist when making an application and to know what you want in advance. Most NHS doctors haven't much idea what is available or appropriate, even though they have the magic signature! The child may have to go to the ALAC to see the Technical Officer, and maybe the Medical Officer, to try the various vehicles. It may be an ordeal for all concerned but can be very rewarding. A friendly Technical Officer can make all the difference.

Models normally available are the Pashley Pickle and Picador chain driven tricycles, the Raleigh Bobcat, Budgie and Disco chain driven bikes with stabilisers and various adaptations such as fixed gear, backrest and belt, toe-clips and skate pedals. The Thistle hand cranked tricycle in two sizes, the 330 fore and aft lever propulsion tricycle and various hand-on-wheel propelled trolleys (Chailey, Jonsport and Explorer) are also provided. Where the need is justifiable the Little Lamb trike, the Shasbah bigger trolley, the Tornado Go Kart with four wheels and pedals, the Hobcart (fore and aft rowing, hand propelled), the Yorkhill Chariot (stand up hands-on-wheel trolley), the Jaybike and the Saddle Seat Engine (sit-on rock and trundle) can be made available.

Some cycles can cost a great deal but many families, especially grandparents, are willing to pay. There is of course the Mobility Allowance for over 5's, if it isn't already committed to Motability. National charities like the BBC's 'Children in Need' or local ones such as Round Tables love buying bikes for handicapped children.

Pat Atkinson
Physiotherapist

Member of ACTIVE Panel and North East ACTIVE

A list of Manufacturers and their products is available free of charge from the Editor on request, with a stamped addressed envelope.

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LETTERS

From: Jean Forrest, 8 Keats Walk, Hutton, Brentwood, Essex.

I am very interested to hear of any useful advice or experience anyone can give on the physical management of muscular dystrophy. I am particularly interested in the prevention of foot and spinal deformities. For example, has anyone experience of using moulded seats, or the more recent Matrix seating? Or of special shoes successfully used for support.

INTRODUCTION TO PAEDIATRIC PHYSIOTHERAPY

All seems to be set for the pilot scheme of the "Introduction to Paediatric Physiotherapy" course to take place in the North West at the beginning of 1984.

The National Committee of the A.P.C.P. has long felt that a formal, structured approach to our speciality is essential, not only to build on the principles and practice covered only superficially in our initial physiotherapy diploma, but also to compliment in-service training and both regional and national courses. The scope of the course will be wide, covering all the areas a paediatric physiotherapist might find herself (or himself) working in, whether it be ward, out-patient department, special school or home; whether with babies or with adolescents; with the minimally or the severely handicapped; with the sick or the disabled child.

The physiotherapist entering paediatrics needs a grounding in all areas of clinical practice, an overview of all sub-specialisms. She must have an understanding of the roles of her co-workers in the field, parents included, must be able to communicate her own information to them. But most of all must be able to see the child first and the child with the problems second, needs from life as a whole first and how his disabilities affect the fulfilment of those needs. If we see the child and his needs first, we can use our professional skill to overcome or try to overcome those problems in a way which is relevant and practical.

The course will include formal lectures, practical sessions, group discussion and clinical supervision. It will take place over a period of 12 - 14 weeks. Blocks of formal teaching will be alternated with periods of clinical supervision and project work to be done in the students own work place. All students will be assigned to a physiotherapist tutor.

The course is to begin with sessions on embryology and child development, play and motivation, communication and role analysis, social and cultural influences. Project work following this will aim to increase the students understanding of her own role and the resources available to her and the role of other professionals and to enable her to explore relationships between the profession and the family.

The next block will cover a wide range of systems disorders from cardio-thoracic conditions to neurological and infective disorders and more, and will give an overview of treatment modalities and assessment principles. It is hoped that project work following this block will further consolidate this information and enable the student to explore in greater depth a particular condition of her choice.

The final block will cover sociological and legal implications, the role of voluntary agencies and professional teams and the importance of independence and fulfilment. The final project should draw together all the information given on the course and enable the student to apply this information to the 'client'.

The course development team hope that students will find the course both interesting and relevant. Its purpose is to improve day to day clinical and personal skills and to provide a basis on which further academic and practical information can be built. We hope it will produce a paediatric physiotherapist who is rightly confident and enthusiastic about her specialism, who can be critical of her own skills and who will see the course as the foundation of further study in the field of paediatrics. We also hope that it will be a pilot scheme, the forerunner of other similar courses held in the other regions of the country.

