ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS

NEWSLETTER

Maggi.

Association of Paediatric Chartered Physiotherapists

Newsletter No. 61 **November 1991**

CARDIFF

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Daniel Baldwin, aged 12, who has athetoid cerebral palsy, shown here as winner of the painting competition organised and supported by the Wales Tourist Board to find a cover for the conference programme. Children with special needs were invited to enter and forty-four paintings were received.

Daniel, who operates his electric wheelchair by a chin control, painted the colourful dragon by mouth. His prize, kindly donated by the Welsh Heart and Handicapped Children Society, was a cheque towards a page turnover.

The second prize, a weekend at the Jane Hodge Hotel, Cowbridge, kindly donated by the John Groom Association, was won by David Jones, aged 15. The Wales Tourist Board kindly donated a prize to all the entrants.

A tremendous WELCOME greeted us all to this International Paediatric Physiotherapy Conference in Cardiff in August. New ground was broken as it was a joint venture between the Association of Paediatric Chartered Physiotherapists and the Association of Chartered Physiotherapists in Respiratory Care.

It all came about in response to the CSP's call to clinical interest groups to arrange events around the World Congress for Physical therapists held in the Barbican.

This was the 18th annual conference of the APCP, and by combining with the ACPRC, together with the Muscular Dystrophy Group, it was possible to arrange a varied and full professional programme, with choices of lectures and workshops. Due to the generosity of local sponsors, it was possible to host the event in the lovely setting of St. David's Hall in the heart of Cardiff.

Our Chairman Comments

The words 'Working Together for Children' used by Cardiff as a motto for the Conference this year, could not have been more appropriate. It surely highlights the need for the continuity of care for our children to be as continuing and as contiguous as possible.

The Seamless Service helps to ensure that the best possible use is made of the resources available.

We had a very valuable and successful joint conference this year involving other Groups, Professional and Voluntary, and many of you feel the need to take this 'Theme' of working together further.

The challenges of some of these changes was also highlighted at the Study Day attached to our A.G.M. Next year, in May, we are taking this a step further forward with the Chartered Society, who are arranging days 'profiling' Paediatric Physiotherapy. A conference day during Nadex will again be looking at ways of 'working together', and efforts being made to provide the best possible future for the children.

Mary Clegg

Paediatric Muscle Conditions - Saturday 3rd August 1991

A Summary Of Lectures

Muscle Condition in Childhood Dr Sheila Wallace

Included a detailed classification of muscle conditions in childhood which enlightened us to the diversity of disorders which directly or indirectly affect muscle tissue.

Screening at 18 months. Dr Rob Smith

Interesting talk detailing the Welsh project to screen all boys who were non-walkers at 18 months old. Unfortunately it concluded that such a population based screening programme was not justified as detection rates were unacceptably low.

All Wales Neonatal Screening Project for D/M/D. Dr Angus Clarke

Well presented lecture which described the reasons for initiating the screening programme, how the programme is operated and included an ongoing evaluation to decide whether the benefits of early diagnosis outweigh the disadvantages.

Handling the Floppy Baby. Mrs Viv Williams

An illustrated description of the early intervention in the management of the floppy baby. A contrast was shown with the full-term floppy baby who often present initially with feeding problems. The babies respond to the handling as a sensori-motor experience improving their head control, feeding and hand/eye co-ordination.

Living with Muscular Dystrophy - The Practical Aspects. A presentation by the Muscle Clinic Team, Cardiff.

An interesting video presentation detailing the current physiotherapy treatment for DMD in South Glamorgan. Followed by an account of the role of the family Care Officer.

Orthotic Management. Mr Alan Davies

An outline of the history of the development of the V.C.G. Swivel Walker followed by its advantages and disadvantages in current day use.

Equipment and Aids of Daily Living. Mrs Phillipa Harpin

Tremendous amount of information detailed in a short space of time regarding aids available to improve the quality of life for DMD boys and their families.

Wheelchairs. **Mrs Clair Walker**

An informative account of both outdoor powered chairs and lightweight manual chairs available at present on the market and a discussion of those most suitable for DMD boys.

Muscular Dystrophy Now. **Dr. David Gardner-Medwin**

Began with an interesting history of how the muscular dystrophies were described and defined as separate entities and then brought us right up to date with the latest genetic developments. Also included a comprehensive overview of the current day management of DMD at Newcastle.

* * * * * * *

Dr. Margaret Griffiths (Hon Member of APCP) and Mary Clegg (APCP Chairman) signing books to which they have both contributed:
Working together with Handicapped Children
Cerebral palsy - Problems and Practise

Wales Region managed to obtain copies of these books, and delegates made a donation to SCF for the autographs. A magnificent £30 was raised in the coffee break which contributed to the £1000 donated to Save the Chidlren Fund.

The following are notes taken by Sue Mickleburgh from the lecture by Dr. Sheila Wallace.

Conditions Of Childhood - Dr Sheila Wallace

Disorders of Muscle

Can be secondary to:

1. General disorders affecting all systems
2. Abnormalities of brain or spinal cord (UMN)
3. Anterior horn diseases
4. Neuromuscular junction
5. Peripheral neuropathy
6. Primary disorder of muscle

1) Generalised disorders affecting other systems in addition to muscle

These usually affect all muscle groups and are often associated with other problems,

e.g.
- mental retardation
- cardiac
- hepatic
- seizures

2) Secondary to upper motor neurone disorders

Main features include:

- alterations in tone
- inappropriate agonist/antagonist activity. Such disturbances may be found in varying conditions, e.g. cerebal palsy

post head injury
post encephalitis

3) Anterior horn cell

There are two groups:

a) **Genetically determined**

e.g.
- spinal muscular atrophy I
- intermediate SMA (typeII) - often have respiratory problems associated with a scoliosis.
- Kugelberg-Welander disease - chronic form.

b) **Acquired**

e.g. following poliomyelitis.

The spinal muscular atrophies are progressive diseases with the weakness greater proximally (except in the distal type). The cranial nerve territory is spared (except in Fazio-Londs disease). The more chronic diseases are associated with severe scoliosis. All have genetic implications so families will require genetic counselling.

4) Neuromuscular Junction

The main features of myaesthesia is extensive fatigue on movement

There are several types e.g. autoimmune myaesthesia gravis, neonatal myaesthesia gravis (affected mother - can need respiratory assistance following birth).

Congenital/hereditary myaethenias.

5) Peripheral Neuropathies

These can be divided into:

- a Acquired e.g. Guillain-Barre eyndrome
- b Hereditary: "primary" e.g. HMSN (hereditary motor and sensory neuropathy) types
  "secondary" e.g. porphyria
  Krabbe, MLD etc.

Hereditary secondary neuropathies are metabolic disorders, can be progressive and affect the brain. The peripheral neuropathies always have weakness which is greater distally. The hereditary types are usually slowly progressive, and often have pes cavus and clawed toes. The main disorder in which muscle problems predominate can be divided into the following categories.

1 Hereditary/Congenital

- a Muscular dystrophies
- b Congenital myopathies
- c Myotonia syndromes

2 Inflammatory

Dermatomyositis/polymositis
Myositis of bacteria parasitic/viral type

1 Hereditary Dystrophy

These include:

1a X-linked Duchenne/Intermediate/Becker
Autosomal Recessive - limb girdle
- scapulohumeral
Autosomal Dominant - Facioscapulohumeral
- Ocular, oculopharyngeal

There is normally an important genetic influence in this group

X-linked muscular dystrophy

The Clinical course is related to dystrophin level in muscle. The acute form e.g. Duchenne type will have very little or no dystrophin present in the muscle. Where there is more dystophin the disease will be more prolonged e.g. Becker type. Initially there will be weakness in the limb girdle which will progress. There is a great danger of contractures and scoliosis - so it is important to try and keep the child as free from these as possible.

