
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 48

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“PAEDIATRICS TOWARD 2000”

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Officers of the Association

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45, Welsford Road
Eaton Rise, Norwich.

Vice Chairman
Mrs. M. Clegg,
Upper Earnstry Park,
Abdon, Craven Arms,
Salop.

Secretary
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3, Charlton Place Cottages,
Mouse Lane, Steyning
West Sussex, BN4 3LX.

Treasurer
Mrs. J. Brownson,
23, Vallance Road,
Hove, Sussex.

P. R. O.
Miss E. Bell,
7 Eildon Street,
Edinburgh.

Editor
Mrs. J. E. Lamond,
22, Wherside Road,
Lancaster LA1 2TA.

Post Reg. Ed.
Mrs. Mary Clegg,
Address as above.

Editorial Board

Miss N. Hare, Miss E. Bell, Mrs. M. Clegg, Mrs. M. Diffey, Miss G. Riley, Mrs. M. Lee,
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EDITORIAL

Once again our Annual Conference has been a succesful gathering thanks to the hard work and dedication of the West Midland Region. It provided the delegates with thought provoking and interesting lectures - some of which are reproduced in precis in this edition - and allowed old friends to meet and new ones to be made.

The title of 'Paediatrics towards 2000' must surely give us all pause to consider just where are we going? Not only in our management of sick and disabled children, but in our attitudes to new ideas, training and political issues of the day. Are we clear in our thoughts and actions, and unafraid to make our skills known? Do we choose our words with care and speak thoughtfully, or do we act in haste? As in all specialities, paediatric physiotherapists are the mirror of their chosen special interest and should reflect its high standards to the world at large. Unafraid of brickbats from the uninformed, sure and confident in their knowledge.

As Editor for the last five years I would like to thank all the people with whom I have been associated for their help and friendship, and offer my best wishes to the new Editor Mrs. Jenny McKinlay.

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The last date for submission of material for the November Edition will be OCTOBER 5th, 1988.

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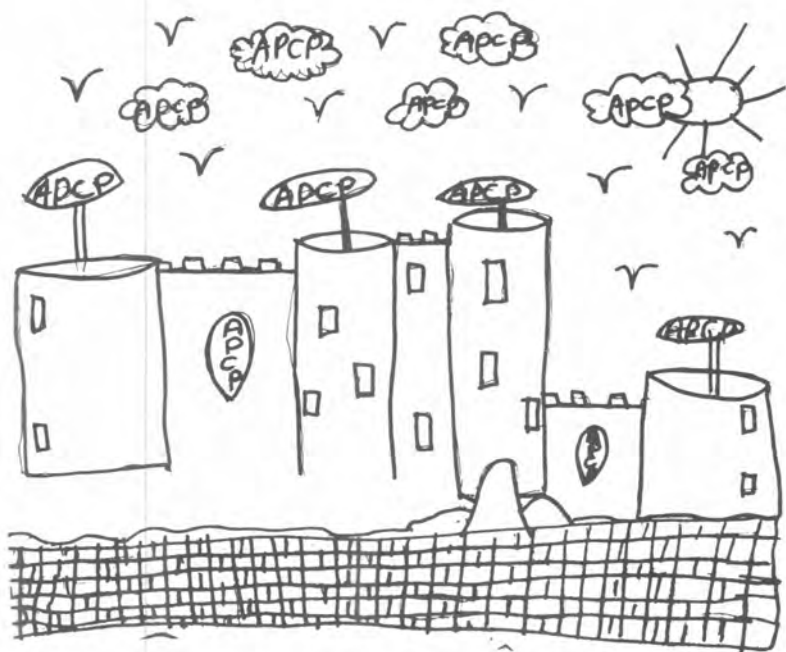
**N.B. As from August the Address of the new Editor will be :
3, Stanley Gardens, Sanderstead, Surrey CR2 9AH.**

The Address of the membership Secretary will be :
22, Whernside Road, Cross Hill, Lancaster LA1 2TA.

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The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence, and reserves the right to edit material submitted.

Annual Conference
Paediatrics Towards
2000
Warwick University.



PHYSIOTHERAPY IN ONCOLOGY

Miss Jenny Llewellyn M.C.S.P.

Children with malignancy are referred to Physiotherapy for a variety of reasons. Some of the more common conditions seen include acute lymphoblastic leukaemia, posterior fossa tumour and wilms' tumour.

Treatment can be divided simply into respiratory care and rehabilitation. Respiratory care involves treating children in the following situations:—

1. immediate post-operative care,
2. acute crisis - ITU/ventilated,
3. immunosuppression - chest infection,
4. primary tumour/secondaries.

For those patients who have undergone abdominal surgery for removal of wilms' tumour or neuroblastoma, immediate post-operative care is essential, and takes the form of positioning/postural drainage, 'blowing' or forced expiration technique, percussion as necessary, and effective coughing with support. An incentive spirometer may also prove to be helpful to aid expansion.

In younger children, tracheal pressure or suction may be used to elicit a cough response and aid clearance of secretions. After two to three days, or as analgesia is withdrawn, the child should be encouraged to mobilise.

Occasionally a child with a malignant condition requires ventilation and intensive physiotherapy, perhaps post-operatively or following reaction to drugs causing major organ dysfunction.

Those patients that are having chemotherapy are prone to chest infections because of their immuno-suppression. Often it is possible to treat these children in out-patients and to teach parents how to carry out physiotherapy at home. For this temporary period, chemotherapy is halted and antibiotics given.

More rarely, patients are referred with primary chest tumours, and our aims of treatment should include to:—

1. prevent collapse/consolidation,
2. aid clearance of secretions,
3. administer adequate humidity/O₂.

Reassurance for the patient and family is particularly important.

Youngsters who have undergone prosthetic replacement for sarcomas, occasionally present with lung secondaries and require treatment following thoracotomy.

Another consequence of immuno-suppression is that patients may have a low platelet count, and therefore care should be taken where chest physiotherapy, especially suction, is being carried out.

Vincristine is a drug widely used in the chemotherapy protocol, and physiotherapists should be aware that a complication of its use can be peripheral neuropathy, leading to drop-foot. Temporary splints can be made until recovery occurs.

In addition to those children who require chest physiotherapy, another group of patients are referred following cranial surgery for resection of posterior fossa tumours.

Immediate post-operative treatment includes chest care and correct positioning/passive movements to maintain joint range and prevent soft tissue contractures. For the first few days, the patient should be encouraged in the normal developmental sequence, gradually progressing from rolling to support sitting and eventually standing and walking. At about one week post-operation, hopefully the child can be transferred daily for treatment in the Physiotherapy Department.

The major problems for these children are ataxia affecting co-ordination and gait, and slow or slurred speech. At times their recovery is slow and they may require a long period of out-patient or community rehabilitation.

Before their discharge, it is important to assess the home situation and the necessity for any aids such as a buggy/wheelchair, bath aids or alternative footwear.

Liaison with other members of the medical team is particularly vital in the long term management of any child with malignant disease. The Occupational Therapist, Speech Therapist, Dietician, Social Worker and Clinical Psychologist may all be involved with a particular patient, so good communication is essential.

Often Physiotherapy has to be arranged around chemotherapy or radiotherapy appointments, and it is good to consider the needs and demands of the whole family during such a stressful time.

Physiotherapy in Oncology is a growing field, and although the prognosis can differ greatly according to the medical background, treatment can be rewarding and a successful outcome is a possible achievement in the lives of many children and young people.

* * * * *

NEONATAL ASSESSMENT

Sister J. Kemp SRN

With the remarkable skill of the obstetricians and their use of scanning equipment a great deal is now known about the infant well before it is born. Some conditions are potentially lethal very soon after birth unless immediate surgery is performed, but when diagnosed antenatally on scanning, the neonates' chance of survival is increased by ensuring that the baby is delivered at a hospital with the facilities to operate and nurse the child immediately. This preparation for delivery is not restricted to neonates who are likely to require surgery. Preterm infants, born in a hospital unable to ventilate or care for sick infants can be at a considerable disadvantage. Whereas, a fetus transferred whilst still in utero to a centre able to deal with sick babies would probably stand a better chance of survival. There are many examples such as these, illustrating the importance of antenatal diagnosis, and stressing how vital the action taken can be in determining the resulting health of both the mother and baby.

In the majority of cases however, the first signs that the baby may need help are immediately prior to delivery, during the delivery, or within the first few hours following birth. In an effort to preempt some of the potential problems a paediatrician is routinely called to attend all deliveries that are recognised as being 'risky'. On these occasions the paediatrician assesses the neonates condition at delivery, and for the first few minutes after birth and decides whether or not the infant will require treatment that cannot be administered by the mothers bedside on the post-natal ward. A system called APGAR scoring is used as a common method to assess and document a newborn baby's condition, by noting the quality of the infant's heart rate, respiratory effort, colour, tone and response at 1 min, 5 mins, and 10 mins of life.

Once it is decided that a neonate will require special or intensive care the neonatal unit is alerted so that preparation can be made for the imminent arrival of the baby. Meanwhile the infant is given as much support as is possible, whether on the labour ward or in the transport incubator during transfer to the unit.

Every neonatal unit nurses and manages it's infants differently. Some procedures and practises carried out on one unit may be considered fool-hardy or unnecessary by another unit, but the ultimate common aim is to produce a mentally and physically healthy child capable of living a normal life.

On admission to the neonatal unit all the infants are weighed, as fluid and drug calculation is based on body weight, and swabs and blood specimens are taken so that any infection can be identified and treated. The baby is then installed in either an intensive, or special care nursery.

Well, but small or slightly pre-term infants may require nothing more than a watchful eye, warmth, and milk until they are big enough to go home. In which case they are usually nursed in an incubator for warmth, until they are able to organize their own body temperature sufficiently well to be nursed in an open cot. They would probably be fed by gastric tube, or be allowed to suck their feed when they have a good sucking reflex. When the parents are confident to care for them, and they are well with good weight gain, they should be ready for discharge home.

On the other hand some babies are extremely sick for many weeks and require a great deal of help.