P.M. Eckersley
Vice-Chairman
Education Sub-Committee

July, 1983

ARTICLES OF INTEREST

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.

APRIL 1983

43. Findley TW et al
Wrist subluxation in juvenile rheumatoid arthritis:
pathophysiology and management.
Arch Phys Med Rehabil 1983 Feb; 64(2): 69-74
54. Seeger BR Caudrey DJ
Biofeedback therapy to achieve symmetrical gait in children with
hemiplegic cerebral palsy: long-term efficacy.
Arch Phys Med Rehabil 1983 Apr; 64(4): 160-2
56. Tsuyuguchi Y et al
Splint therapy for trigger finger in children.
Arch Phys Med Rehabil 1983 Feb; 64(2): 75-6
57. Barnes KJ Pines PL
Assessing and improving services to the handicapped.
ASHA 1982 Aug; 24(8): 555-9
69. Scrutton D
The Newcomen Centre for Handicapped Children. (1. Correction
of asymmetric hip deformity; 2. Polypropylene ankle foot
orthoses.)
Demonstration Centres in Rehabil Newsletter 1983 Feb; 30: 11-3
70. Foulds RA
Applications of microcomputers in the education of the
physically disabled child.
Except Child (Washington) 1982 Oct; 49(2): 155-62
75. Enticknap B
Problems and needs of handicapped school leavers.
Health Visit 1983 May; 56(5): 159-60
85. Nowotny J et al
Efficiency of gait of children suspected of cerebral palsy.
(Brief research report)
Int J Rehabil Res 1983 Mar; 6(1): 63-6
89. Lincoln NB
The Speech questionnaire: an assessment of functional
language ability.
Int Rehabil Med 1982; 4(3): 114-7
91. MacBriar BR
Self-concept of preadolescent and adolescent children with
a meningocele.
Issues Compr Pediatr Nurs 1983 Jan-Feb; 6(1): 1-11
108. Steinke RT et al
A prevocational programme for the severely handicapped:
The Lakeview Prevocational Project.
J Rehabil 1982 Apr-Jun; 48(2): 25-8
114. Ferullo RJ
Objectivity in the assessment of preschool hearing impaired
bilingual-Hispanic children.
J School Health 1983 Feb; 53(2): 131-5

MAY 1983

1. Aids for the disabled.
Sutton: IPC Business Pr. (Available from: Community Care,
Surrey House, 1 Throwley Way, Sutton, Surrey.)
1982 £4.75
8. Caston D
Easy to make aids for your handicapped child: a guide for
parents and teachers.
Englewood Cliffs: Prentice Hall
1982 \$6.95
9. Centre on environment for the handicapped
Living independently.
London: CEH (126 Albert Street, London NW1 7 NF)
£5.00
19. Kleinberg SB
Educating the chronically ill child.
Gaithersburg MD: Aspen Systems Corporation
\$27.95
21. Leicester AJ
Integrating disabled children in play.
Sheffield: Sheffield Children's Integrated Play Association
(124 Devonshire Street, Sheffield S3 7SF. 35p p & p)
1982 £1.00
22. Leveté G
No handicap to dance.
London : Souvenir Pr.
£4.95
23. National Bureau for Handicapped Students
Students with disabilities 1982/83. (also on cassette)
London: NBHS (40 Brunswick Sq., London WC1N 1 AZ)
24. National Deaf Childrens Society
Help for parents of deaf children. New edn.
London: NDCS (45 Hereford Rd., London W2 5AH)
25. Newson E Hipgrave T
Getting through to your handicapped child.
Cambridge: CUP
£3.95
35. Turner G
The right job for you. (For hearing-impaired school-
leavers)
London: Heinemann
1982 £4.50

JUNE 1983

2. Ghory JE
Physical rehabilitation of the asthmatic child
Allergol Immunopathol (Madr) 1981; Suppl 9: 95-8
7. Potter J
Cleft palate - fifty years on.
Ann Plast Surg 1983 Jan; 10(1): 12-4
56. Suss T
Maternal behaviour and handicapped infants.
Nurs Montreal 1982 Nov; 6(5): 7-8
65. Martinek TJ Karper WB
Entry level motor performance and self concepts of
handicapped and non-handicapped children in mainstream
physical education classes: a preliminary study.
Percept Mot Skills 1982 Dec; 55(3 Pt 1) : 1002
- 13 -

66. Rider RA Candeletti G
Influence of motor therapy on children with multisensory
disabilities: a preliminary study.
Percept Mot Skills 1982 Dec; 55(3 Pt 1) : 809-10

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PRODUCT NOTES

New non-spillable battery

Safe for air travel produced by Gates Energy Products Inc., 1050 South Broadway
P.O. Box 100, Ashburn, Virginia, 220111, U.S.A.