1b Congenital Myopathies

e.g.
- central core disease
- minicore disease
- nemaline myopathy
- myotubular myopathy with type I fibre hypertrophy
- myotubular myopathy (centro-tubular myopathy).

These have variable presentations e.g. weakness, floppiness, contractures at birth, floppy infant, can also get later onset weakness.

The duration is variable, e.g. limb girdle
generalised + ocular muscle involvement
muscles often small
genetic implications variable.

1c Myotonia syndromes

Myotonia congenita

These patients have difficulty with relaxation following a sustained contraction, e.g. could be stiff if they wanted to get up from sitting. They do have fairly large muscles.

Dystrophia Myotonica

Features include:
Ptosis
Facial weakness
Wasting of sternomastoids
Distal greater than proximal weakness
Myotonic males can be infertile

Infants with Dystrophia Myotonica

Problems include:
Hypotonia
Respiratory difficulties
Feeding difficulties
Talipes equinovarus

2 Dermomyositis

This is an acquired auto-immune condition. The patient is usually ill with pain, may be febrile, has skin lesions and gets discolouration of eyelids with a rash. There may be erythema over joints and particularly mild contractures in flexion and pronation of elbow and they often have stiff shoulder joints.

The distribution of muscle weakness is symmetrical with proximal muscles more affected, e.g. they have slender thigh muscles and large calf muscles
etc.

INTRODUCTION

I am taking the opportunity and the platform presented to me by my collaboration with your association at the recent International Conference organised in Cardiff.

Last year I was appointed the National Training and Education Officer for the Muscular Dystrophy Group, and for the seven years prior to that appointment I was a Family Care Officer for the Group working in South Wales. I have therefore had good experience of working in team setting with people with neuromuscular disease.

I am also very aware that muscle disease in children is relatively rare and although you as physiotherapists are far more likely to come across cases of Duchenne muscular dystrophy, than your GP colleagues for example, individually you will not all be treating Duchenne let alone less common neuromuscular diseases.

To get back to my belief and the aims behind the creation of my post, which covers the United Kingdom.

1 We aim to raise the profile of the neuromuscular disease.

2 We aim to inform and advise the professionals about the emotional, the practical, and medical problems of those with neuromuscular disease.

3 We therefore aim to improve the services and thereby the quality of life for people with neuromuscular disease.

The first aims lead into the last which has to be the raison d'etre of it all, improving services and quality of life.

We propose to do this by organising training across a wide range of professionals, and also to actively seek to participate in and provide input into the training programmes of other agencies, such as health authorities, local authorities, and other statutory and voluntary organisations.

Now, the reason for writing. Physiotherapists are crucial people to interest and involve, because not only do you have a huge influence both in a hands on situation, with our patient group, but you are also in a good position to positively influence the medical team.

You are involved often quite intimately with older boys and with younger children, and are in a position to hear a lot of the emotional worries and the family troubles as well as the medical and management problemss.

I am very keen to arrange meetings and seminars around the country, that will give me the opportunity to speak to health care professionals involved in the care of our patient group. I am happy to speak myself at any meeting you may be organising, large or small or alternately I am keen to arrange for you a local speaker on aspects of caring for people with neuromuscular diseases.

What I am really saying to you is that I'm here and happy to help in any way that will give you advice and information and promote the interests of our patient group.

Mrs Sue Sibert
National Training and Education Officer for the Muscular Dystrophy Group
Institute of Medical Genetics
University Hospital of Wales
Heath Park
Cardiff CF4 4XW Tel - 0222 744021

HANDLING THE FLOPPY CHILD

Reading List

Berta Bobath (1967)
The Very Early Treatment of Cerebral Palsy.
Developmental medicine and child neurology 9, 370-90.

Dubowitz Lily and Dubowitz Victor (1981)
The Neurological Assessment of Pre Term and Full Term Newborn Infant.
Clinics in developmental medicine No. 79 SIMP and Heinemann Medical Books, London.

PRECHTL H.F.R. (1977)
The Neurological Examination of the Full Term Infant.
Clinics in developmental medicine No. SIMP and Heinemann Medical Books, London.

R. S. Illingumet
Basic Developmental Screening 0 - 2 years.
Blackwell Scientific Publications
Oxford London Edinburgh Melbourne.

Mary D. Sheriden
Children's Developmental Progress for Birth to Five years.
NFER Publishing Company Ltd.

N. Gordon and Ian McKinlay
Children with Neurological Disorders Book 2
Neurologically sick children.
Blackwell Scientific Publications.

Sophie Lewitt
Paediatric DevelopmentalTherapy
Blackwell Scientific Publications.

J. Lesney, M. Proskova, P. Zoban
Development of Flexor Spastic Signs in Pre Term Infants
Developmental Medicine & Child Neurology 1986 28 45-48.

The Floppy Infant
V. Dubowitz
Blackwell

A Colour Atlas of Muscle Disorders in Childhood
V. Dubowitz
WOLFE

The High-risk Infant - Some new views in early assessment
F. M. Murphy 367-371
Physiotherapy V. 77 No. 6.

V. Williams July 1991

WORKSHOP REPORTS - 1

Coping with the daily problems of a child with a chronic chest condition.

This workshop consisting of above 20 therapists, was lead by Ms Melanie Andrews from the Hospital For Sick Children at Great Ormond Street. The majority of people in the group were involved in the treatment of asthma and/or cystic fibrosis and included community and hospital based therapists.

The wider issues of chronic chest conditions were considered firstly, and were narrowed down to four main areas of consideration:-

1. The child's true realisation of their illness, and the consequences of it.
2. Copying with rebellion especially in adolescence.
3. Overprotection of the child by the family.
4 Problems within the family resulting from the illness.

Group 1 was asked to look at the question:-

1 What are the problems with administering therapy at home? Emphasis was to be placed on:-
   a) practical and
   b) emotional aspects.

The second group were to consider:-

2. The effect of the chronic chest condition on the family unit and the influence which health care workers can have on this.

After a short period of discussion the groups reassembled and discussed their findings.

1. The practical problems of administering therapy at home included widely varying considerations including

   a) Funding of equipment
   b) Having enough space at home to store and use equipment
   c) Maintenance of nebulisors
   d) Practicalities of carrying out treatment - eg time
   e) Implications of the white paper
   f) Communication between therapists about changing treatments etc
   g) Schooling

On the emotional side aspects such as:-

1. Rebellion of the adolescent child
2. Denial of the child of his condition
3. Over treatment of the patient
4. Feelings of failure and guilt by the parents

In the 2 group the effect on the family unit was considered from each member of the unit.

Firstly the relationship of the parents and the roles each has defined in the care of their child. Is one parent taking all the responsibility for care. Health care workers can ensure that both parents are taught and are capable of doing treatment regimes.

The effect on other siblings was also considered. Their reaction can be one of anger or resentment. They can be protective towards the affected childd or can feel left out. By including other siblings and perhaps setting them small practical tasks to assist the affected child we may alleviate some of their emotional difficulties.