With the increasing ability of neonatal units to save babies born at 23-24 weeks gestation, neonatal units are becoming busier with higher expectations put upon them.

A neonate may be admitted to an intensive care unit if he requires help to maintain his heartrate or respirations, his oxygen levels, his blood pressure, or if he is extremely sick for some other reason.

Any stress, which can take the form of decreased oxygen levels, low blood sugar levels, or low temperature amongst others can damage the baby and decrease his chance of full recovery. Therefore it is important to monitor the baby's condition carefully, whilst at the same time keep these stress factors to a minimum. On our unit we nurse our intensive care babies in incubators, and are able to monitor their heart and resp. rate, temperature, blood pressure, O_2 levels and give fluids intravenously without actually disturbing the baby. In addition the baby can easily be seen through the clear incubator walls.

We handle the sick babies as little as possible so tend to perform all routine tasks like nappy changes and turning about 8-12 hourly at first, becoming more frequent as the child becomes more stable.

Some infants, particularly the severely preterm may be sick for many weeks so it is important to involve the parents as much as possible, encouraging them to just stroke and talk to their baby initially, then to change their nappy and hold them later.

Infection control is a major headache on any neonatal unit as babies have a low or non-existent immunity if born early. Therefore, the importance of good hygiene must be stressed to all who enter the unit, and great care is taken to ensure that bits and pieces used by one baby are not shared with others.

THE ROLE OF THE PHYSIOTHERAPIST IN THE S.C.B.U.

Mrs. A. Parker M.C.S.P.

There are three areas in which physiotherapy plays a role:

- a) chest physiotherapy
- b) mobilization and positioning
- c) neurodevelopmental physiotherapy

As most S.C.B.U.'s do not have full-time physiotherapists, education of the staff is a major part of the physiotherapists role. New staff to the unit should be taught individually as part of their orientation programme and there should be regular sessions for discussion and update with all nursing members.

Chest Physiotherapy has a crucial role in the respiratory care of infants on a S.C.B.U. Hypoxia and bradycardia are often unwanted side-effects of physiotherapy and suction, so it is essential that a thorough assessment is made

prior to each treatment to ascertain if physiotherapy is necessary. Treatment should only be given when indicated and not as a routine.

Indications for Chest Physiotherapy

1) Increase and/or retention of secretions due to:—

- a) long-term intubation i.e. more than 36-48 hours when mucosal irritation by the endotracheal tube causes increased secretions.
- b) meconium aspiration - for removal of remaining meconium plugs and increased secretions due to chemical irritation of mucosa.
- c) post-operatively - as in older child.
- d) pneumonia - chest physiotherapy is useful in the productive phase but of doubtful benefit when the lung is consolidated.

2) Lung collapse due to mucus plugging:—

a common problem due to small diameter airways. The right upper lobe is particularly affected.

Contraindications to Chest Physiotherapy

1) Head down tip:

periventricular haemorrhage
recent cranial surgery e.g. shunt insertion
abdominal distension

The head down position causes intracranial pressure to rise, and also can increase respiratory distress as neonates are primarily diaphragmatic breathers.

2) Prone - most infants like the prone position and tolerate it well. They should not be placed in the prone position when they have an umbilical arterial catheter, anterior chest drain or severe abdominal distension.

Precautions of Postural drainage

- 1) Reduced tolerance in the unwell infant
- 2) Preferential ventilation of upper lung in side-lying

Manual Techniques

1) Percussion:

In neonates and L.B.W. infants percussion may be applied to in three ways:—

- a) tenting - using 3 - 4 fingers of one hand, slightly elevating middle finger.

- b) contact heel percussion - percussion using thenar and hypothenar eminences alternatively.
- c) cup-shaped objects e.g. face mask with soft plastic or foam cuff.

Percussion should be done over clothing or a towel except when using a face mask. The face mask has been shown to be a very effective method of percussion. (Tudehope & Bagley, 1980).

2) Shaking and Vibrations:

These should be carefully applied using only the fingertips. Neonates have very compliant chest walls so vibrations can be very effective at removing secretions. It is often easier to vibrate rapidly breathing infants every second or third exhalation rather than on each breath.

Precautions of Percussion and Vibrations:

- a) Osteoporosis or rickets
- b) Bruised damaged skin
- c) Presence of chest drain
- d) Thoracic incision
- e) Bronchospasm

3) Manual Hyperinflation:

This is not a technique used in the treatment of L.B.W. infants as the risk of pneumothorax is so high

Manual hyperinflation may be used cautiously in the full-term neonate in certain circumstances e.g. post-operatively. It should not be used as a physiotherapy technique when alveolar hyperinflation is a problem e.g. after meconium aspiration.

All other precautions that apply to older children also apply to neonates.

Mobilization and Positioning

Mobilization

Unlike the older child and adult passive movements are not routinely required in the LBW infant. Preterm infants are hypotonic, and over-vigorous passive handling can damage joints which are poorly protected by lax ligaments and hypotonic musculature.

L.B.W. infants are often not paralysed and sedated for ventilation for long periods as they are usually treated with IMV or CPAP and therefore can move and breathe actively.

Gentle passive movements may be required in full-term infants with peripheral neuropathies or birth injuries such as Erb's Palsy.

Careful passive movements may be needed in infants who have had "drip burns". These occur when an intravenous infusion leaks into surrounding tissues, often around a joint e.g. wrist, ankle, elbow. This causes inflammation of the tissues leading to ulceration, fibrosis and scarring. Particularly damaging are the preparations for intravenous nutrition e.g. Vamin - an amino acid preparation, intralipid - a fat emulsion. Regular observation of infusion sites is essential, a severe burn can develop in only fifteen minutes. Treatment consists of elevation of limb to reduce oedema and daily dressings with cream, such as Flamazine, to keep burn clean and moist and to encourage healing.

During this time regular gentle passive movements are necessary to maintain joint range and prevent contraction of healing tissue. Drip burns are extremely painful and infants can become hypoxic and bradycardic when joint movements are carried out. Severe drip burns may require skin grafting.

Positioning

A normal full-term infant spends the last 4 - 6 weeks in utero in the flexed "foetal" position. This is due to the increased size of the infant and decreased amount of liquor allowing less room for movement.

A L.B.W. infant does not experience this flexion and so exhibits an extended posture. These infants often prefer the prone lying position which accentuates extension. The LBW infant often goes on to develop retracted shoulders, externally rotated hips and everted feet.

When infants can tolerate position changes nursing staff are encouraged to nurse infants in alternate side lying in a flexed position with shoulders forward and hands in midline. When the infant is lifted out of the incubator the flexed position is maintained. Swaddling in a small blanket or sheet is good for maintenance of the flexed posture but cannot be used for infants who require close monitoring.

Mothers are encouraged to continue positioning infants in this way at home.

Neurodevelopmental Physiotherapy

Many infants who have suffered birth asphyxia and periventricular haemorrhages will need to be seen by the neurodevelopmental physiotherapist.

These infants will need individual assessments to decide on the optimum treatment programme.

Ideally the physiotherapist who will treat the infant after discharge should be involved early if possible to carry out the initial assessment when the infant is able to tolerate handling.

In these infants treatment in the early stages is minimal, consisting of advice on handling and positioning to mother and nursing staff.

The optimum time for assessment and treatment is when the infants are awake, alert and content - these periods may be brief! If infants are cold, tired, hungry or miserable then treatment should not be attempted.

The use of stimulation programmes in these infants is controversial. The LBW or preterm infant may already be overstimulated due to the amount of noise, light and handling it is receiving.

Signs of overstimulation and stress include gaze aversion, vomiting and hiccups.

A.P.C.P. CONFERENCE 1988

Members of National and West Midlands Committees meet together.



CONFERENCE DINNER

The Conference Dinner was held at the Manor Hotel, Meridan with the Guest of Honor being Sir John Cox KBE. It was preceded by a sherry reception.

Proposing the Welcome Toast to the Guests, the Conference Chairman, Mrs. Caroline Dunn sent her best wishes to absent friends and colleagues, and went on to mention that the Conference had given the West Midlands Region, an opportunity to demonstrate what it could offer both in the clinical field and the environment. She then outlined the facets of industry, beautiful countryside, architecture and history. Praising the hard work of the local organising committee, she said that the Conference would not have been possible without their help.

Mrs. Dunn introduced the Guest of Honor - Sir John Cox KBE who was present with his wife-describing him as 'A retired Admiral, now involved with many charities, notably those connected with Naval Officers widows, and orphans, and also cerebral palsy.

In his speech Sir John asked "Why am I here? I am not a parent, nor a grandparent of a disabled child, and not a member of the medical profession! He answered it by saying "I'm here as a member of the public who knows just how much we owe to your skills. I have been privileged to see many of you at work. I also have seen the result of your skills with disabled children, I'm therefore a believer!

He went on to state that he was on several Boards of Charities, among which were the Cerebral Palsy Society, Cerebral Palsy Overseas and the Bobath Centre. He had recently helped organise a Seminar in Cambridge on Disability Overseas. Sir John pointed out the need for more research and statistics in our field, and impressed on us the importance of publicity, pointing out the desperate need for proper, responsible, investigative journalism, with a constant positive thrust from each and every one of us. He urged us to use local radio, television and press to further our cause, and regretted the lack of resources for physiotherapy. He also noted we were in the front line and unfairly blamed for these shortages, and suggested that it was now time for even more publicity - not aggressive, not complaining, but positive! The public must be aware of our enormous responsibilities.

Advocating self belief and confidence in ourselves as the way forward. Sir John said that we as a profession were respected and admired by many thousands. He concluded by saying "The recipe for a perfect evening is to eat with nice people, drink with nice people and sleep with a clear conscience. Ladies and gentlemen you should sleep very well!"

Mrs. Maggie Diffey, Chairman of APCP thanked Sir John for his speech which had given everyone much 'food for thought'.

Replying on behalf of the guests Miss Moyna Gilbertson, an inaugural member and first Chairman of APCP, reminded everyone that the first meeting of the Association was held in 1972, and that this thriving Association was now more than half way towards the year 2000. She thanked the Chairman on behalf of the guests.