Booster Seats

Available from a firm called Kiddy Mail Ltd, 9-10 Rich Industrial Estate,
Crimscott St, London S.E.1 5 TE.

Potty Chairs

A new potty chair made by a Scandinavian firm is on the market from John Lewis
partnerships.

NOMEQ now make self adhesive feet (dots) to put on the back of paper and books
to prevent them slipping.

TARQUIN MAGNETIC MATERIAL

Tarquin Publications, Diss, Norfolk produce a whole range of magnetic tiles
and work surfaces.

* * * * *

TOY IDEAS

1. Pelican Crossing

A simple and effective battery operated device providing an efficient way
of teaching road safety to children. £32.50 (inc. p. & p.)

2. Sound Bubble

A versatile and practical toy to encourage movement, co ordination, and
audio-visual response in a handicapped child. £26.50 (inc. p. & p.)

3. Eccentric Discs

A toy to provide encouragement of arm and head movement, together with
sound and colour recognition. £27.50 (inc. p. & p.)

Further information on these from:-

Deron Electronics,
New Enterprise Workshops
Albion Row
Byker
Newcastle-on-Tyne NE6 1LQ

Huntercraft, Ransom Stables, Priestlands Lane, Sherborne, Dorset., have
produced an Ideas Sheet with their catalogue of equipment for the severely
mentally handicapped which contains some excellent simple to make toys and
equipment. Price 50p from the above address.

EQUIPMENT IDEAS

Push Toy - Hannibal

Faced with the frustration of this useful toys comparatively inextensible arms, we asked the hospital fitters to supply us with tubular arms 60 cms. in length to exchange with those supplied by the makers which were only 28cm. long. This was easily and speedily accomplished. The original hand grips are exchangeable and we now have a useful toy that we can successfully use with a larger age range of children.

Available from: Theramed Limited
Therapeutic and Medical Devices
P.O. Box 57
Camberley
Surrey
Tel: (0276) 27060



'Hannibal'
A Childrens' Walking Aid

Mrs. K.L. Jones
Senior Physiotherapist
Brockhall Hospital
Old Langho
Blackburn

PUBLICATIONS

1. Play and Handicapped Children
Book giving sources and resources of information on adventure playgrounds, playschemes, Toy Libraries etc.
Available from - Fair Play for Children
248 Kentish Town Road
London NW1
Price £1.50 including p. & p.
2. Free Stuff for Kids
Good resource book with cheap offers, plus 150 free offers to send for.
Available from - Exley Publications Ltd.
12 Ye Corner
Chalk Hill
Watford
Herts WD1 4BS
Price £1.95
3. Blue Remembered Hills by Rosemary Sutcliffe
Autobiography of the authors girlhood when she suffered from Stills Disease
4. Directory on Non Medical Research relating to Handicapped People - 1982
Information on 616 research projects on education, play, communication, recreation, services, aids and functional assessment.
Available from - Handicapped Persons Research Unit
Newcastle-on-Tyne Polytechnic
No. 1 Coach Lane
Coach Lane Campus
Newcastle NE7
5. Research on Disabled School Leavers
Report on a seminar for people working in research on disabled school leavers
Available from - R.A.D.A.R.
25 Mortimer Street
London WIN 8AB
6. By the Year 1990
A new quarterly newsletter to publicize the aim of W.H.O. to provide immunisation services for all children of the world by 1990. Annual Subscription to newsletter £1.
Available from - By the Year 1990
Wildhanger
Amberly
Arundel
West Sussex BN18 9NR
7. Insurance for Childrens Play
A guide by the National Playing Fields Association setting out clearly what insurance is necessary for those looking after children.
Available from - National Playing Fields Association
25 Ovington Place
London SW3 1 LQ
Price £1.50 inc. p. & p.