The relationship of the affected child within the family unit differs for each family, but we should attempt to ensure that the child comes first and their condition second and not vice versa.

The effect of health care workers coming into the home was also considered. The benefits achieved included providing a back-up for parents, and showing how treatments can be carried out at home.The child's normal behaviour can be assessed and further assistance given if required by social workers etc. On the minus side too many health care workers may interfere unnecessarily with the family unit.

In conclusion of the workshop references were made to further reading on the subjects discussed. These included:-

HARRIS A, SUPER M. CYSTIC FIBROSIS: 2nd EDITION OXFORD MEDICAL PUBLICATIONS 1991.

SUTHERLAND S., HELP ME MUMMY I CAN'T BREATHE: COPE WITH CHILDHOOD ASTHMA, SOUVENIR PRESS 1987.

ROSE M. M. THOMAS R. B., CHILDREN WITH CHRONIC CONDITIONS: NURSING IN A FAMILY AND COMMUNITY CONTEXT, GRUNE & STRATTON 1987.

Ruth Graham, N.I. Rep.

HELPING PARENTS AT TIMES OF STRESS - 2

Workshop Leader Jim Richardson
Department of Nursing Studies
University of Wales.

Stress was defined as 'unpleasant pressures that were brought to bear on people', each person responding to it in an individual way, some even thriving on it.

As a professional coping with parents under stress it was felt that one had to listen to them and carefully assess the situation, treating them with dignity.

The most important factor in dealing with their stress was felt to be communication, with the family and also with other colleagues involved, so that the advice given or being given was consistent. It was stated that the more information parents received the better able they were to cope, but that this information should be presented in a way that they could understand, not in 'jargonistic' terms. Also the fewer people involved with the family the better, as the parents feel less threatened. With this in mind it was felt that a 'key' worker should be appointed to co-ordinate and communicate information giving a more unified approach and where the parents would not feel excluded. This person should act as the advocate for the family.

Self-help groups were considered valuable in helping the parents to cope and it was part of the health professionals remit to inform the parents about them.

Another point raised was that the health professionals also suffer with stress and need support, that this should be recognised by their managers; they should be given permission 'to care'. 'Hands off' treatment, listening, is at times extremely important and that with increasing workloads and financial pressures they should not feel guilty about this.

In summary it was felt that stress was an individual emotion, that the situation should be carefully assessed and that communication was the most important issue in dealing with this.

Alex Winney, Merseyside

Workshop on Heart Children - 3

This was one of the lesser subscribed workshops, arranged at a late date in response to the recently opened Paediatric Cardiac Surgery Unit at the University Hospital of Wales, and to cater for the large number of delegates wishing to participate in the Sunday Morning Workshops.

The Workshop leader was Miss Elerie Harris, Senior Social Worker, who introduced delegates to the issues involved working with paediatric cardiac surgery patients and their families.

Miss Harris played two tape recordings of different families relating their experiences of discovering their child had a problem, their anxiety as they waited for the results of tests, and how the news was eventually broken.

The first family had a Downs Syndrome child. They were given all the relevant information candidly and always in a very sympathetic manner. They emphasised that the doctor repeated the information over and over again and that they were encouraged to ask questions, always spoken to with respect, and never ridiculed nor spoken down to. The overall picture was of a very caring, loving family, devastated by the news not only that their child had Downs Syndrome, but that he also needed cardiac surgery. They felt they had been treated with care and compassion which gave them the strength to cope with the trauma of diagnosis, surgery and their child's future.

This story contrasted strongly with that of the young mother in the second tape who had known "there was something wrong" with her child, but had continually been dismissed as an over anxious mother. The eventual diagnosis and cardiac surgery left her feeling demoralised and very angry and bitter.

A Case Presentation followed of a young, single parent with social problems, whom the Nursing Staff had referred to the Social Worker. They felt that there was a possibility of the child being taken into foster care as the mother visited so infrequently. A confrontation with the doctor, threatening a care order, infuriated the mother and she became very aggressive, but in consequence stayed with her child continuously throughout the remainder of his stay in hospital. It transpired that the mother lived 30 miles from the hospital, was single, having split up with her partner, had poor housing, very little money and minimal family support. She felt intimidated and inadequate amidst all the technology of an Intensive Care Unit. With encouragement and support, the mother was able to feel part of the team caring for her child, and so her confidence and self esteem improved. With practical, emotional and social help she was eventually able to take her baby home.

Animated discussion followed. It was felt that all professionals had condemned this mother on face value. Delegates concluded that all relevant knowledge should be knowledge shared and shared accurately with empathy. Professionals should not stand in judgement of parents, nor condemn them for apparently inappropriate behaviour, but be seen to support parents through their crisis, liasing with each other to achieve this aim.

The Workshop, therefore, supplied much food for thought and a salutary lesson for some of us.

Book reference:

Heart Children - A Practical Handbook published by Heartline Association, Great Ormond Street.

Taking Home Your Special Baby - 4

Miss Judith Gibby
Paediatric Social Worker, University Hospital of Wales, Cardiff.

Miss Gibby introduced this workshop by explaining the traumatic experience for parents when their baby is admitted to the Special Care Baby Unit, usually without pre-natal preparation because there is no indication of need.

Research has shown that parental views range from devastation and guilt, to relief that such expertise is available. The parents are usually unable to express all their feelings.

The baby is cared for 24 hours a day, there is much equipment with bleeps, lights flashing and numbers. Baby will look fragile and the parents may feel frightened of him. Input from Staff can be debilitating for parents, but when they take baby home there is a feeling of sudden isolation.

The group was told about Melissa - a baby admitted to S.C.B.U. with problems later identified as Cornelia de Lange Syndrome. She is the first baby of unmarried late teenage parents, sharing inadequate housing, father being currently unemployed, claiming joint benefits. The parents, who had no warning ante-natally of a problem visited several times daily and were distressed at the technology and at the high Staff to baby ratio. Melissa was likely to need nasal gastric tube feeding on discharge.

Referral to the Genetic Department was made at one week.

Small Groups Discussed:

1. What were the main counselling and practical needs for the parents.
    a) Whilst Melissa remained on S.C.B.U.
    b) Following her discharge into the Community.
2. How, as professionals working on S.C.B.U. can we improve the services currently offered to parents during this very stressful time.

A summary of the conclusions follow, ideas on all three issues overlapping.

Parents anxieties must be addressed with honesty, giving as much information as possible in a way they can understand, repeated often if necessary. The parents will need help with their relationship with each other under these circumstances. Waiting for a diagnosis can be devastating but once there is one it can be a starting point.

Help may be needed with bus fares for visiting, or if great distances are involved parent accommodation may be a better alternative. Bonding, with the help of photographs, parenting skills and feeding via the nasal gastric tube should be encouraged. Housing issues should be looked at.

When Melissa goes home the parents will need to be linked with the Community Team. If possible the extended family will be involved. Care should be taken to regulate the number of people going into the home, but the parents must feel confident that they are not alone and know how to contact those who can help them.

Two tapes followed, each of parent and social worker discussing the parents experiences of S.C.B.U. and taking the baby home.

The first mother had to fight to find anything out, felt that too much was expected of her, that she was not helped enough, just left to get on with getting to know her baby and was not counselled enough. She said going home with baby was frightening, that there was no security and without her family she could not have coped.