* * * * *

CONFERENCE REVIEW

Mrs. Mary Clegg - Vice Chairman APCP.

It is my very pleasant duty to take you back over the past few days in an effort to bring to your minds, some of the many and varied things we have heard about, and done, over this quite amazing week-end!

Events leading up to these few days began to happen some months ago, when we were discussing future Conferences at one of the National Committee meetings. The venues came up and the member from the East Midlands made the point that the Chartered Society Conference amongst other things, was due to be held in Nottingham this year, and perhaps this would put enough strain on the generosity of the local people. Could another Region possibly run it in 1988? I should explain at this point, there is usually a 'run in' of about three years in order to plan a Conference - and this discussion took place about 12 months ago! The London Region at that stage were searching for a venue, and realising we were next on the list I suggested we could do it. I must admit I have felt extremely guilty about the enormous amount of work that decision created for the very dedicated local committee, with whom I have spent very little time. However they did it, and what a Conference it has proved to be.

The title itself, 'Paediatrics Toward 2000' has proved a talking point, and last night our first chairman, Miss Gilbertson said, that since the formation of APCP we were now halfway towards 2000! The week-end started for me with a frantic checking of last minute things with the local committee, then on to a long and busy National Committee meeting, followed by a very pleasant supper where the two committees were able to meet each other and chat.

Friday arrived, and Dr. John Cash who has given APCP so much support in the West Midlands, opened our Conference. he said he had 16 pages of introduction but wouldn't bother with them as we must start on time! I was sorry about that because from past experience I know it would have entertained us. The first lecturer, Dr. Michael Stevens, Paediatric Oncologist at Birmingham Childrens Hospital spoke on 'A perspective of Children with Cancer'. He very much 'set the scene' for a day devoted to different aspects of Oncology. He told us that childhood Cancer affects 1:7000 children before the age of 15 and that it is second only to accidents as the cause of death in the first year of life. He went on to give a brief outline of the epidemiology of cancer in children, outlining new approaches to treatment, and describing certain conditions in some detail. He pointed out the improvements in the survival rate since as recently as 1983/84, the reasons for this, and he was guardedly optimistic about the future.

Mr. Sneath, Consultant Orthopaedic Surgeon, continued the morning by giving a vividly illustrated lecture on the treatment of bone tumours. He showed the development of the earlier Stanmore growing prosthesis, through to the present model for lengthening the prosthesis to adapt to the needs of growing children. He showed numerous slides on the operative procedures for the removal of bone tumours, his enthusiasm for his field being reflected in his presentation, and the extremely functional results which he obtained are remarkable.

Miss Jenny Llewellyn, Physiotherapist at the Birmingham Childrens Hospital, started the afternoon talking about the Physiotherapy treatment of children with cancer. She stressed the importance of chest care and the reasons for it. The role of

the physiotherapist in the long term rehabilitation of brain tumours was explained, and some of the other conditions encountered were illustrated by some excellent case histories. She also spoke on team involvement, her membership of it, and its importance, ending on a note of hope for the future.

Miss Christine Burge, Physiotherapist, continued the afternoon with an excellent lecture, clearly and logically presented, describing the role of the physiotherapist in the management of tumour in the lower limb. She stated that bone tumours affect 1:250,000 per head of population and that there were now, alternatives to amputation. She emphasised the importance of good assessment prior to diagnosis and treatment planning. She also stressed the importance of the team approach, and then outlined three treatment plans in detail. These routines varied according to the site of the tumour, soft tissue disturbance and the magnitude of the prosthesis itself. The programmes, goals and expectations were clearly described. A most enjoyable and informative lecture.

After tea, Miss Margaret Randell spoke on Psychology related to the Oncology patient and his family, saying it was the most challenging post she had ever held, and that she felt humbled to find herself in such a role. Her quiet, calm presentation underlined her sensitive understanding of the needs and perceptions of children with tumours, and their relationships with their families and the outside world. She explained that psychology is about life, how you respond to it, and how people respond to you. She explained that her contact with the children must be a forum for an information exchange, and an opportunity to talk a child through his/her feelings. She gave us all a greater understanding of the emotional upheaval cancer brings to the life of a child, and showed some very thought provoking slides of drawings done by children suffering from terminal cancer. I am sure we were all made more aware of the overt and covert fears of these children and their families.

The day ended for some of us, with a visit to that most famous of places, the Stratford Theatre, where we were able to relax and enjoy an outstanding performance of 'Much Ado About Nothing'.

Saturday morning was chaired by Dr. Griffiths, and Dr. Fardon, Consultant in Clinical Genetics from Birmingham, gave us a lively description of the developments in Genetics. Asking the question 'why make a genetic diagnosis?'. He said we do it for information, prevention, to give genetic counselling, and to provide a pre-natal diagnosis. The structure of chromosomes was described together with Dominant and Recessive inheritance factors. He ended by explaining the importance of good genetic counselling, stressing that the information given, must be in the correct atmosphere. A fascinating lecture with some provocative ideas, put forward. The silence during parts of the presentation was golden.

He was followed by Dr. Durbin who described himself as a pianist with two harpists! He, Sister Kemp from Kings College Hospital and Mrs. Annette Parker-Physiotherapist - gave an interdisciplinary account on neo-natal intensive care of the very immature baby. They asked what it was all about, and where is it going? With all the speakers we were taken very clearly through the problems arising in neo-natal units. Dr. Durbin reinforcing attention to the smallest detail, by saying "too much oxygen turns you blind, and too little makes you daft"! The enormous complexities of handling the very small pre-term infant were highlighted by Sister Kemp and Mrs. Parker.

Dr. Durbin then summed up the presentations by talking about the financial

implications of neo-natal care - explaining the debits and credits, and concluding that with their knowledge to date there seems to have been considerable justification for what is comparatively small expenditure, when costs are related to outcome, and compared to other areas in the Health Service.

After lunch our APCP Chairman, Mrs. Maggie Diffey, chaired the session. Only one word can describe Professor Salmons' Exploration and Exploitation of the Adaptive Potential of Skeletal Muscle' - it was Electrifying. He took us through the history of early electrotherapy, and went on to describe the way that use could change a muscle. He described how it was now possible to take Latissimus Dorsi and create a second heart muscle, and told us how research has shown that although muscle form can be changed - it is reversible. A thought provoking idea to all of us. Following this, Mr. Barnett and Miss Smith from Strathclyde University described aspects of their research programme to evaluate the effect of electrical stimulation on spinal injuries patients, the therapeutic benefits, functional effects and physiological processes. The most exciting development to date, is Sequential efferent stimulation using floor reaction ankle foot orthosis, and while this form of walking will not replace a wheelchair for general mobility, it is hoped that its use will enable patients to remain physically fit, and avoid some of the long term complications often associated with spinal injuries.

We were welcomed to Coventry this morning by Miss Jo Barnacle - District Physiotherapist, who was chairing the morning session. Dr. Scott then took the stand speaking of the Epidemiology of Handicap, and how not only are diagnostic patterns changing, but also the way in which we serve and reach the children and their families has changed. He went on to describe the changing ideas in the classifying and defining of Cerebral Palsy etc. Dr. Greens Lecture, the Future of Handicap, concluded the programme to the Conference. His lecture was a vibrant summary to a pattern of thought: taken from recent advances in paediatric medicine; through the relatively new problems of neonatal care and the immature baby, to the changing pattern of handicap.

Dr. Green suggested that future causes of handicap would change. As genetic and medical science advance and there is a greater ability to control conditions, then the uncontrollable causes like trauma, may in future account for a greater percentage of handicap. Attention was also drawn to future management and treatment of disability. His comments were a challenging insight into the future of handicap and its implications to paediatric physiotherapy.

May I now briefly go back to the Conference Dinner and say what a fitting climax it was to these few days. Sir John Cox said that he considered Physiotherapy as a career to be an Adventure for life. On the quieter side he reminded us of the need for more research and for us to publicise ourselves more. This has been a hard lesson to learn, but learning it we are. He reminded us of the need for self appraisal, before ending by saying how much he had enjoyed being asked to speak.

Caroline Dunn, our local Chairman outlined the nice things about the West Midlands, and hoped you had enjoyed your visit to the centre of England. Miss Gilbertson replied for the guests and spoke about the founding of APCP. I can only add that in my opinion the week-end has in no way been Much Ado About Nothing!

Chairman's closing remarks

At the close of this 15th Annual Conference of the APCP I will be brief. It has been a really splendid week-end with first class lectures as you have heard from Mary's excellent review, and we shall go away with a great deal to think about. The lectures have covered a wide number of issues important for paediatric physiotherapists, and ought to give us renewed enthusiasm in whatever sub-branch of paediatrics we find ourselves working.

Although the weather has been disappointing, the staff on the Campus have been most helpful, and the space for the trade stands has been appreciated. Last evening the Dinner was superb, and it was helpful to have coaches laid on for both evenings. Congratulations to the team who booked the venue for last night, and how good it was to have Sir John Cox with us.

The local committee have worked very hard and been most supportive of all our needs, it was pleasant and helpful to meet with them on Thursday evening. Thank you to Caroline Dunn and her band of helpers. My grateful thanks to everyone, seen and unseen, who have in any way contributed to this very successful conference.

I wish you all a safe journey home, and look forward to next years Conference in Guildford, and meeting everyone again I now declare the conference closed.

Oh Dear !!

We regret that in the 'What does that mean?' feature in our May edition, the address of ASBAH was out of date, it is of course: 22 Upper Woburn Place, London WC1H 0EP. The telephone number was correct.

Also in the May edition we are sure readers will have realised that the diagrams of HGO's and RGO's on page 17 of Mrs. Herbert's excellent article had been transposed. B should have been A.... and A should have been B.... you did, didn't you??

ANNUAL REPORT

Mrs. Maggie Diffey, Chairman APCP

As we approach the end of the 15th Annual Conference, we can look back and review the last twelve months. As we move steadfastly forward in the field of paediatrics, it has again proved to be very busy.