8. Sudden Death in Infancy: the "Cot Death Syndrome" by Bernard Knight
A book discussing the prevalence, causes, legal problems and social consequences of cot deaths. A chapter is devoted to counselling parents and explains where additional help may be obtained.
Published by - Faber & Faber Ltd.
Price £3.50
9. The Playgroup Movement by Brenda Crowe
A revised and updated version of the original 1973 edition, this book defines Playgroups, examines their needs and problems and traces the growth of the association.
Published by - Unwin Paperbacks
Price £2.50
10. Aids for the Disabled. A Community Care Directory
Edited by Mary Manning
A new attempt to improve the information available on aids and providing a handy sized list of manufacturers and suppliers of aids.
Published by - Community Care / I.P.C. Business Press
Price £4.75
11. Essential Community Medicine by R.J. Donaldson and L.J. Donaldson
A definitive guide to the spectrum of community medicine, with emphasis on the scope for prevention in health problems along with the needs of the elderly, mentally disabled, physically handicapped, mothers and their children.
Published by - M.T.P. Press Ltd.
Price £6.95
12. Special School Leavers
Pappenheim K (Ed)
Greater London Association for the Disabled.
Price £1.75
13. The use of the polypropylene ankle-foot orthosis in the management of the cerebral palsied child.
Details available from -
Handicapped Childrens Service
Armistead Child Development Centre
94 Monifieth Road
Dundee
14. Get Fit for Sport by Tom McNab
A new training leaflet describing how different sports require different fitness levels.
Available free from -
Scholl Sports Aid Division
192 St. Johns Street
London EC1
Please include stamped addressed envelope

15. Annie's Coming Out by Rosemary Crossley & Arne McDonald
 A true story of an intelligent athetoid girl who spent 15 years in a hospital for severely retarded children.
 Published by - Penguin Books - Pelican Series
 Price £2.25 (paperback)
16. Toys and Play for the Handicapped Child by Barbara Riddick
 A detailed study of the role of toys and play in the development of normal and handicapped children.
 Published by - Croom Helm
 Price £9.95

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AUDIO VISUAL AIDS

NEW TITLES AUDIOVISUAL LIBRARY

1. A set of new documentary films:
- | | |
|----|--------------------------------|
| 1) | Social Deprivation |
| 2) | One Parent Families; Divorce |
| 3) | Delinquency |
| 4) | Accidents & Safety |
| 5) | Art Music & Drama inc. Therapy |
| 6) | Employment of the Handicapped |
- Available from Filmlist
 Nat. Childrens Bureau
 Information Service & Bureau
 8 Wakley St
 London C1V 7QE
2. Living with Cystic Fibrosis
 New film made by the Cystic Fibrosis Research Trust. 16mm
 Available free from -
 Bill Dower
 C.F. Research Trust
 Alexandra House
 5 Blyth Road
 Bromley Kent BR1 3RS
3. Cerebral Palsied Child
 Series of tape / slide programmes dealing with the care of spastic children. Early Posture Care for Babies
 Available from Camera Talks Ltd.
 31 North Road
 London W1R 2EN
4. Mental Handicap - A Social View
 New Video programme
 Available from Graves Medical Audiovisual Library
 220 New London Road
 Chelmsford
 Essex CM2 9BT

5. Mental Health Film Catalogue

Useful resource for films on a whole range of Mental Health

Available from - Pamela Edwards
22 Harley Street
London W1V 2ED

SLIDES

A set of 75 coloured slides have been prepared by Rifton Equipment Ltd. showing their many products. This set is free for loan and accompanied by an explanatory text.

Available from - Community Playthings (Rifton Equipment)
Robertsbridge
East Sussex TN32 5DR

3 Sets of slides aimed at children in the 4 - 9 age group setting out the unpleasant effects of smoking, too much alcohol, and obesity have been prepared - (George the Mole Who Smoked, George the Mole and the Black Horse, Daniel and Mac)

Available from - Dept. of Medical Illustration
John Radcliffe Hospital
Headington
Oxford

* * * * *

DID YOU KNOW

ABOUT - Changes in the Orange Badge Scheme - for parking concessions.

The Parliamentary Under Secretary of State for Transport has proposed new regulations now coming into force, these will make Badges available to:

- 1) Recipients of mobility allowance.
- 2) The blind.
- 3) Those using vehicles supplied by Government Departments or receiving grants towards their own vehicles.
- 4) Other people with a permanent and substantial disability which causes very considerable difficulty in walking.