The second tape was of a better experience. The parents thought they had been given enough information and that Nursing Staff had made them feel at ease. Mum found it difficult on the Maternity Ward without baby but the parents had been involved in feeding.

On taking baby home, the parents had difficulty in adjusting and found the situation frightening and needed their family. They would have liked more professional help.

Discussion on these tapes could not take place due to lack of time, but listening to them and taking part in this workshop was a very valuable experience.

Judith Hemming-Allen
Sandwell H.A

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Presentation of Save the Children Fund cheque at the Conference Dinner in Cardiff Castle.
(left to right:- Liz Rowbottom, Rep. from Respiratory Group, Mary Clegg, Chairman APCP, Guest of Honour, Hon. Mrs. Legge Gourke, Lady in Waiting to the Princess Royal and Chairman of the Welsh Branch of the S.C.F., Lyn Horrocks, Key Worker for Conference, Sue Sibert, Natinal Training and Education Officer for the Muscular Dystrophy Group.

CONFERENCE DINNER - CARDIFF 1991

Jeanne Lamond

Those of us who attended the 1984 APCP Conference in Cardiff have fond memories of a Mediaeval Banquet in the environs of Cardiff Castle and some more mature delegates (?) making music with the peacocks under the stars! Naturally, with this in mind, the opportunity to partake once more of Welsh hospitality for a first Paediatric International Conference, was not one to be missed.

This time the setting, though still in Cardiff Castle was rather more formal. To be precise - the library and Banqueting Hall of the section once owned and used by the then Marquis of Bute. We gathered before Dinner in the Library, an impressive room heavy with carvings in wood and stone, and of counsellors. It was a warm evening, and as the liquid refreshment circulated the conversations flourised, as members in colourful dresses relaxed after the days lectures and workshops.

Eventually Dinner was announced and we proceeded into the magnificent Banqueting Hall. The circular tables with centrepieces of flowers and lighted candles, were set against a background of carvings and heraldic devices, richly coloured in bright blues, reds, greens and gold with a carved Knight in armour sitting on his horse, above the mantelpiece. Having found our places, Grace was said by Miss Ann Grimley, a former Chairman and Honorary member, before we settled down to enjoy a lavish meal. Soup, chicken, salmon, salads, wonderful raspberry meringue, Welsh cheese and coffee disappeared rapidly, and as the light outside faded, the open windows showed us the lights of Cardiff against the dark sky - and of course we heard the peacocks calling below, vying with the harpist who had played to us during our meal.

Mellow and replete, we sat back to listen to our speaker and Guest of Honour, the Hon. Mrs. Legge Bourke, Lady in Waiting, to the Princess Royal and Chariman of the Welsh Branch of the Save the Children Fund. An extremely elegant lady with a strong resemblance to the Princess, she chose as her subject "Hats". As she explained, travelling the world with her "Boss" the variety of headgear worn by local peoples varied enormously, and specimens were easy to collect and include in her luggage as souvenirs. Speaking at high speed she then produced from the depths of a large laundry basket, a succession of highly individual hats, each accompanied by amusing anecdotes which kept us laughing. However, we also learnt of travelling in the far north of Canada, through various countries in Africa, the heat and flies in India, of Tibet and areas of the Middle East. We heard of day long journeys in the African bush, on the hot leather seats of Land Rovers, of 7 hour walks in the Himalayas and climbing up 1500 stone steps to a Tibetan Temple. Obviously you have to be tough to be a lady in waiting! The dedicated work of Save the Children workers in the field was vividly portrayed for us with stories. We heard of the Delivery room in a hut, ready with its scrubbed table - 'the equipment': a sterile razor blade and ball of string! We listened to the story of the health visitor whose clinics were all on top of various 10,000 ft. mountains, needless to say she is very fit! Fascinated, we could have listened all night, but sadly and all too soon, time ran out - with some hats still in the basket.

Our Chairman, Mrs. Mary Clegg, rising to propose the vote of thanks, had a difficult act to follow, but managed it with her usual gentle efficiency, including her speech congratulations to Miss M. Gilbertson on being awarded the OBE in the recent Honours List.

Finally a cheque for £1000 for the Save the Children Fund was presented to Mrs. Legge-Bourke by the Welsh Committee, who are to be warmly congratulated on their organisation not only of a highly successful Dinner, but also a highly successful Conference.

Needless to say our memories of Welsh hospitality were not false, and I for one will always be happy to go back to Wales, where they keep a welcome in Cardiff as well as on the hillsides.

PHYSIOTHERAPISTS ARE WELCOME IN MY UNIT

Mark Reid MB, FRCP (Glas.), FRCPI,
Consultant Neonatologist,
Belfast City and Royal Group of Hospitals

Physiotherapists should be seen as part of the team of professionals involved in neonatal care. They have a role in intensive and special units in the care of infants in acute situations, but also in the longer term, in the assessment of developmental, neurological or orthopaedic problems, which may be obvious while the children are inpatients, or only become revealed over the first year of life. [1,2]

They may be required to use their expertise, particularly in infants with pulmonary problems. Chest physiotherapy is valuable in a selected number of infants who require intermittent positive pressure ventilation (IPPV). Physiotherapy is not usually required or appropriate in the first 2-3 days of life, as during this time infants are often in a precarious state, with labile blood pressure and easily induced hypoxia. [3]. Furthermore, physiotherapy carried out in infants with respiratory distress syndrome may be counter-productive, particularly if they had installation of exogenous surfactant; introduction of airway suction and physiotherapy might then only remove the surfactant from the airways into which it had been placed to improve ventilation and aid recovery. Furthermore, in the early stages of respiratory distress syndrome, the infants do not have significant amounts of bronchial secretions. [4].

Babies who have severe meconium aspirations, however may benefit from physiotherapy via suction of the intra-tracheal tube in order to remove the plugs of meconium. Again, these infants often are hypotensive and may have neurological problems, which may be exacerbated if they are handled excessively. Moreover, they run significant risks of pneumothrax. Therefore, once more they must be in a stable condition prior to physiotherapy being carried out.

It can be seen therefore that physiotherapy has a small, but significant part to play in those infants who have significant bronchial secretions, where obstruction of the airways may prolong their time in intensive care areas and their need for mechanical ventilation; i.e. those with longstanding respiratory distress syndrome, meconium aspiration, or those infants with pneumonia or purulent secretions. There are also infants who have localised atelectasis following incorrect positioning of the intra-tracheal tube, or plugging of the bronchi with meconium or pus who will benefit from postural drainage and physiotherapy, if it is done quickly and expertly. [5,6,7].

The infant's condition may be judged as being stable, by clinical observation and with the use of cardio-respiratory monitors, and the presence of stable blood pressure, diminishing oxygen requirements and the absence of significant acidosis. Initially, the intra-tracheal suction may be carried out 6-hourly, following installation of 0.5 mls normal saline down the intra-tracheal tube. Physiotherapy should be carried out by a pair of operators; one to hand the physiotherapist the saline, suction, and also observe the infant's monitor readings, while the physiotherapist performs the suction and 'bagging'. These procedures should be carried out in the briefest time as feasible and hyperoxia should also be avoided as much as hypoxia. Percussion postural drainage can be applied, using fingertips or possibly electric toothbrushes; although there has been dispute regarding the effectiveness of the latter. [8].