We have had four National Committee meetings. The agenda becomes longer and we have had to allow increasingly more time for these meetings. We cover a wide range of topics, and there is always a large amount of correspondence to be dealt with. During the past twelve months two small sub-committees were set up.... one looked at aspects of Conductive Education.... this sub committee sent out questionnaires to APCP members enclosed with the Newsletter. The results are being collated and hopefully will be published soon. They also formulated the APCP statement on the relationship between Paediatric Physiotherapists and Conductive Education, to be published in the May Newsletter.

The second sub-committee investigated "Guidelines for Good Practice in Paediatric Physiotherapy". Their preliminary findings were published in the February Newsletter, and members were asked to communicate any comments back to the sub-committee. More work is being done by members of the National Committee to expound on the key points, and further findings will be published in subsequent Newsletters.

Mary Clegg, our Vice-Chairman was invited to represent us on the Kilroy Silk programme on BBC1 which followed the showing of "From Hungary with Love". This was the follow-up programme to "Standing Up for Joe". It was unfortunate that Mary was not given the opportunity to speak.

Our quarterly Newsletter is as popular as ever, copies being sent to many parts of the world, and there are frequent requests for back copies from non-members, most recently from Dubai and the US Airforce. The Editorial Board has met twice during the year, once in Birmingham and once in London, and contents are planned until November 1989. One of the original members of the Board, Mrs. Celia Ball, has resigned after four years sterling work. Her sound commonsense will be much missed and we thank her for her services. In her place we welcome Viv Williams. Jenny McKinley has also joined the board in preparation for taking over from Jeanne Lamond who is resigning as Editor later this year. Jeanne has been a tower of strength as Editor and Chairman of the Editorial Board, for the last five years and inaugurated the new look Newsletter with its distinctive pink cover. The circulation figures are ever increasing, and the publication is widely praised by many people outside APCP who have been lucky enough to see a copy. Much of the success of the Newsletter has been due to Jeanne and the many hours of hard work she has put in. She will be greatly missed and we wish her well in her retirement.

At the last Editorial board meeting some preliminary work was done on a draft constitution for the Editorial Board, which will be presented to the National Committee for ratification in due course.

Miss Elma Bell, our PRO is happy that at Conference the Notice Board is a focus for friendly meeting and discussion. She would like to thank the Visual Aids Department of the Royal Hospital for Sick Children in Edinburgh for their help in preparing the present version. My thanks to Elma for her continuing support to the Committee as PRO.

Meetings with the Regional Representatives have begun again and these will take place before each National Committee meeting. Please, if there are any difficulties or anxieties or matters of interest, communicate them to your Regional Representative and consideration will be given to them. Help us to help you to make the APCP strong and forward looking and not an introspective limited body.

During the year an article in the Newsletter highlighted some of the dangers and problems associated with Baby Walkers. Following publication of this article, there was a statement by CSP and opinions sought by the Press and local Radio Stations. This demonstrates how far some of our recommendations go!

In my capacity as Chairman of this Association, I was invited to the House of Lords to an evening reception marking the Golden Jubilee of the Association of British Paediatric Nurses. It was a most pleasant evening and a chance to 'fly the flag' for paediatric physiotherapists.

I take this opportunity to thank fellow members of the Committee.... Jill Brownson, our Treasurer, with her awesome responsibility for the accounts and the wise use of members Annual subscriptions.... Mary Clegg and Pam Eckersley for their work with the Post Registration Education programme. Unfortunately Pam is not able to be with us this weekend, as some of you may know, she has had a change of post and is now Director of Special Education Resource Services in Manchester. Regrettably she feels she must tender her resignation, and I am sorry not to have the opportunity to thank her publicly for all the work she has done for APCP. Mary will now take over the running of the Post Registration Education and will be forming an Educational Committee. My thanks to Michelle Lee, who is now publications officer and I understand has a spare room at home filled with APCP booklets, which are good value for money!

My thanks to the Regional Representatives who faithfully come to the Committee meetings and then return to their Regions to report, in a two-way dialogue between members and the committee. They also have the task of receiving the Newsletter from the carrier and distributing it to local members along with any local information to be included. Thank you for working so hard to keep everyone informed.

Finally my thanks to Sandra, who is retiring as Secretary. She has taken on the double role of Secretary and Membership Secretary and has had an enormous load to carry. She is for the time being carrying on as Membership Secretary, but relinquishing her post as Secretary to the Committee. My personal thanks to her for all her guidance and sound common-sense during my term in office.

TREASURER'S REPORT

Mrs. Jill Brownson - Honorary Treasurer

This Report usually explains the Summary of Accounts as presented at the A.G.M. but following the A.G.M. in Warwick I have been asked to use the newsletter to explain aspects of the Association's Accounts more fully.

Following the presentation of the Accounts at the A.G.M. a substantial increase in the Membership fee was proposed and seconded. This increase was proposed as a direct result of a deficit occurring for the year ending December 31st 1987; it must be assumed that a similar deficit is likely to occur for the year ending December 31st 1988 and of course the association should not be allowed to run at a loss for more than two consecutive years.

The increase in membership fee is substantial especially if viewed as a percentage of the existing fee but the elected National Committee have resisted an increase on behalf of the member for several years; although members might wish in retrospect that it had been increased in two easy stages. Members should be aware that all Regions now hold their own Regional Account which is audited with the National Account to produce a Consolidated Account for the A.G.M. Regions are bound by the constitution to pay into the National Account any money, held at December 31st of each year, in excess of a pre-set limit (currently £500), to assist in running costs. At a meeting of Regional Treasurer's in August of last year, it was concluded that this created some resentment between the Regions and the National Committee. As a result of this a suggestion was made that the Membership Fee should be increased so that it covered the costs of running the Association, producing the Newsletters etc. and that money raised in the Regions could remain in the Regional Accounts, although of course the Regional Accounts will still be Audited and presented at the A.G.M. in a consolidated form with the National Account.

Last year I stated that consideration should be given to Bursaries being made available in the future. Assets of £11,647 held in the National Account at December 31st 1987 are not enough to make this feasible yet, but if more money is to be held Regionally then the Members have more opportunity through their Regional Committees to propose funding for places at Conference or Congress (several Regions already do this).

A large number of members continue to pay a Standing Order to the Association, sometimes in addition to the current membership fee. If you have ever paid by Standing Order please check with your bank that it has been cancelled.

POST REGISTRATION EDUCATION REPORT

Mrs. P. Eckersley

The past year has been one where the processes involved in paediatric education have been consolidated, and there has been an opportunity to re-assess and reevaluate the role of, and the requirements for entering the field of paediatric physiotherapy.

Four major developments have been important:

1. The course "An Introduction to Paediatric Physiotherapy" has been revalidated for another year. Feedback from the students who completed the course in 1986/87 was very positive and the 1988 'package' will run with only minor amendments to the content. However, the original course package was designed and first run in 1984. Since then, there have been developments in the field of paediatrics generally, as well as changes in professional practice, clinical needs and current legislation. Teaching styles and curriculum developments have also changed. This would seem to be an opportune time to look at the present course format and content to ensure that it accurately reflects those changes.

Any feedback or comments from members would be very welcome.

2. During the year the committee has also taken the opportunity to educate itself. A study weekend was held at Cheadle Royal Hospital, in Manchester in May 1987, organised by Ann Grimley, who also tutored on the course, and the North West Regional Health Authority. The Workshop was on Roles and Responsibilities; and the committee looked at job analysis, job descriptions, role demands and conflicts - and constraints. A very valuable and enjoyable weekend which led on to the Working Party convened by APCP on Good Practice in Paediatric Physiotherapy.

3. A meeting was held in July 1987 with John Huntington, Education Officer CSP, to discuss a joint proposal with the College of Occupational Therapists on paediatric training. As a result, a document was drawn up on the possibility of a study to investigate the needs and required competences of remedial paediatric therapists. It is proposed that this should be submitted to the NHSTA.

4. The practices and processes of the 1981 Education Act form ongoing topics for debate. The University of London Institute of Education, completed a pilot document on "Decision Making for Special Needs" funded by the D.E.S. APCP was asked through the CSP for comments on this document, which allowed us to give our views on the needs of therapists, children, parents and the need for co-ordination and liaison of services. Many thanks to Jill Brownson and Jenny McKinlay for all their help. New legislation also has a bearing on our work. Sections 5 and 6 of the Disabled Persons (Services, Consultation and Representation) Act 1986 are now implemented, and as with the 1981 Education Act our input will be required.

Thanks as always to all the members of the committee for all their help, particularly Mary Clegg; and to the Chartered Society for their continuing support and encouragement.

April 1988

APPRECIATION

It is with deep regret that we record the resignation of Pamela Eckersley from the National Committee, and wish her well in her new post as Director of the Special Education Resoure Information Service in Manchester. She was a member of the National Committee for some years, and became a co-opted member taking on the duties of Post Registratiton Education Officer, following the expiration of her original term of office on the National Committee. She has given a total of ten years service. One of the principle instigators of the Validated Course in Paediatrics, she was responsible for much of the planning for it, and was course leader for the Pilot run in the North West Region in 1984. As a representative of APCP at many National events she upheld the professionalism of Paediatric Physiotherapists with a whole hearted dedication. She also researched and co-authored the "1981 Education Act" published by the CSP as an official reference for APCP and other paediatric professionals. Her support and the sound advice she was able to give was well known to many members, and her pertinant comments and immaculate presence will be sadly missed by all who had the privilege of working with her. Thank you, Pam.

LETTERS

"I am a paediatric physiotherapist and I am doing a project which is part of a two year Diploma course (Southampton). The project is concerned with the effect of the early use of leg gaiters for improvement in posture, gait and hip stability in the Down Syndrome child. Is there any physiotherapist who is using the same method, and would like to help me with my project? If so I would be grateful if you could ring or write to me to compare results. It would also involve a short questionnaire.

My address is:- Mrs. Brigitte Toro, Child Development Centre, Milton Keynes General Hospital, Standing Way, Eagleston, Milton Keynes MK6 5LD. Tel: 0908 660033 ext. 2313. Thank you in anticipation.

