

**ASSOCIATION OF  
PAEDIATRIC  
CHARTERED  
PHYSIOTHERAPISTS**

**JOURNAL**



**MARCH 2000**

ISSUE  
NO. 94

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**The Editorial Board does not necessarily agree with opinions expressed in articles and  
correspondence, and does not necessarily endorse courses advertised**

## EDITORIAL

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LIN WAKLEY

Editor

As this is the first Journal of the new Millenium I thought I would take the opportunity to look back on how it has evolved since the first issue in June 1974. As some of you will recall the very first newsletters were typed on foolscap paper and it wasn't until the 11<sup>th</sup> issue in May 1979 that it became a small A5 booklet. Five years later the familiar pink cover was added and it took a further 10 years before it changed its name to Journal and became slightly larger and glossy. This is the Journal of today but I have no doubts that there will be changes and improvements in the future.

It is not only the outward appearance of the Journal that has changed. In the five years since I became editor there have been changes in the preparation of the Journal. When I first took over all the material was sent to me by post and I sent only printed material to the printers. Now I receive material by post, on floppy discs and by e-mail and I send most of it to the printers on disc.

I have included a copy of the first newsletter which has been scanned off the original rather than re-typed. I felt this would give a better idea of what it is like. It was obviously typed on a typewriter and the copying techniques were not as good because the type is lighter in places. It contains sections, which have developed into APCP Matters, Regional Reports, Here and There, and Courses in today's Journal. This issue is also interesting because it sets out the objectives of the Association, which are still relevant.

As some of you already know this is the last Journal I will be editing. After five years I felt it was time for me to hand the reins over to someone else. That 'some one else' is Sally Braithewaite. I will officially hand over to her at the next National Committee Meeting in May.

Looking back at my first editorial in February 1995 I wrote 'It was with some trepidation but a sense of challenge that I agreed to become the new editor of the Journal'. It was not as terrifying as I thought it would be and I have enjoyed the challenge of producing the journal every 3 months although it has had its ups and downs.

I would like to thank all the previous editors who laid an excellent foundation on which I was able to build, the Editorial Board and National Committee for their support and last but not least all the members of the association who have provided the material without which there would be no Journal.

Finally I would like to wish Sally all the best. Although it may look a daunting prospect at the moment I know she will enjoy the challenge of taking the Journal into the new Millennium.

All material for future Journals must be sent to :

Mrs Sally Braithewaite  
531 Church Road  
Yardley  
Birmingham  
B33 8PG

## LETTERS

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Dawn Narborough  
Senior Community  
Paediatric Physiotherapist  
Community Health Services  
NHS Trust,  
Southern Derbyshire.

Dear Lin,

Re: Promoting healthy playtime activities in school.

A small working party in Derbyshire is looking at developing a training package for schools, targeting mid-day supervisors, SENCOs & ECOs.

The project aims to :

- Encourage healthy and co-operative play in schools.
- To improve children's motors and social skills.

The working party includes a Community Paediatric Occupational Therapist, Health Promoting Schools Co-ordinator and myself, a Community Paediatric Physiotherapist.

We would be grateful to hear from anyone who has similar plans or who has already established a similar project.

Many thanks

Yours sincerely,

Dawn Narborough

Ingrid Stanfield  
Senior Physiotherapist  
Community Physiotherapy  
Service  
One Stop Resource Centre  
Dane Road Industrial Estate  
Dane Road  
Sale  
Cheshire

Dear Mrs Kinley

Re: Standardised Assessment

We are currently looking at various standardised assessments for pre-school children, specifically aged 0-3 years with a wide range of problems from P.M.L.D. to developmental delay.

I received an information pack last summer but if you have any further information, in particular on :-

Alberton Infant Motor Scale

Chailey Level of Ability

Gross Motor Function Measure

Peabody Development Motor Scale

Toddler Infant Motor Education

Bayley Scales of Infant Development

it would be much appreciated. Also, would it be possible for you to put a request in the journal, that if anyone has used, or is using any of the above assessments, could they contact me at the above address and pass on any information?

Many thanks

Yours sincerely

Ingrid Stanfield

## LETTERS

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Katie Kinch  
Lesley Bruce  
Linda Haworth  
Lyndsay Currie  
Pierette Melville  
Emily Lemarie  
Senior Paediatric Physiotherapists  
Fife Primary Care,  
Carnegie Clinic  
Inglis Street  
Dunfermline  
Fife KY12 7AX

Dear Editor

“Paediatric Physios Sometimes Do It On The Floor”

On behalf of the physiotherapists in our department we would like to express our disbelief and strong disapproval of this bumper sticker. The saying alone is grossly inappropriate but to have our professional logo on it as well makes it even worse.

In a time when professionals working with children need to be beyond reproach, to have a bumper sticker with such a crude innuendo - apparently backed by the national professional body, is inexcusable.