Excessive secretions are frequently seen in infants with chronic lung disease, e.g. caused by broncho-pulmonary dysplasia. This is seen particularly in infants who have been ventilated for more than one week, in oxygen concentrations more than 70%; ie. those with severe respiratory distress syndrome, meconium aspirations or of extreme low birth weight. In these infants there is destruction of aveoli and secondary emphysema and pulmonary fibrosis. It is therefore important to remove any secretion from the airways to reduce the need for continued ventilation or oxygen treatment, both of which may further exacerbate the underlying pathology. These patients may perform a significant proportion of long stay infants in newborn nurseries, and a few will be sent home with domiciliary oxygen. Obviously, therefore, parental instruction in the use of physiotherapy to these small number of patients is advantageous.

Those working with infants in this highly intensive situation must take precautions to avoid cross-infection. Infections caused by organisms such as staphlococcus aureus, coliforms and monilia are frequent problems in over-crowded, busy intensive care units,and therefore strict attention must be paid to hand washing and asepsis in the treatment of these infants, particularly when moving from patient to patient to avoid the potentially fatal complications of systemic or pulmonary sepsis.

There is therefore in the early neonatal period a very important and obvious role for the physiotherapist in these chest problems indicated above; in addition there is their role in the treament of deformities caused by fetal deformations, such as some varieties of talipes, genu recurvatum or those acquired disorders such as brachial nerve palsies. Many of the infants with talipes will recover spontaneously, but early physiotherapy may be of some benefit in speeding the positioning of the joint into a more normal position. Brachial nerve palsies are usually seen in the form of Erbs Palsy, particularly frequent in those infants who are weighing more than 4.5 kgs, or following delivery after shoulder dystocia, or delivery by breech. Possibly up to 90% recover spontaneously, but physiotherapy is of use in preventing later joint contracture of wrist, elbow and shoulder. It is obviously important to show these physiotherapy manoeuvres or treatments to the parents of the baby, so they can be conducted in a planned fashion at home after discharge from hospital.

The physiotherapy treatment of infants with neurological dysfunction, caused by cerebral palsy in the early intervention role is becoming increasingly popular, following the pioneer work of Bobath. 9. The detection of the infant with cerebral palsy may not be possible in the majority of infants until they are at an age of at least 4 months. 1. Thus these infants are most frequently identified in follow-up clinics of infants who have been at high risk during the immediate peri-natal period, i.e., those with a history of extreme low birth weight, convulsions etc.

It would obviously be advantageous if the physiotherapist who had been working in the acute situation are then able to partake in this follow-up, they being familiar with the infant's history and have had time to possibly establish a suitably empathetic relationship with the parents concerned, and thus be able to organise treatment on a joint basis with the paediatric staff in their dual role in the outpatient clinic.

The work of Bobath [9], Wyke [10] and Kormer [11] have shown that infant's behaviour and development depend upon their sensory experiences and input, and thus appropriate handling and stimulation of infants who have neurological deficit or defect caused by cerebral palsy, may enable them to improve their developmental skills and the co-ordination required to attain the appropriate milestones. Of course, these goals may be modified by the severity of the underlying neurological condition and the infant's intellectual capacity, as well as the ability of parents to understand and carry out the appropriate manoeuvres.

It has been shown that infants involved in an early intervention programme have had an improved ability to sit and to stand and attain independent ambulation, compared to those infants not given this treatment. There is also less parental rejection of these patients, compared with those families in whom no early intervention had taken place, as shown by Sobolof. [12].

Early intervention programme in children with Down's Syndrome have been more controversial, as indicated by Gibson and Harris [13]. They examined the pooled findings from twenty-one early intervention studies; they showed that there was a consistent short-term benefit in the development of motor skills and social repertoire could be attained, but did not show that these gains were sustained in the longer term. However, in the majority of these studies, these programmes were not started in the neonatal period, and therefore it remains to be seen whether programmes started in the immediate post-natal period in the maternity hospital may have longer term benefit.

It is certainly my personal feeling that there is a strong psychological benefit to be obtained by the parents of these children, by involvement with the physiotherapist and physician at an early stage once the diagnosis of neurological disease had been established, and then by helping parents to come to terms with this traumatic and dramatic event in their life, through counselling and handling of their baby. This can be done by reinforcing with them the vital and important role in the infant's moulding and upbringing, leading into the pre-school age. Family relationships through this early period may then be maintained and strengthened. This may avoid the problems as described by Gath et al [14], which did show substantially increased psychiatric and marital problems in the parents of families with Down's Syndrome.

I hope I have therefore shown that there is indeed an important role of the physiotherapist in the assessment, treatment and management of children with pulmonary, orthopaedic and neurological problems, both in the early and neonatal period, then in the follow-up period following what may have been a dramatic and traumatic time in early neonatal life. This role will have a vital therapeutic input into both physical and psychological problems relating to the condition described above.

My thanks are due to Ms S. Hutchman, D. O'Neill, I. Thompson, and their colleagues, for their help and assistance over the past few years in treatment with patients in the Royal Maternity and Jubilee Maternity Hospitals.

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PHYSIOTHERAPY FOR CHILDREN

In 1990, The Chartered Society held its first ever National Physiotherapy Week which was an undoubted success. The theme for the week 'Every Body's Health Matters' meant that members could choose which area of their work to promote. This ranged from sports injuries to rehabilitation of stroke patients or simply trying to give an overview of the role of chartered physiotherapists.

After evaluating the week, it was decided that in future, rather than a general look at physiotherapy, specific client group/treatment techniques should be targeted. In 1992 we will be holding two physiotherapy days, one in May, and another later in the year. Following discussions with your Chairman and other members of the committee, it has been decided that we should highlight the work of paediatric physiotherapists.

We have chosen Tuesday 19th May 1992 when we hope that all chartered physiotherapists who work with children, whether it be in special schools, child development centres, general hospitals or in the community, will organise an event to promote their work.

Examples of the type of events that could be planned are 'open days' for children to visit hospital departments to find out more about physiotherapy; invitations to local mainstream schools for pupils to visit special schools and vice versa, so that children can discover more about their counterparts.

If you work in a child development centre, you may wish particularly to ask your local media along to see the specialist work undertaken with children of varying degrees of special needs.

Another excellent idea is one used by a number of physiotherapists during National Physiotherapy Week. They went to a local school and gave able-bodied children the opportunity to catch a glimpse of what life is like when disabled. The children spent a morning around the town in wheelchairs and learnt a little more about the difficulties of everyday life if you are wheelchair bound.

Many chartered physiotherapsts do, of course, spend a great deal of time talking to school children about how to avoid back, neck and shoulder problems and giving preventative advice. This is another area of work that can be highlighted. I am sure you will have many more thoughts, ideas and inspirations about what you can do on the day. Do let the PR Department at the CSP know, we don't have the monopoly on ideas, and will be more than happy to pass any ideas, information you may have on to the membership.

The Society hopes to produce a poster and leaflet highlighting the work of physiotherapists with children and also have balloons available for distribution, we are also proposing to produce a leaflet for children themselves explaining what to expect when seeing a physiotherapist for treatment.

If you have any clinical drawings/paintings about physiotherapy we would be pleased to receive them for possible inclusion in the leaflet. If there is a suitable one we also hope to have balloons printed with the child's drawing of their 'physio'.

Materials for the day will be distributed via Branch PRO's and the paediatric regional representatives early in 1992. Do contact them if you want any of the literature available.