From Mrs. Margaret Sharpe, Senior Physiotherapist, Brookfields School

As a postscript to the correspondence on the Ballerina Syndrome may I offer two articles for reading that cover this subject well:

Papariello, S. G., Skinner, S. R., J. Paediatric Orthopaedics, 5: 171-175, 1985.

"Dynamic E. M. G. Analysis of Habitual Toe-Walkers".

Kalen V. et al, J. Paediatric Orthopaedics, 6: 31-33, 1986.

"E. M. G. of Idiopathic Toe-Walking".

The main items of interest from these articles are:-

1. E. M. G. findings of abnormal timings of both onset and duration of contraction in gastrocnemius and anterior tibial muscles.
2. Boys pre-dominate (78%) with 71% showing an inherited tendency and 67% of male relatives being affected.
3. 20% of affected children, or more, have learning problems which may be visual, minor speech and reading difficulty, or just slowness. Autism and emotional liability were also found.

Sharrard (Sharrard, W. J. W. 1979 "Paediatric Orthopaedics and Fractures", Vol. 1) also has a few interesting things to say about his condition. A distinction should be drawn between congenital short tendo-achilles and minimal cerebral palsy, as conservative treatment may suffice for the former, whereas recourse to surgery may be required for the latter. The only child seen at this special school for mental handicap had causation of the first group and did well with serial plastering followed by daily manual stretching of tendo-achilles and such tactics as heel pounding and backward dragging to stimulate the anterior tibial muscles.

A puzzling condition indeed!

**Re Standing Frames.
From Dr. E. Green, Chailey Heritage**

Some of our children with severe forms of cerebral palsy have experienced 'funny turns' whilst strapped in their standing frames. Each child stands regularly for about forty-five minutes, three times a week, and the stands used during these occurrences have been Junior Flexistand and Jenx prone stander.

One child flopped forwards in the Flexistand and went blue, one child flopped forwards in the Jenx prone stander and passed out.

Two children have extended strongly in the Flexistands, and one in a prone stander and become blue. On moving the children, they each recovered immediately. Each occurrence was within the classroom setting, except for one child where it happened at home.

The classroom helpers and parents had all been shown how to put the children in the frames, with something at a reasonable height in front for hand play. We asked if straps behind their bottoms had been loose, but it has been difficult to discover the cause.

Has anyone else had a similar experience? If so please contact me.

From Jamie Wright, aged 9 years

I am at the Hospital today,
I don't like it much,
Everyone nags at me.
But when I see a girl

In a wheelchair - could it be
Could it be she is worse
Than me?

From Lesley Edwards, Secretary, West Midlands Region

The amount collected for the Members Benevolent fund at the Warwick Conference was £64.90. It has been forwarded to the fund via C.S.P. We thank those who contributed.

STANDING UP FOR NORMALITY

Lorraine Gradwell

Development Worker, Greater Manchester Coalition of Disabled People

We have heard a lot about Conductive Education: the media have had a field day.

We find ourselves confronted with television programmes entitled "Standing up for Joe" and "To Hungary with Love": and Sunday Colour Supplement front pages carrying the headline Walking against the Odds - crippled British children find new hope in Budapest.

This high media profile has publicised the feelings of the parents and families of children with cerebral palsy, who say the provision for their children is both inappropriate and inadequate, and want to promote the conductive education methods in this country.

There are many different issues to be untangled here; such as why can these children not get appropriate treatment in this country? Are their parents right in their claim that conductive education is what the children need? And why should they have to rely on emotive press campaigns to highlight their concern?

On top of all this is the fact that the claims made on behalf of conductive education have not been objectively researched and examined.

"The Peto Institute"

Conductive education is practised in the Peto Institute in Budapest; it was developed by Dr. Andras Peto who for almost twenty years was a Professor at the Training College for Teachers of the Handicapped until 1963, and who died in 1967.

The work of the Peto Institute is based on the theory that a motor disorder is a learning difficulty, a problem of bodily control which can be acquired by intensive work and skilled teaching.

Claims are made that up to 75% of the children at the Peto Institute achieve orthofunction, that is the capability to eventually live independently without the need for special help or equipment.

The children and sometimes adults, are trained by conductors who are teachers, physiotherapists, speech therapists and a hundred other specialists rolled into one. Wheelchairs are not allowed, only basic sticks or callipers, and the main entrance

to the Institute is by way of a flight of thirty steps. The children are required to walk.

Herein lies one of the dangers of the benefits attributed to conductive education. The implication is that if only they try hard enough, these children will become normal and will be able to walk and talk like other children.

Ignoring for the moment this dubious notion of normality, the fact is that not enough is known about the benefits, both long and short term, of conductive education. It may well be that the intensive methods practised have good results for some children and adults, but it is cruel and thoughtless to raise the hopes of hundreds of people who may believe all the media hype about conductive education, and come to regard it as some kind of miracle cure.

What we have not seen in the press and the media is hard evidence about the effectiveness of conductive education and the long term benefits, if any, which result. If conductive education has been practised for twenty years, where are the adults who benefited from the treatment as children, and are they still feeling beneficial effects? Also, suggestions have been heard that perhaps the Peto Institute only accepts those children who have a high level of motor ability anyway, and hence their claimed 75% success rate; other people, however, claim to have seen very severely impaired children make great progress at the Peto Institute.

In response to a parliamentary question on October 29th 1987, Mrs. Edwina Currie stated that as yet no proper evaluation of the benefits of conductive education has been undertaken either here or abroad. The Department of Education and Science has agreed to fund a Birmingham University research evaluation of the Foundation for Conductive Education's pilot project in Birmingham; maybe this research will provide some of the concrete answers which are needed.

“A National Obsession”

The Foundation for Conductive Education is a national charity established in 1986 which recently opened its first unit for conductive education in Birmingham, and it is this project which will be the subject of Government funded research. The project will train British conductors with a small group of ten children; the numbers will increase as the conductors gain experience, and in the third year of the four year course an adult group will be set up for people with Parkinson's disease.

The Foundation has the support of RACE (Rapid Action for Conductive Education), a lobbying group, mostly of parents, whose name is self explanatory.

RACE are asking for a short-life working party of MP's to be set up to report back to the House of Commons, the DHSS, the DES, and the Foreign Office on a strategy for the development of conductive education. They are also proposing that future co-operation on conductive education should be included as commitment in the British/Hungarian Cultural Exchange Agreement which is to be reviewed next year.

These would seem to be reasonable, well thought out objectives which, even if you do not agree with conductive education, can hardly cause offence. On the other hand we have the deliberately heart-rending appeals in the colour supplements which rudely interrupt our Sunday mornings!

To come back to this dubious notion of normality.

The media are one of the worst culprits in promoting the idea of physical

perfection: women in general have long been the objects of this kind of idealisation. Disabled people in particular are the butt of this similar kind of image building, although image destroying would be a more accurate term.

Disabled people are portrayed as helpless or dependent to some degree, unattractive, burdensome and troublesome. So of course it is up to disabled people to strive to be as normal as possible. Isn't that so?

Just as it is up to women to strive to be as attractive and decorative (and as much like the pin-up of the day) as possible. Isn't that so?

Well, of course not: at long last women in general realise that they do not have to conform to some idealistic standard of what a woman should be. Similarly, disabled people are beginning to question the notion of normality to which we are supposed to conform. One of the stumbling blocks of course, is fitness and the whole idea again of physical perfection. But being fit does not necessarily mean being able to walk, or talk, or see for that matter.

Normal is not a fixed concept; it changes according to fashion, prejudice bigotry, and all manner of influences. So let us stop imposing an absurd notion of normality on people, whether those people are women, disabled people, or any other group of people who have been required to conform to certain standards.

Let us be fit, or try to be; and let those who can, walk; and those who can, talk; but let us not make it an obsession.

This article first appeared in the G.M.C.D.P. Coalition News, and we are grateful to Lorraine Gradwell for her permission to reprint it.

SEATING, A PARENTS VIEW

A talk given by Bernard and Pat Fleming to a meeting of N. West APCP

When considering seating for a handicapped child there are four main points:

1. Persuade us, the parents, why we need to use special seating for our child.
2. The child's comfort.
3. Improvement of the child's medical condition.
4. The convenience of the equipment when in use.

Why Should I use Special Seating?

Ideally I would like physiotherapists to explain the future problems of poor seating to the parents when they are first seen. This may mean 'frightening' them with pictures/examples of the results of bad posture. As professionals we all have a mental picture of a child with severe scoliosis, kyphosis or lordosis to encourage us to give the best possible support from day one to our children, normal or handicapped. However, most parents haven't ever seen these cases and do not understand the need for STRAIGHT, FIRM, support to the spine, to stop the occurrence of these problems. Our first speaker said about scoliosis "if we get them

early enough we can prevent it happening". You as physiotherapists need to get this message through to the parents to ensure that they use the seating you provide, and don't use bean bags or corners of the sofa, which they see as more comfortable.

The Child's Comfort

The child needs to actually use the seating provided. If the parent can't see the need to use the seat to help with posture, she won't use it. If it is seen as uncomfortable or awkward to use around the house, it may stay in the garage!

Some discomfort may be acceptable to correct a severe postural problem, but the primary need is COMFORT and SUPPORT. Most chairs need a windshield to protect the legs from draughts. All pushchairs have them and our children have greater need, as they don't move their legs to keep warm. The disabled spend most of their life seated, so they need to be comfy.

From the CDC we were offered two seats.

The HAYES CHAIR which moved well around the house, but had no sideways support to stop scoliosis in the floppy child like Tim. It's slightly rounded shape encouraged kyphosis, as did the weight of his floppy head and arms.

The CORNER SEAT.... great if the child can sit up, but in the floppy child head and arm weight encourage kyphosis.

These were the two seats offered to us for Tim up to two years-old.... were they the right choice for him? Or were they all that was available at the time, making the best of an inadequate job within financial restrictions?

Around this time, as Tim was poorly, we frequently used a plastic sledge with a foam mattress. It could be easily pulled from room to room, with him lying semi-prone. If he needed to be tipped a cushion could be put under one end to achieve it. A simple idea for other parents with poorly babies.