The badge has been redesigned and the issue fee which may be charged increased to £2 from £1.

ABOUT - Screening for Children

A leaflet for new parents encouraging them to ask Doctors or Health Visitors to organise development check-ups and hearing tests.

Produced by the mother of 2 deaf daughters in a campaign for earlier screening.

Copies of leaflet or posters and further information available from:

Kathy Robinson
183 High Street
Maske-by-Sea
Redcar
Cleveland

ABOUT - Possible Causes of Congenital Limb Amputation or Deformity - Reach

A two year project has been launched in conjunction with the Child Health Department at Bristol University. The first project of its kind in Britain and possibly the world to teach this subject, which affects between 150 - 200 children in Britain yearly.

Reach - is an organisation of these childrens parents to try to get better artificial arms, information and insurance cover for the childs good arm in case of accident.

ABOUT - Stafford Group of R.D.A. who have a ramp and mounting platform to loan to any Group in need of it.

Apply to - Gail Summers
Woodbine Cottage
Whiston
Penkrige
Stafford

ABOUT - Mencap and the production team of 'Crossroads' who have had discussions resulting in plans to introduce Mental Handicap into the Autumn programme.

ABOUT - 'Earlybird'

A new Puffin Bookclub for the very young. Each 'Earlybird' Book choice made with the co-operation of P.P.A.

Enquiries from: Earlybird Bookclub
The Penguin Bookshop
Richmond-upon-Thames
Surrey TW9 1BR

ABOUT - Graves Medical A.V.A. Library have a publicity area at the British Hospital Display Centre, 22 Newman Street, London W1. with some sample programmes.

ABOUT - The Parawalker

Developed by a team of engineers, Doctors and Scientists in a Research Unit at the Robert Jones and Agnes Hunt Hospital in Oswestry, for helping Spina Bifida Children who were growing older to move about more freely, it is now finding a wide field of application.

Basically, a swivel walker with the body supported by crutches. As with the swivel walker, the wearer changes the position of his centre of gravity to allow his legs to move while supporting his body on crutches. Hinges allow the wearer to sit down.

ABOUT - The new AOF5G Form for wheelchairs

A pilot study has been commenced to establish the effectiveness of a revised form to simplify the process of recommending wheelchairs. This study is being carried out at ALAC's at Manchester, Liverpool, and Preston.

The new form (AOF5G) is much shorter than its predecessor and allows details of the prescription at Part B to be completed by a therapist if a doctor so wishes. The new form still requires a medical recommendation at Part A.

PAEDIATRICS IN EDINBURGH

A well established swimming group for asthmatic children has been set up, one class for toddlers, one school age beginners and one for school age swimmers. These are held weekly in corporation swimming pools and are very popular and well attended. A physiotherapist is always present at these sessions, both in an advisory capacity and out of interest. Peak flow levels are read before and after the swimming and recorded principally from an interest point of view. A Nebuliser is always taken to these sessions but up to now it has not been needed.

There is a well established Community Service for children in Edinburgh, the preschool child being visited on a domiciliary basis by one of the departments in the area. Children with Cystic Fibrosis are seen by a physiotherapist monthly and a monthly evening clinic is held for older children, who find it difficult to attend clinics during the day. There are regular fund raising events to raise money for the physiotherapy fund which is then used to buy equipment for children, which is not obtainable through the Health Service channels.

ABSTRACT

The Problems of Children born of Drug Addicts

Increasing numbers of children are being delivered of drug-abusing parents. The children remain a highly at-risk group even after discharge from hospital and require a high level of surveillance.

The three groups of drugs which are most important clinically are narcotics, amphetamines and barbiturate. A baby's withdrawal symptoms and their severity is related to the type of drugs, degree of abuse and timing during pregnancy. The symptoms are variable but all withdrawing babies tend to be irritable, jittery and tremulous. Severe withdrawal can lead to death either with seizures or with fluid and electrolyte loss due to diarrhoea.

The aims of treatment are to prevent serious side effects and to allow normal feeding with periods of sleep in between. Various drugs are used, including Chlorpromazine, Diazepam, Phenobarbitone and Pangorik. The dosage is decreased gradually when control is adequate.

Additional neonatal problems include the risk of asphyxia and low birth weight due to prematurity and to retarded ultra-uterine growth.