(Mary Clegg writes as your Chairman to say: "We encourage paediatric managers to promote, illustrate and highlight all areas and aspects o their local paediatric physiotherapy services. In other workds:

SELL YOURSELVES

to management, G.P.'s, Social Services, Education and the public in general).

The following day - Wednesday 20th May 1992 - there will be a

MAJOR CONFERENCE ON THE TEAM APPROACH TO THE INTEGRATED MANAGEMENT OF CHILDREN WITH SPECIAL NEEDS

This will take place at the Birmingham NEC to coincide with the Naidex Exhibition. Teams of speakers from around the UK will present their approaches, and the day will be open to all disciplines as well as parents and their children.

If you would like to know more about the paediatric day or the conference, please do not hesitate to contact either myself, Lyn Duxbury, or Stuart Skyte in the PR Department at the CSP.

* * * * *

PRO REPORT

We have been reminded yet again at rather short notice, that the annual "Children of Courage" (Woman's Own) time is with us. I am assured that this is an ongoing situation, with the announcements being made each Christmas. I am certain that physiotherapists must be in a position to know of children, perhaps in their care, who have either shown outstanding courage in facing illness or disability or who have given consistent and unusual care to another child. If you know of children who might fall within these categories, you may contact directly: Eva Walters, Features Editor, Woman's Own, Tel: 071 261 7018.

The C.S.P. has dispatched a press release citing repeated heavy lifting as the main cause of back injury affecting 50% of physiotherapists at some time. It stresses the importance of maintaining adequate staffing levels, the availability of mechanical lifting equipment, and the ability of the physiotherapist to change her work area to avoid long periods in potentially stressful area.

The C.S.P. now has more blue sweatshirts at £9.95 plus £1 p&p, and are negotiating to have track suits made with 'Chartered Physiotherapist' across front and back. These will be available in a variety of colours.

The careers leaflet has been updated and the leaflet 'Taking care of your family' has been extensively revised.

Caroline Dunn, Hon. PRO

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POST REG EDUCATIONAL REPORT

The Post Reg Education Comittee held a meeting in Leciester on 25 July 1991.
Present were: Mary Clegg, Jenny French, Sandra Holt and Viv Williams

The following items were discussed:-

1. The Committee is to meet in November for 2 days to produce an outline for setting standards of care in Paediatric Physiotherapy. It is hoped that this will be a brief advisory document to help people write their standards.

2. The Birmingham Polytechnic Course was given the go-ahead to run today by the Dean of the Faculty of Health Sciences, following sufficient recruitment. The Course starts on 9 September 1991 and will run over 2 academic semesters. Mary reported that the enquiry level even without advertising had been very high.

3. Sandra reported that an MSc in Physiotherapy has been validated at the North East London Polytechnic and she is negotiating regarding an MSc in Paediatric Physiotherapy.

Mary Clegg

HERE AND THERE

Physiotherapy is muscular dystrophy.

Intermittent compression and other physical treatments in muscular dystrophy.

There are many physiotherapists in paediatrics who are involved with the treatment of patients with muscular dystrophy. With the incidence of these dystrophies varying from 1:3,000 male births (Duchenne muscular dystrophy) to 1:30,000 (Becker muscular dystrophy)[1] it is unlikely that many therapists will see more than two or three patients at any one time. Treatment for these patients follow similar guidelines throughout the country but detailed management will of course vary between areas and between physiotherapists.

My interest lies in one specific area of this physiotherapy management, that of intermittent compression therapy (ICT), i.e. the use of the flowtron or flowpulse. Many physiotherapists feel that this treatment is of benefit, helping to reduce muscle cramp, limit ankle joint contracture and soften the hard hypertrophic calf muscle. Others feel that there is a risk of damaging the muscle during compression and a more "hands on" aproach should be taken.

Although much is known about the role of ICT in the management of oedema, wounds and ulcers, joint contractures and the prevention of deep vein thrombosis post operatively, there is little if any published work on the role ICT in the management of muscular dystrophy.

For this reason the Muscular Dystrophy Group of Great Britain and Northern Ireland has commissioned this research to study the physiological effects of ICT and to establish whether there is a role for ICT in the management of muscular dystrophy and if so to provide guidelines for the use of this equipment.

However, in order to achieve this it is necessary to contact as many physiotherapists as possible to obtain their views on the treatments used in the management of muscular dystrophy.

Please help us so that in turn we can help you to help those suffering with muscular dystrophy.

If you would be willing to complete a questionnaire or discuss your views on physiotherapy treatments then please write to:-

Jennifer Davies MCSP, Research Physiotherapist, Department of Medicine, P.O. Box 147, Liverpool L69 3BX.
Tel: 051 706 2000, Ext. 4085. Fax: 051 706 5802

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Thanks

To: The APCP Committee and Members

I wish to express my thanks for the unique opportunity I had to be a part of the World Confederation for Physical Therapy (July 29th - August 2nd).

As a newly joined member of the APCP attending my first A.G.M. in April, I felt very lucky - if not a little cheeky - in winning the draw for the five day ticket! Now, having attended, I still feel lucky - I greatly enjoyed myself listening to the scientific research findings, treatment techniques and physiotherapy programmes from all around the world.

Topics relating to paediatrics were extensive e.g. various treatment modalities for cerebral palsy were covered by presentations from United Kingdom, United States of America, Australia, Yugoslavia, Sweden, U.S.S.R., Germany and Austria; the subject of pre-terms - from United Kingdom, Australia, Netherlands and South Africa; and a Cystic Fibrosis study afternoon heard speakers from United Kingdom, Sweden and Belgium. Other interesting presentations included physiotherapy for H.I.V. babies (U.S.A.), A.F.O.'s (U.K.) hippotherapy (Austria) and a talipes learning package (Australia).

There is no way I could attempt to precis or illustrate what I learned from the varied days, suffice it to say I left the Barbican at the end of the week feeling saturated with knowledge!

Perhaps something which I, as a newly specialised paediatric physiotherapist, found most useful were a few points from a lecture on 'Trends in the management of the C.P. child' (David Scrutton, U.K.) - namely the great importance of Assessment; treatment/management appropriate to the individual and of constantly updating our understanding of the scientific basis behind our treatments.

It was a week to remember and as physiotherapists from world-wide filled the Barbican, with at least 10 lectures occurring at any one time during every day, it was obvious that physiotherapy is a progressing profession.

Lisa Cox

Senior II Paediatric Physiotherapist, Child Development Centre, Milton Keynes Hospital

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International Conference on Orthotics, Dundee. 16-20 September 1991.

Lyn Horrocks and Pat Straker (from Cardiff) returned from this excellent orthotic conference consisting of papers, research and lectures presented by many different professionals from U.K., Scandinavia, Australia, Europe and USA.

As physiotherapists, they were given a greater insight into the design, manufacture and fitting of different types of orthoses. Many conditions were discussed including cerebral palsy, spina bifida, scoliosis, trauma and neuropathies.

The multi-disciplinary team approach was emphasised throughout. They learnt a lot about the mechanical principles involved in the designs, modern materials available; manufacturing techniques; surgical intervention; follow-up therapy and orthoses.

They feel they will now have a better understanding of the orthotists' role in the overall management of the children that they treat, and look forward to discussing orthoses in detail in their special schools and clinics.

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The British Institute for Sensory Integration

The BISI was established on 28th March this year. Anyone requiring information abut the purposes of this Institution, its principles and practises, should contact Susan Williams, The Membership Secretary, BISI, 18A Thirlemere Road, London N10 2DN.