Improvement of the Child's Medical Condition

THINK what the child needs, not what is available in the store. Some equipment offered to us was both inappropriate and expensive. The ALVEMA CHAIR.... was offered as it is one of the few seats to fold and tip back. But it wouldn't tip far enough for Tim on a bad day. Also having spoken to a Mother who has one, it's great around town, but impossible to get on and off buses. They had to change to an estate car to get it in the boot, and on a wet day, the lovely soft covering gets soaked while you put it up and rethread the harness through three different layers in the back!

ALAC have a range of chairs on offer.... none were appropriate for a child like Tim. We were shown all they had on the shelves, and they did not seem to understand initially why we could find nothing suitable. We did eventually accept a THAMES TILT for Tim at school. It didn't tip back far enough for him even on a good day, and its narrow wheelbase made it awful on our country lanes. I must add they have now supplied (with medical recommendation) a MATRIX SEAT which gives him the support he needs.

Convenience of the equipment in use

Discuss with the parents what is really needed. If they live in the country like us, the chair must go into the car, and needs wheels suitable to the rough country lanes as well as town streets.

We have a KIRTON chair which allows Tim, to "slouch" it is not the ideal sitting position, but it's his soft comfy armchair, and we have needed to make a wedge to get the footstool at a reasonable angle when he is tipped back. The tray was too small, and we have made a better one to which we added plastic removable sides so he can play with battery operated toys while I wash up.

Tim now has his MATRIX SEAT which positions him very well and has a windshield behind his legs. The buggy major frame is very good around town but it gives a rough ride in the country, as it has no suspension, and the wheels lock on muddy tracks. The SNUG SEAT would also have been suitable for Tim, but was not available to us.

Upright seats are excellent if the child has some muscle control, but in the floppy child you need seating that will tip back, far enough to support him on the bad days, and stop his head dropping forward, pulling his spine out of shape. But for the good days you need the facility to be as upright as the child can manage, to encourage good posture, in the long term.

What about the purpose built seat?

Many parents are competent DIY handymen and may be able to build a seat that may be uneconomical to buy. When we took Tim to Naidex '87 in our FLEMING MARK 1 seat, at least ten physios asked us where they could get one! The next seats are our answer to our problems with Tim's seating:- because we couldn't find a seat on the market that was satisfactory for Tim, and the only one's we were offered had at least one major drawback each, we decided to make one ourselves that would work.

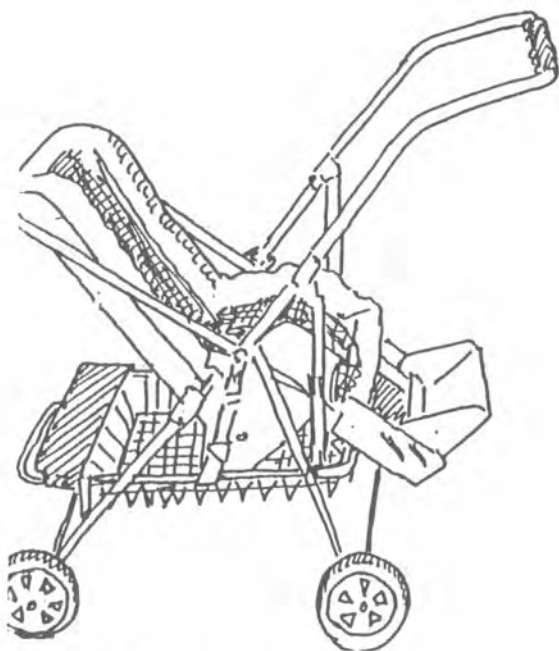
The results were as follows:-

BASIC TRANSPORT SEATS - Mark 1 the Addis Bin Seat.

A new plastic bin was cut/sawn up and reassembled, plus a few nuts and bolts etc. to form a two right-angled seat that was adjustable for growth. Support was provided by foam packing fitted inside a slip over upholstery cover. The seat was made to fit into a standard Silver Cross pushchair, but would also fit the Mothercare etc. ones on the market. This also allowed us to use the pushchairs recline facility for his good and bad days.

Mark 2 - the BAC SEAT - basically a stronger, more precision made, and better version of the Addis bin. We did the design, and drew the plans and the BAC factory engineered it. A bit over the top, but a very good job that worked well in daily use for some considerable time.

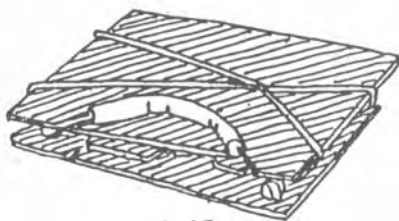
Mark 3 - the Hurst Green Plastics seat, a further version of the Mark 2 but built out of 'bent' plastic sheet by a helpful local firm. Designed to be lighter than the Mark 2.



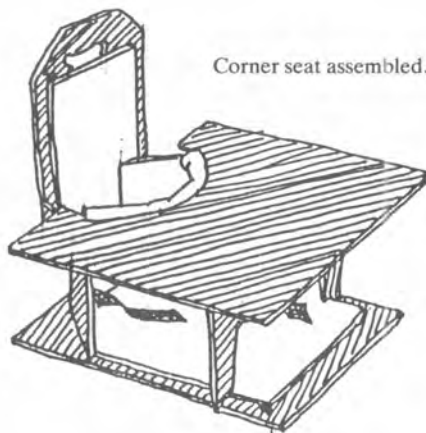
Mark 2 and 3 seat in pushchair.

THERAPEUTIC SEATS

Collapsible Corner Seat. This when assembled, is a wooden corner seat with or without integral tray. Corner seats we had been given were large and took up too much space to use at home, so this one was designed to be rigid when assembled, but easily taken to pieces and packed flat.



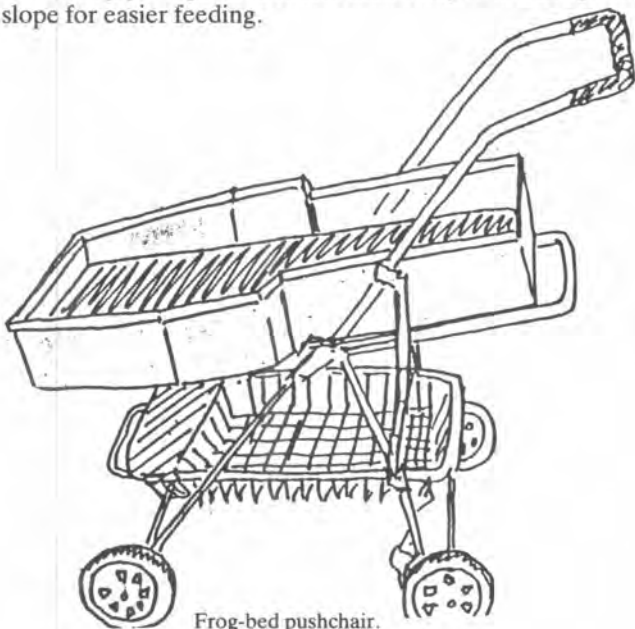
Corner seat, packed flat.



Corner seat assembled.

Frog-Bed pushchair seat

After tendon-release etc. it was necessary to nurse Tim in a 'frog' position. The only seat we were offered was a twin pushchair - this was totally unsuitable because it was too big and too heavy to go in the car, was too low to lift him out of, and would not fit through any of the house doors. The "flying coffin" was shaped to fit through the doors, was at a workable height, and clipped on and off a standard pushchair. It was simply a shaped plywood base with plastic sides, strengthened with a metal strip and held on with pipe-clips. It took less than a day to knock up, and Tim could also be on a slope for easier feeding.



Frog-bed pushchair.

OTHER SEATS

Car seats - When small, no car seats would recline enough for Tim, so we packed him with triangular foam wedges.

Potty chair - As he needs to be supported for quite a time on the loo before he performs, we use the seat part of a "7-in-one Baby Relax" high chair. Unusual to find a high chair in the loo, but it works well!

Rocking/Bouncing seat - A spring-action rocking horse with the horse taken off, and an old baby car seat and footrest bolted on. Probably of no physiotherapeutic value, as he is totally unsupported and flops around a lot in it! However, he does enjoy being bounced and thrown around.

To RECAP

Not all families live in a barn, it can be difficult to get all this equipment in a modern house! Kirton Chair, Prone Board, Side Lyer, Matrix Seat, Corner Seat, Computer, Suction Unit, Nebuliser.

What's missing from this sitting room? Mum, Dad, other kids, three piece suite etc.!

Please see if all possible equipment can be collapsible. Equipment stored in the garage never comes back, and is a waste of money. For Transport, Mum, Dad and two kids plus a wheelchair fill the average family car plus boot. Anything extra means a second trip or a second car.

Practicalities

Simple things make life easier.... velcro needs to be the right way round i.e. with the hooks up away from jumpers, thus avoiding nasty snags.

Car seat belts without an arm loop avoid the danger of dislocation, a belt that will separate all five straps, also makes it easier to see to a child having a fit in the seat.

Seats and chairs should fold easily, and go into a normal sized boot.

If possible pushchairs/wheelchairs should be suitable to attach to the special Supermarket trolleys. Asda and Sainsbury's have adapted trolleys that will attach to a wheelchair and avoid the need for a 'push and pull' expedition.

Appropriateness

Is the seat right for the use to which it will be put?... A McClaren buggy is a problem if you live in the country.... For indoor use castors are ideal and avoid scratched furniture (well some of it). However, castors of the supermarket trolley standard are a definite hazard. Castors work better for the pushed chair if they are at the back and not the front, although no manufacturers have noticed this yet!

Cosmetics

What does the chair look like? You can always spot the disabled child from a distance, as he is the one definitely NOT in a pushchair. If a chair can be made to look reasonable and normal, it is better for us and our children.... especially those that have no mental handicap.

Weight

The chair should be easily lifted by Mum into the boot of a car, without the need to recruit Dad or a hefty passer-by. Some seating isn't used because Mum can't manage it alone.