Long term risks apply throughout childhood and adolescence. The most common difficulties are delayed development, language delay, learning difficulties, enuresis and tantrums. Forming relationships is also more difficult. Studies of addicts show them to be manipulative people and that supervision of these families needs to be by experienced workers.

Maternal and Child Health

The Problems of Children born of Drug Addicts Michael J H Williams June 1983

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COURSES DIARY

<u>DATE</u>		<u>SUBJECT</u>	<u>ORGANISER / VENUE</u>
AUGUST 19 - 21	FRI - SUN	Teaching the Child with Cerebral Palsy to Use the Hands	Castle Priory College Wallingford Oxon
AUTUMN 1983		Multidisciplinary Course in Mental Handicap	Nottingham
SEPTEMBER 12 - 16	MON - FRI	Education of the Profoundly Multiply Handicapped	Avoncroft College Bromsgrove
SEPTEMBER 13 for 10 weeks	TUES	The Handicapped Child in the classroom and nursery	Mencap National Centre 123 Golden Lane London EC1Y 0RT
SEPTEMBER 14 for 10 weeks	WED	Management of the Severely Handicapped Child and Adult with Emphasis on Physical Aspects of Care	Mencap National Centre 123 Golden Lane London EC1Y 0RT
SEPTEMBER 12 - 15	MON - THURS	Speech Therapy and the Handicapped Adolescent	Castle Priory College Wallingford Oxon
SEPTEMBER 9 - 11	FRI - SUN	Makaton Sign System	Castle Priory College Wallingford Oxon
SEPTEMBER 15	THURS	Treatment of exercise induced asthma in children	Booth Hall Childrens Hospital Manchester
SEPTEMBER 16	FRI	Psychiatric Problems of the Mentally Handicapped	Thingwall Hall Thames Drive Broad Green Liverpool
SEPTEMBER 24	SAT	Parents Annual Conference of research trust for Metabolic Disease in Children	Leighton Hospital Nr. Crewe
SEPTEMBER 23	FRI	Learning and communication problems in children	Canterbury
SEPTEMBER 23 - 25	FRI - SUN	Developing a Toy Library	Holly Royde College 56-62 Palatine Road Manchester 20
OCTOBER to DECEMBER		Inter-disciplinary Course in Mental Handicap	Priory Special School Hexham Northumberland
OCTOBER 5	WED	Assessment and Placement of Severely Physically Handicapped Young People: Open Day & Conference	Banstead Place Park Road Banstead Surrey

<u>DATE</u>		<u>SUBJECT</u>	<u>ORGANISER/VENUE</u>
OCTOBER 3 - 6	MON - THURS	Assessment and intervention in child language	National Hospitals College of Speech Sciences 84a Heath Street Hampstead London NW3 1DN
OCTOBER 6	THURS	Using Micro-Electronic Aids with Mentally Handicapped People	Newcastle Polytechnic Newcastle-upon-Tyne
OCTOBER 14	FRI	Ethnic Minority Families with a Mentally Handicapped Child: Conference	Bateman Centre Birch Hill Hospital Rochdale
OCTOBER 15 - 22	SAT - SAT	International Week for Young Disabled People living in Institutions and their friends	Werkenrode Institute Groesbeek, Netherlands Mobility International 62 Union Street London SE1 1TD
OCTOBER 21	FRI	Music for Mentally Handicapped People	Lea Castle Hospital Wolverley Nr. Kidderminster Worc.
NOVEMBER 15	TUES	Riding for Disabled National Conference AGM	Grand Hotel Bristol
DECEMBER 4 - 7	SUN - WED	Short Course in Rehabilitation Engineering - Aimed at medical and para medical staff involved in rehabilitation of the disabled	Northern Regional Training Centre Stannington Nr. Morpeth
<u>LATE ADDITIONS</u>			
OCTOBER 20	THURS	Study Day on Orthopaedics in Paediatric Physiotherapy	Miss. P.M. Eckersley Supt. Physiotherapist Lancastrian School Withington Hospital Manchester
OCTOBER 21 - 23	FRI - SUN	Week-end Conference British Assoc. of Teachers of the Deaf	Programme from Miss. A. Guy 3 Fforest Glade Newport Gwent
OCTOBER 29	SAT	'ACTIVE' Autumn Conf.	Damascus House The Ridgeway London NW7
MAY 21 - 25 1984		Play is a Language. 3rd International Conf. of Toy Libraries	Brussels M. Claude Paulet Federation des Ludotheques Bruxelloises Rue de la Loi, 15-Bte 091 B-1040 Bruquelles Belgium