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APOLOGIES to Elvidina Nabuco Adamson-Mecedo for various editorial typing errors in the last issue regarding her article entitled 'Stroking, Emotion and Cognition: 11 years on'. Correspondence to the International League for Essential Nutrition and Stimulaton should be directed to her at: Yetts O' Huaxu, Glendevon, by Dollar, Scotland FK14 7JY.

HOWIE DUAL CYCLE

Patent applied for

Child's seat in position with back support

Dual Cycling Philisophy

I strongly believe that, if disabled children are held in a safe comfortable position, in an enjoyable situation, some of them may be motivated to some degree of achievement.

Basis	The basis for integrated cycling is a stable structure controlled from the right hand side by a competent driver or conductor.
Balance	The need for this is eliminated by the frames ability to keep up-right and hold the riders in a vertical position. Further stability can be achieved by adding saddle supports.
Propulsion	When the disabled side is in fixed cog mode the conductor can rotate their pedals at a rate acceptable to the child. As both riders can sit upright when the cycle is stationery instruction can begin from zero movement. Any side G-force created is strictly controlled by the conductor's steering, brakes are also controlled by the ocnductor.
Aims	To motivate each child to her or his maximum capacity in rotation, balance, and co-ordination.

THE HOWIE CAR TRICYCLE

Patent applied for

The Howie Car Trike (Prototype)

Philosophy

We strongly believe that, if disabled children are held in a safe, comfortable position, in an enjoyable situation, some of them may be motivated to some degree of achievement.

General Information

Balance	Because a tricycle has three wheels most people assume it to be stable, however, it must be appreciated that a tricycle with one wheel at the front can turn quickly creating considerable G-force in the opposite direction. We feel that our new concept of two wheels at the front will greatly reduce this G-force and give the rider a feeling of stability and safety when turning with similar charactreistics of a small pedal car.
Stability	This tricycle has a wide wheel base in relation to its frame length, stabilisers are also fitted which remain off the ground.
Frame	The frame structure is very strong and access to the saddle is easy due to the frame design and small wheels.

Seating A large seat pin with location holes, clevis pin and R clip make saddle adjustment easy and extensive.

Back Support Strong adjustable back support available.

Pedals Platform type with heel plate and straps.

POLES We consider the function of the poles to be very important, apart from pushing and restraining they are the connectors between the rider, therapists, parent, and it is very encouraging for the children to have the support and involvement of an adult at this early stage.

Pole No 1 In conjunction with a fixed cog on the rear wheel this pole will gently push the tricycle and rotate the pedals at a rate acceptable to the child.

Until the children learn to rotate their legs some resistance to the pole must be expected.

Pole No 2 This pole when connected to the handlebar will allow the therapists, parent, to steer the tricycle, again there will be some resistance to the pole from the children in the process of learning to steer. Hopefully this will decrease in time and the children will become competent to steer and propel their tricycles in safe areas, we would advise that the poles should not be withdrawn too soon after some progress is evident.

Summary The Howie Car Trike is an invention designed solely for the benefit of disabled children. In producing a successful product certain criteria must be met both from the child's view point therapists and parents.

From the Child's View Point the tricycle must look attractive and bright and when aboard must feel comfortable and safe. To them this is a new experience and it is important they get off to a good and enjoyable start which is the basis for a successful finish.

From the therapists, parents view point the child in front of them is secure on a very stable machine and hopefully in a position to be motivated and with the help of the poles will have complete control from a comfortable walking position.

No one can say for sure what the disabled can or cannot achieve but surely they must be given every opportunity to develop towards independence, and this is our concept.

If more details are required, please contact Howie Cycles, 113 Main Street, Auchinleck,
Scotland KA18 2AF. Tel: 0290 25910.

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New Laterally Adjustable Stabilisers to Help Handicapped Children and Adults Learn to Ride Bicycles.

After nearly 2 years of determined efforts, our hemiplegic son, Jeremy, could pedal a bicycle without foot straps, but not without stabilisers. Being a Design Engineer, I invented stabilisers whose wheels are easily adjustable, so that, by small stages, they can be placed closer and closer to the rear bicycle wheel.

Good's Adjustable Stabiliser Positions

Initial **Intermediate (example)** **Final**

It worked wonderfully by gradually improving the balance of Jeremy and, afterwards, other handicapped children suggested by his splendid physiotherapist. Her letter or recommendation states:

"Jeremy's father was determined to help Jeremy gain the balance skill required in independent bike riding, and set about designing a most ingenious set of stabilisers. These stabilisers gradually reduce their support and the child can learn the balance skill in small stages, until he is finally confident without stabilisers. Jeremy learnt to ride the bicycle in a few months, and achieved the skill just before his eighth birthday. We tried them on other children who had been struggling to gain this skill with good results; they learnt to ride independently in a few months, with a six year old child learning in just six weeks. I think these stabilisers are an excellent piece of equipment and I can highly recommend them." (Mrs. E. Owen, Supt. Physiotherapist, CDC, Bangor, Gwynedd).

Jeremy and his bicycle.

The stabilisers are under £60, have many further improvements, fit bicycles with wheels of 16" diameter or more, and support riders weighing up to 11 stone.

Further details and stabilisers are available from:- R.J. David Good, C. Eng., M.I.C.E., Good Designs, 60 Gwel Eryri, Llandegfan, Mental Bridge, Gwynedd LL59 5RD.

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REMEMBER THAT FROM NOVEMBER 1st ....

Access to Health Records Act comes into force.

Your Health Authority should have supplied you with information on this matter, but for a brief summary, and to let you know that the public will now be aware of this new right, there is a useful summary of the Act on the back page of the October issue of 'Which?'.

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Play Matters Publications

Provide a range of booklets in response to enquiries from parents, professionals and toy libraries about various aspects of play. The booklets are intended to give advice and stimulate ideas on play. For further details:

The National Toy Libraries Association
Reg. Charity No. 270291
68 Churchway
London NW1 1LT
Tel: 071 387 9592

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Parents Against Tobacco - or 'PAT'

The PAT bill completed its passage through Parliament, and will shortly receive Royal Assent and go onto the statute book as the Children and Young Persons (Protection from Tobacco) Act 1991.

For full details of the Bill's present contents, please enquire of:-

June Dunmore, Director, Parents Against Tobacco,
46 Arundel Street, Brighton BN2 5TH. Tel: (0273) 601312.

LETTER TO THE EDITOR

Dear Madam

I have been treating a child with Linear Nevus Sebaceous Syndrome. She presents with severe learning difficulties and a dense hemiplegia. As she has approached adolescence, her mobility has decreased rapidly. She is becoming more flexed and appears to be becoming generally weaker.

I would be interested to hear from anyone who has treated children with a similar syndrome and particularly if these children upon reaching adolescence have remained independently mobile.

Yours faithfully
Helen Hollett,
Senior Paediatric Physiotherapist,
Paediatric Community Unit, Nurses Home, Whiston Hospital, Prescot,
Merseyside L35 5DR.

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COURSES

Association of Professionals for Mentally Handicapped People

TALKING TOGETHER **Thursday 21st November 1991**

Venue: Kings Fund Centre, 126 Albert Street, London NW1 7NF

Mrs. Virginia Bottomley, Minister of State for Health will attend the launch of APMH's latest booklet: 'Talking Together'. This publication is the result of a series of highly successful nationwide workshops and residential weekend at the University of Bristol in June.