Tim is not the worst child in the world to seat, but he is floppy at times, and through our continued vigilance, so far has little spinal deformity. This is how we've coped with his seating problems over the years, but what everyone else who hasn't a nursing background, and the knowledge of the dangers of bad seating, to ensure their child's spine stays straight. With your help, maybe we can inform them, and prevent the next generation from getting spinal deformities.

**Plans of the Fleming Flat Pack Chair (corner seat) can be obtained from:- Mrs. B. Edwards, Warth Cottage, Coppice Lane, White Coppice, Chorley, Lancs. PR6 9DB. Cost £1 inc. p. & p. (see over).

Cheques to be made out to APCP North West. Proceeds from the sale of the plans to be donated to Timmy Flemming.**

BOOKS

Easy to Make Learning Toys.

John Coxon.
Blandford Press £7.95.

Communication Before Speech. Normal Development and Impaired Communication.

Edited by Judith Coupe and Juliet Goldbart.
Croom Helm. £7.95.

Pre-Feeding Skills.

Suzanne Evans and Marsha Klein.
Winslow Press. £25.

Occupational Therapy for Children with Disabilities.

Dorothy Penso.
Croom Helm. £8.95.

Windows to our Children.

Violet Oaklander.
Real People Press. Price ??.

RESULTS OF NATIONAL CHILD DEVELOPMENT CENTRE SURVEY 1988

Following the questionnaire sent out in the February Newsletter regarding Child Development Centres, forty-two replies were received from various parts of the country as widespread as Exeter in the south to the lowlands of Scotland.

Average Number of registered patients per year	468
Average Number of patients referred for physiotherapy per year	120
Type of physiotherapy (per Centre)	
Assessment only	10
Assessment and Treatment	42
Physiotherapy Staff: Whole Time Equivalent	69.75
Comprising of:	
Supt. III	12

Senior I		36
Senior II		13
Junior		2
Helper		1

OTHER CENTRE STAFF

	Total Replies	Full Time	Part Time
Co-ordinator	14	10	4
Secretary	40	30	22
Paediatricians	42	22	57
O.T.	36	20	31
S.T.	41	12	42
Teacher	21	14	20
Social Worker	36	13	25
Mental Handicap Nurse	3	2	2
Nurse	25	20	15
Health Visitor	23	9	11 Liaison 7
Playgroup Leader	19	14	11
Student	12	P.T.5, O.T.3, S.T.1, Nurse 4,	H.V.2
Aide	8	2	10
Interpreter	8	0	10
Clinical Psychologist	29	3	31
Educational Psychologist	23	3	22

VISITING STAFF

Orthopist	24	2	22
Audiologist	21	2	20
Orthopaedic Consultant	22	2	22
Orthotist	18	0	19

OTHER STAFF NOTED

S.C.M.O.	4	1	4
Nursery Nurse	13	12	8
Dietician	2	0	2
Dentist	1	0	1
Music Therapist	1	0	1

Standard of Equipment:	Good	Fair	Poor
	20	12	6

Funding Source:	NHS	NHS+Charity	Voluntary	Joint Finance
	24	8	2	8

Years established averaged 11.

Situations: Hospital - 31, Community - 9 (41 replies)

CONCLUSION

Child Development Centres vary enormously in their size and staffing, and the two do not always correspond. While the above is useful information, it may be necessary to expand the survey further to specify more clearly the objectives of the study.

Copies of the Survey Results and full details are available from Mrs. C. Burnett, MSCP, Senior I Physiotherapist, Slough Child Development Centre, 51 Ladbroke Road, Chalvey High Street, Slough SL1 2SR. Please send a S.A.E.

Result of Survey on Conductive Education

The time scale of meetings had precluded the interesting results of this survey, being seen by the National Committee prior to publication. It will therefore be published in the November Issue.

From Mrs. M. Peeler, Supt. Physiotherapist, Manor House Hospital, Aylebury

THE LING CHAIR

From 1950, Mr. Ling, an office furniture maker, became interested in the needs of Physically Handicapped children. He lived very close to The Great Ormond Street Hospital for Sick Children, and began designing and making special chairs, balancing equipment and other individual aids. The first chair he designed with a friend was called the 'Lynvic Chair'. Later this was modified, following discussions with medical and paramedical staff. The outcome was the corner seat, with an adjustable tray and footboard. On page 172 of the 2nd Edition of Nancie Finnies book 'Handling the Young Cerebral Palsied Child at Home' there is a picture of the Ling Chair familiar to paediatric physiotherapists. Some of these chairs have found their way to America and Saudi Arabia. Mr. Ling had his own business, but made no money out of this special equipment. He charged only for the materials, but nothing for his own time.

Mr. Ling became seriously ill in 1987 and was very anxious that four chairs ordered, but never collected, should be given to someone who needed them. The local hospitals said they had no transport to collect them. Mr. Ling's nephew rang Stoke Mandeville Hospital, and the call was passed on to the Physiotherapy Department in Manor House Hospital. Mentally and Physically Handicapped children have the greatest need for good supporting chairs in their earliest years and the physiotherapists were overjoyed at their good fortune, in receiving a gift of four desperately needed chairs. A member of the Physiotherapy staff, drove to Mr. Ling's home in Walthamstow and managed to get all four chairs into and onto her car. During her short visit a telephone call informed the family of Mr. Ling's death.

Although a sad moment, the family regarded the coincidence as a happy one, which would have given Mr. Ling both pleasure and peace of mind.

STUDY DAYS/COURSES

An Introduction and General overview of the Concept and Practice of the Halliwick Swimming method

October 1st 1988. 9.30 a.m. - 4.30 p.m. Vallance School, Westerham.

Tutor: Beverley Denny, Snr. Physiotherapist, Franklin Delaw Roosevelt School, London.

Registration 9.15 a.m. £12. APCP Members. £14 non-members includes coffee, lunch and tea. Cheques to be made payable to - APCP South East Region.

Applications:- Mrs. H. Voisey, 3 Stapleford Court, Sevenoaks, Kent TN13 2LB.

Child Development Centres: Current and Future Trends

Organised by: RCDC Leeds and ACPP (York).

October 19th 1988.

Clinical Sciences Building, St. James University Hospital, Leeds LS9 7TF.

The Conference will hear papers from six leading figures in Developmental Paediatrics on the current state and future trends in Child Development Centres, and should be of special interest to disciplines associated with Child Development Centres. Physiotherapists will be made especially welcome.

Details and Application forms: Mr. T. Ganssen, RCDC St. James University Hospital, Beckett Street, Leeds LS9 7TF. Tel. 0532 433144 ext. 5838 £15 (Association for Child Psychology and Psychiatry members) £20 non-members. Includes coffee, lunch and tea.

Scoliosis Study Day. St. George's Hospital, Long Leys Road, Lincoln

November 1st 1988.

Programme includes:-

General Outline and Surgical Procedures.

Mr. John Webb FRCS, Harlow Wood and University Hospital, Nottingham.

Respiratory Care - Professor A. D. Milner, Professor Paediatric Respiratory Medicine, University Hospital, Nottingham.

Pre and Post Operative Nursing Care - Jenny Sycamore, Nursing Sister, Harlow Wood Orthopaedic Hospital, Mansfield.

Physiotherapy Management. Miss Noreen Hare MCSP, Supt. Paediatric Physiotherapist, University Hospital, Nottingham.

Research - Outcome and Effectiveness - Mrs. Renate Hallett MCSP, University Hospital, Nottingham.

Orthotic Management. Mr. J. Pembleton FBIST, Snr. Orthotist, Harlow Wood Orthopaedic Hospital, Mansfield.

APCP Members £15. Non-members £20. Details with s.a.e. please:- Mrs. J. Butson, 9 Alderley Way, North Hykeham, Lincoln LN6 8UU. Tel: 0522 684500. Closing date for applications: October 17th 1988.

CALL FOR DISCUSSION PAPERS

**Chartered Society of Physiotherapy
Annual Congress 1989**

September 20 - 22, 1989

HARROGATE

Persons wishing to participate in the Discussion Papers Lecture Presentation at the CSP Annual Congress 1989 are invited to submit 500-word summaries for papers on the following topics:

- The role of physiotherapy in primary health care
- The role of physiotherapist in health education
- New dimensions for the physiotherapist

Preference will be given to papers that have not previously been presented.

The final date for submission of summaries is November 30, 1988.

Please submit summaries to the
Chairman, Scientific Programme
Organising Committee,
c/o Public Relations Department,
14 Bedford Row, London WC1R 4ED.

POSTER PRESENTATION

**Chartered Society of Physiotherapy
Annual Congress 1989**

September 20 - 22, 1989

HARROGATE

Persons wishing to participate in the Poster Presentation at the CSP Annual Congress 1989 are invited to submit applications. This presentation format provides the opportunity to display visual materials critical to the understanding of objectives, methods and conclusions of a specific study. Time will be included in the programme for discussion of posters.

Electrical outlets will be available.

Display board size will be provided on application.

The final date for applications is November 30, 1988.

Please apply to the
Chairman, Scientific Programme
Organising Committee,
c/o Public Relations Department,
14 Bedford Row, London WC1R 4ED.

ABSTRACTS

Title: **Neonatal Screening for Cystic Fibrosis.**

Authors: F. Bowling, G. Cleghorn, A. Chister, J. Curran, B. Grittin, J. Prado, P. Francis, R. Shepherd, Neonatal Screening Laboratory, Cystic Fibrosis Clinic, Royal Children's Hospital and Department of Child Health, University of Queensland, Brisbane, Australia.

Source: Archives of Disease in Childhood 1988. Vol. 63. pp 196-198.

Controversy exists as to whether the long term benefits of neonatal screening for Cystic Fibrosis outweigh the economic and psychosocial costs. Techniques have recently been greatly improved by the use of human trypsinogen monoclonal antibody assay.

The clinical progress during the first two years of life of twenty-eight patients diagnosed by neonatal screening as having CF was compared with twenty-three patients who were clinically diagnosed later in life. The children were matched in terms of age and management.