DATES

Microfair - Electronic Aids for the Handicapped

Rutherford Hall
Newcastle upon Tyne Polytechnic
Monday 12th to Friday 16th September

The Galleries
Sheffield Polytechnic
Monday 26th to Friday 30th September

Hereward College, Coventry
Monday 3rd to Friday 7th October

The School of Oriental and African Studies
London University
Monday 24th to Friday 28th October

The Gallery
South Glamorgan Institute of Higher Education
Cardiff
Monday 31st October to Friday 4th November

Scottish Health Service Centre
Edinburgh
Monday 28th November to Friday 2nd December
Monday to Friday 10.00 a.m. to 4.30 p.m. (Thursday till 7.30 p.m.)
at all venues.

ADMISSION FREE

For further information contact:

Ed Wilson, Dale Robertson or Peter Curran
Handicapped Persons Research Unit,
No. 1 Coach Lane
Newcastle upon Tyne Polytechnic
Tel: (0632) 664061

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REGIONAL REPORTS

East Anglia

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

There will be a meeting at Harperbury Hospital in Harper House on Wednesday October 19th at 7.30 p.m. prompt. David Scrutton, Superintendent Physiotherapist at the Newcomen Centre, will talk about hip adduction deformity, pre and post operatively. A.P.C.P. members £1.25, non-members £1.75

North West

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

We hope all those who attended enjoyed the Conference at Lancaster. We had many letters from participants congratulating us on a stimulating week-end both for lectures, company, and last but by no means least, food!

We have covered our costs and will have made a profit - exact figures will be available shortly. We are preparing a list of all the jobs that needed to be done to organise a conference and will pass this on to the Cardiff Committee.

We shall be arranging either a study day or week-end in the Autumn but until then we are taking a well earned break.

Scotland

Reg. Rep. Mrs. L. Furnell, Glensherup House, Glen Devon, by
Dollar Perthshire

A two day Intensive Care Course was held in June, which was fully attended and very successful.

A paediatric Local Interest Group has been formed, which meets on an informal basis from time to time, when informal lectures, demonstrations and presentations of case histories are given.

Further information from Miss. M. Grant, Royal Hospital for Sick Children, Sciennes Road, Edinburgh.

London

Reg. Rep. Fiona Graham, Leon Gillis Unit, Queen Mary's Hospital,
Roehampton London SW15.

A successful day seminar on asthma was held on June 12 - among those speaking were Dr. John Warner, Miss Diana Gaskell and Miss Diana Coggins. Emphasis throughout the day was on the role of the physiotherapist in the treatment of asthma and the effect of physical activity. Two films were shown by the Fison's representative and a small trade exhibition was also present. Abstracts from the lectures will be given in the Regional Newsletter.

Another study day will be held on October 29th at Guy's Hospital - the subjects will be Haemophilia and Brittle Bones. Details will be published in a later edition of the Physiotherapy Journal.

There have been some changes on the Committee of the London Region - Miss Fiona Graham is now the Regional Representative and Ms Chris Howell of Queen Elizabeth Hospital for Children, Hackney, is the secretary. Details of this will be in the Regional Newsletter.

South West

Reg. Rep. Mrs. Jane Perks

A successful and highly informative study day was held at Poole on 8th July, the subject being "Paediatric Problems of the Lower Extremity."

At the AGM held on the same day Mrs. Jane Perks kindly agreed to take on the job of regional representative. Jane is Superintendent Physiotherapist at Lord Mayor Treloar College, Alton, Hampshire.

South East

Reg. Rep. Miss S. Raymond, 55 Gates Green Road, West Wickham, Kent.

The next meeting will be on Saturday 15th October at De La Rue School, Tonbridge, Kent. Dr. Joan Martin will lecture and demonstrate the Halliwick method of swimming instruction. Coffee and Registration will be at 10.30 a.m. and the day will close with tea at 4.00 p.m. Cost to members £5 and non-members £6.50. Application with money and stamped addressed envelope to Mrs. C. Foster, Physiotherapy Dept, Chailey Heritage, Chailey, Nr. Lewis, Sussex by 5th October.

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