Fee for representatives of statutory and voluntary organisations: £15.

Applications by 8th November to: The Administrator, APMH, Greytree Lodge, Second Avenue, Ross-on-Wye, Herefordshire HR9 7HT.

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BOOK REVIEW

Show Me What My Friends Can See

Patricia Sonksen, Branch Stiff
Pp65, figs 75, £3.50 (plus £1.00 p&p within U.K.), The Wyseliot Trust.
ISBN 0 9517526 0 X.
Obtainable from: 'Development Guide', The Wolfson Centre, Mecklenburgh Square,
London WC1N 2AP.

This neat little A5 booklet comes as a developmental guide for parents of babies with severely impaired sight and their professional advisors. By guiding the reader through the many aspects of development in the baby with full vision, our attention is drawn to the difficulties experienced by the blind baby and ways in which we can counter these difficulties. Our own eyes, in reading, are surely drawn to the artistic illustrations of Blanch Stiff. The reader is encouraged to look to global aspects of development, not just the motor, to promote vision so that other areas of development can be advanced, and there are then provided expanded ideas to assist the stimulation of babies with other disabilities.

This is a little book which would enhance any physiotherapy department, and would be very suitable for parents to take home.

REGIONAL REPORTS

South West

Carol Hurran, 23 Bayswater Ave., Westbury Park, Bristol BS67 7NU.

Avon Branch will be getting together after rather a long break on Monday November 18th for a social evening and feedback on the Cardiff Conference last August.

Your South-West Rep. is tackling the new Advanced Paediatric Physiotherapy Course based at Birmingham Polytechnic, along with 14 other intrepid physios from all over the country. So far enjoyable, stimulating and lots of hard work. The course lasts one year and leads to an accredited professional and academic award integrated into the CNAA's scheme of PACE. Please, South West membership, send in your news; something must be happening out there!

South-East

Terri Fearn, 38 Woodland Close, Peacehaven, E. Sussex BN10 7SF.

London

Rowenna Hughes, 87 Norbury Hill, London SW16 3RU.

A most interesting study day was held on 'Deformity' at Northwick Park Hospital on Saturday 14th September. The areas covered were neo-nates, young adults with C.P. and Juvenile Chronic Arthritis, and also the use of orthotics.

The speakers were John Fixen, Consultant Orthopaedic Surgeon, Sheila Lawton, Ocupational Therapist, Pauline Pope, Physiotherapist and Chris Drake, Orthotist.

After such a poor response to previous courses, it was heartening to see such a well attended study day. Our thanks go to all who made this day such a stimulating and interesting course.

Future programmes for 1992 will include topics on sports injuries and due to demand and the success of the last course, another practical workshop will be organised on inhibitory casting.

East Anglia

Jackie Reynolds, Church Farm House, Ornsby St. Michael
NR29 3LN.

Trent

Jenny Gill, 42 Brittania Ave., Arnold Road, Nottingham.

Membership numbers within Trent have shown a marked increase since the AGM in March - there are currently 59 paid up members. With these members in mind and in an effort to form a more cohesive branch, a local newsheet will be included with the quarterly national newsletter. Comments and ideas from all members would be gratefully received either by myself or other Trent committee members.

The Trent Committee are very conscious that local APCP courses are needed to get members together as well as raise some funds, of course! Plans are underway for study days in Sheffield and Lincolnshire - more details to follow at a later date.

West Midlands

Carol Foster, Physiotherapist Dept., The Childrens Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET.

Following the successful evening discussion on Conductive Education in June, it is sad to report that the Sensory Stimulation Course planned for October 12th had to be cancelled through lack of interest - plans are going ahead for the four orthopaedic evenings in March, April, May and June 1992 and an Autumn 1992 course in Neuro Anatomy, Neuro Physiology and its applications is being explored.

Have you thought about T.U.C. affiliation yet? Please read the July Journal and also 'Affiliation to T.U.C. - A Discussion Paper' June 1991. Please send your comments to the C.S.P., or through your Regional Steward by November.

Wales

Barbara Bowen, Children's Assessment Centre, East Glamorgan Hospital, Church Village, Nr. Pontypridd, Mid Glamorgan.

The 1991 Congress in Cardiff proved a tremendous success all round. St. David's Hall was an ideal venue, the staff were unobtrusive, very helpful and professional, ensuring the smooth running of the proceedings.

The Craft and Charity stalls on the Saturday lent a festive air to events and the Trade Staff Holders reported keen interest by delegates.

All lectures were well received and many delegates were observed rushing to and fro between the Muscle and Respiratory lectures as they felt spoilt for choice.

Accommodation at the International Hotel was highly praised and the Lord Mayor's Reception and Conference Dinner at Cardiff Castle enjoyed immensely. All feedback has been very positive and a fitting tribute to all the hard work by Lyn Horrocks and team.

Rather jet lagged after conference, we haven't had a further meeting but were in the process of organising a 2-3 day counselling course relating to the handicapped child and family. Members have been invited to join our colleagues in the Mental Handicap Group to a study day on 'Techniques of Measuring Windswept Deformity' at Ely Hospital, Cardiff on 8th October. In addition I have been invited, along with other representatives of other specific interest groups, to the next meeting of the Cardiff and East Wales Branch of the CSP to publicise and inform colleagues of the APCP.

North West

Alex Winney, 14 Longley Road, Spital, Bebington, Wirral, Merseyside L63 9HW.

North East

Carrie Jackson, 4 Abbotsway, Moncaster Gate, York YO3 9LB.

Scotland

Lyn Cambell, 19 Craigmount Ave. North, Edinburgh EH12 8DH.

N. Ireland

Ruth Graham, 75 Ravenhill Gdns., Belfast BT6 8EQ.

The next meeting will be held on Monday 18th November at the Board Room of the Royal Belfast Hospital for Sick Children. The theme of the talk will be 'Music and Dance Therapy' and will include a social evening. Visitors will be most welcome.

Other forthcoming events include a talk of Sexual Abuse on January 20th in the Board Room R.B.G.S.C. A further study day is being planned for March. Details to follow.

ANNUAL SUBSCRIPTIONS REMAIN AT £15 for 1992

These should be renewed **BEFORE** 1st January 1992.

Ordinary Membership is open to suitably qualified members of the Chartered Society of Physiotherapy

Associate Membership is open to suitably qualified professionals working in the field of Paediatrics

Retired Members are only required to pay HALF the total annual subscripiton.

Membership runs from January to December.

Cheques made payable to 'APCP' should be sent to:
Membership Secretary, Mrs. Jeanne Lamond,
22 Whernside Rd., Cross Hill, Lancaster LA1 2TA.

Members are reminded that we cannot refund money paid to APCP by Banker's Order, and are once again requested to cancel all such orders.

COPY FOR THE FEBRUARY 1992 NEWSLETTER MUST BE WITH THE EDITOR BY

FRIDAY 20TH DECEMBER 1991.

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

NOMINATIONS ARE INVITED

for two places on the National Committee of the APCP when they become available next March at the AGM in Norwich.

For Nomination forms, please contact your Regional Rep.
(Reg. Rep. addresses all under 'Regional Reports')

Forms must be returned to the APCP Secretary, Michelle Lee, by four weeks prior to the A.G.M.

Associate Membership

Any new applications for Associate Membership of the APCP, as from January 1992, require to be proposed and seconded by full members of the Association.