Fewer medical attendances, fewer chest infection needing treatment are improved overall weight gain was noted in those children screened in the neonatal period. In this group diagnosed clinically, significant differences in the age of diagnosis, number of medical consultations prior to diagnosis and number of chest infections was apparent. Body weight at the age of six months was significantly lower in the latter group and the average weight at two years remained in the 35th percentile. In the group diagnosed by neonatal screening the average weight at two years was on the 50th percentile.

The authors draw the conclusion that neonatal screening programme deserve wider application and study.

Title: Giving Assessment Reports to Parents

Authors: H. McConachie, S. Lingam, B. Stiff, K. S. Holt, Wolfson Centre, Institute of Child Health, London.

Source: Archives of Disease in Childhood 1988. Vol. 63. pp 209-210.

It was decided to conduct a small evaluation study to see the advantages and possible difficulties of routinely sending written reports to parents whose children had been assessed by the multi-disciplinary team at the Wolfson Centre such reports were already sent to referring doctor.

Twenty-five children presenting a complex picture of disability were seen by one of the paediatricians - the average age being five years eight months. The parents received the same reports as was sent to the professionals involved with the children and were subsequently contacted either by telephone or by their Health Visitor.

Parents reactions to these reports were overwhelmingly positive - only two stating the reports were difficult to understand and only one saying they were not helpful. Parents of the younger children tended to be more critical but all said they found them helpful, in recalling the various points of the detailed assessment and as usual basis for discussion with their families and involved professionals.

With some reservations about particular circumstances it was concluded the study had shown the practice of giving written assessment reports to parents had been very helpful.

Title: Joint Mobility and Motor Development

Authors: M. Jaffe, E. Tirosh, A. Choen and Y. Taub, Department of Paediatrics and Faculty of Industrial Engineering, Haifa, Israel.

Source: Archives of Disease in Childhood 1988. Vol. pp 158-161.

The association between hypermobile joints and motor development in infancy has not yet been comprehensively evaluated - norms for the very young age group do not exist.

This study was conducted in 715 babies between the ages of 8-14 months to investigate whether in the presence of hypermobile joints there was an increased incidence of motor delay - i specific joints were more affected and to follow those

babies with positive signs and compare their motor progress with controls.

All the babies involved in this study had been previously screened and classified as not having general developmental delay, a systemic illness or a systemic syndrome.

The study consisted of two stages, Stage 1 consisted of a detailed physical and neurological examination, parents were simultaneously given a Denver Developmental Parent's Questionnaire and seven named joints were measured.

Stage 2 - a random number were re-examined. Joint mobility at the seven joints previously measured were re-measured and motor achievement noted by means of the Denver Developmental Screening Test.

The results confirming that infants aged 8-14 months with hypermobile joints have a significantly increased incidence of motor delay.

Over the ensuing six months 75% of the infants with hypermobile lost their excessive mobility; 83% of the infants with delayed development whose joints had become normal had caught up with their motor development whereas 11%, with persistent joint mobility had achieved normal motor function.

Implication paired are that infants with normal muscle strength, tendon reflexes and motor delay with increased joint mobility constitute a definable clinical entity and have a favourable prognosis.

HAVE YOU HEARD????

★ A survey by the National Federation of Consumer Groups, using a rolling sample of twenty hospitals found 302 babies receiving treatment last year, because of accidents involving baby walkers. The figures suggest the national total could be 6,100 accidents each year.

★ Research is being undertaken at Great Ormond Street into crying babies as causes of family problems and child abuse. 200 families who have had problems with crying babies are participating. A questionnaire is to include Mothers pregnancy history, delivery, effects on family health. Results to be published next year.

★ Since 1960, diabetes in young people has doubled, and there are now about 18,000 insulin dependent diabetics under the age of twenty in Britain. The condition is responsible for 20,000 deaths annually.

★ In the first five months of this year 39,000 unvaccinated children had measles, as against 17,000 last year, six have died. Parents are being urged to take the responsibility of ensuring their children are vaccinated, and so help to stem a measles epidemic.

★ A chain of American supermarkets is providing baby sitting facilities on the premises. They are equipped for children from six months to six years, and are heralded as a godsend by parents. For up to two hours of free child care, parents must spend at least twenty-five dollars.

★ Papworth Hospital is using Teddy Bears to help children recover from surgery. Hugged tightly they help to support weak chest walls, and relieve the pain of coughing.

★ Dr. Bryan - a founder member of T.A.M.B.A. plans a Multiple Births Foundation to provide colleagues, obstetricians, G.P.'s and Health Visitors with specialist advice on helping families who have had multiple births, because the practical difficulties can be enormous - have you tried taking a pram for triplets through a shop door? Also these babies tend to suffer more problems than single ones and are more likely to need intensive care.

★ Doctors at Great Ormond Street can now use the worlds most advanced body scanner to help diagnose and treat childrens conditions with the least amount of trauma. The £3 million magnetic resonance imaging unit is a gift from Mr. Mohamed Al Fayad, the owner of Harrods.

★ The Cystic Fibrosis Research Trust has named Dr. Margaret McPherson as the first holder of a sponsored five year lectureship, at the University of Wales College of Medicine. She will be working on solving the biochemical problems of Cystic Fibrosis.

★ A most comprehensive illustrated guide to Wheelchairs and what is available, has just been published. The sixth edition of "Wheelchairs" in the Equipment for Disabled Series, is available at low cost from:- The Manager, Equipment for the Disabled, Mary Marlborough Lodge, Nuffield Orthopaedic Centre, Headington, Oxford OX3.

REGIONAL REPORTS

Trent

Reg. Rep. Mrs. M. Meagher, 9 Oak Road, Thulston, Derby DE7 3EW

At the end of April, Miss Moyna Gilbertson gave us a brief update on the management of Spina Bifida from her wealth of experience on the subject.

The three day course on Sensory Integration at Harlow Wood was well attended and enjoyed by all disciplines. Future events planned are:-

A Study Day on Visual Impairment in the Multiply Handicapped Child, to be held on Saturday October 22nd 1988 at Westbrook School, Thoresby Road, Long Eaton. Tel: (0602) 729769 (Pysio Department). Details from M. Meagher, address above. Cost £15 APCP members, £20 non-members. Closing date October 4th 1988. s.a.e. please. A Scoliosis Study Day on Tuesday November 1st 1988 at St. George's Hospital, Lincoln. See Course Notices. Have we any artists in the region? If any members would like a specific topic for future courses would they let us know?

W. Midlands Reg. Rep. Mrs. C. Dunn, The Haven, Martley, Worcester WR6 6PQ.

This region hopes the members will forgive the low level of activity by way of programme, this being due to the Warwick conference and its organisation. I would like to take this opportunity of thanking any helpers who may not already have been contacted, for all their co-operation. Although the committee was fairly exhausted at the conclusion of the Conference, I think I speak for all when I say that we enjoyed it, and hope that all our guests did too. The committee hopes to put on a modest programme of events in the next few months, details of which will be published in due course.

London Reg. Rep. Miss V. Read, Flat 2, 62 Madeley Road, Ealing, London W5

The "Basic Counselling Skills" study day held on Saturday 14th May proved to be very successful due to popular demand for the topic. There will be another one on Saturday 29th October 1988 at the Newcomen Centre, Guy Hospital. Please apply to Jenny Mark, 35 Shepherds Hill, London N6 5QT. Tel: 3408743. There is also to be a follow-up study evening for those paediatric physiotherapists who have done a basic counselling skills course. This will be on "Bereavement".

On Saturday September 24th there is to be a basic paediatric study day for junior physiotherapists.

S. East Reg. Rep. Isabelle Johnson, 2 Baye Oast, Ickham, Nr. Canterbury, Kent.

A successful study day was held recently at Chailey Heritage, entitled 'Recent Developments in Alternative Seating'. Our next study day is to be held on Saturday October 1st 1988 at Valance School, Westerham, on "An Introduction to Halliwick".

Questionnaires completed on recent study days have been particularly useful for getting members' ideas for future study days. We hope to include Autism and Vibration Therapy as topics for next year.

N. East Reg. Rep. Judith Baigent, 16 Valley Bridge Parade, Scarborough, North Yorks 7011 2PF.

On Tuesday September 13th we will be holding an evening meeting at York when Dr. David Cundall, Tutor in Paediatrics at Leeds University will talk on "How do we measure handicap in children with Cerebral Palsy?" Questionnaires from Dr. Cundall will be sent to all members prior to the meeting, to provide a basis for discussion. It is hoped that members who are unable to attend the meeting will still fill in the questionnaires and return them to a member of the Regional Committee.

On Tuesday November 22nd, also at York, Christine Lumley, Area Manager at Leeds ALAC, Chapel Allerton Hospital, will give

us an update on the McColl report. Details of both meetings will be circulated closer to the dates.

S. West **Reg. Rep. Miss G. Riley, Meadows, Bowerchalke, Nr. Salisbury, Wilts.**

The newly elected committee met in April, and have outlined a Provisional programme for the next two years. It is hoped to run a course on Clumsy Children in March/April next year. Various local study days are being held throughout the region in the Autumn - details will be given in the Regional Newsletter.

S. West **Reg. Rep. Lin Wakley, 2 Ash Bank, Pipers Ash, Chester CH3 7EH.**

In June 1988 the North West Committee organised two one-day "splinting workshops" as a follow up from the study day on Juvenile Chronic Arthritis last Autumn. Unfortunately for practical reasons, numbers were limited, but we hope that those participating will be available to advise colleagues. Plans are now well under way for a study day on "Downs Syndrome" in October, details of which will be available soon. This will be followed later in the year by a day on "Clumsy Children", and the AGM in March 1989 will deal with "Epilepsy in Childhood".

HELP WANTED

Dear Editor,

The parents of a seven year old boy with mild left hemiparesis are faced with the decision whether to agree to the following surgical procedure: tibial derotation osteotomy.

The child has good overall function with an intoeing gait on the left side. There is $\frac{3}{4}$ shortening of the left leg.

The parents would like to hear from other parents or physiotherapists who have seen results of this procedure.

Letters to : Mrs. L. J. H. de Rijke at Trengweath School, Hartley Road, Plymouth, Devon PL3 5LP.