We would strongly advise the APCP to stop all production and sales of this bumper sticker.

Yours sincerely

Katie Kinch  
Lesley Bruce  
Linda Haworth  
Lyndsay Currie  
Pierette Melville  
Emily Lemarie

Alison Spanner  
Acting Superintendent  
Physiotherapist  
Newham Physiotherapy Service  
for Children  
West Ham Lane Healthcare  
Centre  
84 West Ham Lane  
Stratford  
London E15 4PT  
Tel: 0208 250 7365  
Fax: 0208 250 7357

*A second reply to Sue Booth's letter re : DNAs in September 1999 Journal*

Dear Sue

I am afraid I am behind in my correspondence, and you may have solved your DNA problem. If so, please let me know the secret!

I thought I would write and let you know what we do. Due to the increasing demands on our service we have had to become quite strict, and do in fact operate a policy of discharging children who do not attend. Although this may seem, at first thought, unfair on the child, parents do need to take responsibility for their children's treatment, and if they don't even turn up to appointments then the chances of them carrying out any advice or therapy programme may be slim, and our intervention less than effective.

For initial appointments, parents are offered two chances, after one DNA a second appointment is offered but says that if they DNA again or do not contact us they will not receive another appointment. If they fail to attend again, then they are discharged and letters are sent to the referrer, G.P., and any other relevant professionals informing of the child's discharge after failing to attend. We do find that sometimes the referrer or Health Visitor will contact us with a reason why the family did not attend, or will say that they will re-iterate the importance of attending, or will request copies of an appointment so they can encourage the family to attend. In these circumstances we will offer one further appointment.

For children who are being reviewed or monitored they will be offered a second appointment or a letter asking them to contact us by a certain date depending on the child's condition i.e. minor things such as flat feet etc.

## LETTERS

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which may have resolved, and the parents may simply not be concerned any more.

The above system does not solve the DNA problem but at least gets children moving through the system. The most important part of it is keeping everyone involved with the child informed, otherwise the parents may say to their consultant they have not received any physiotherapy, when in reality they haven't turned up to the appointments.

We do not have a waiting list for assessment, but if we did I would have no hesitation in putting on our letters that the child would need to be re-referred and will be placed back onto the waiting list if they DNA'd a second appointment.

If any other departments had alternative solutions I would be interested in hearing them!

Yours Sincerely  
Alison Spanner

Cathy White  
Superintendent Community  
Paediatric Physiotherapist  
Child & Family Health Centre  
Ashurst Hospital  
Lyndhurst Road  
Ashurst,  
Southampton SO40 7AR  
Tel. 01703 743000

Dear Liz

***Re: Conductive Education/Conventional Therapy for Cerebral Palsy***

The opening of a Conductive Education Centre in our locality has brought up again problems for us where parents choose to use Conductive Education but still wish that their children be seen as normal by our service and with our liaison with the Education Authorities.

My query is twofold, 1. What advice does the APCP give regarding these matters? 2. Do other departments have written policies/guidelines on dealing with these issues?

I would be grateful for any advice that you can give us on this matter and could you possibly forward my letter for publication in the journal to see what answers to the second query there may be, in general.

Yours sincerely  
Cathy White

Liz Hardy  
Chair APCP

***Reply to Previous Letter***

11th January 2000

Dear Cathy

***Re: Conductive Education/Conventional Therapy for CP***

Thank you for your letter with regard to the above issue.

As you are probably aware APCP, together with a number of other organisations, produced a short document providing 'Guidance for parents and professionals working with children with motor impairments' in September 1998. This was subsequently reprinted in the *APCP Journal* in December 1998. The document was written with the aim of ensuring that

## LETTERS

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physiotherapists and professionals from other agencies and disciplines should 'work together' in an enhanced fashion for the good of the child. Clearly this is, however, open to interpretation.

In other fields of physiotherapy, treatment would not be carried out if it is already being provided by a practitioner from another disciplines, eg. osteopath, chiropractor etc. From personal experience, this is also the situation in paediatric physiotherapy *if the principles of treatment, or aims and objectives differ from those being provided by the child's main therapist*. It is unlikely that a Bobath-trained therapist would take issue with a child in their care being seen by another Bobath-trained therapist on a private basis, but there could be difficulties (as you are finding) with other treatment regimes.

Once a child has been referred to physiotherapy and has been assessed and identified as 'likely to benefit from physiotherapy' the therapist has a duty of care to maintain involvement and input until such a time as the child is unlikely to gain further benefit, when he/she can be discharged. Many physiotherapists, in the situation in which you find yourselves would not provide treatment as such, but would continue to assess for seating, wheelchairs and orthoses as appropriate during the time the child is receiving 'alternative' therapy provision. Whilst not agreeing to regular reassessment, therapists should reassure parents that 'the door remains open' for them to bring their child back for conventional therapy when they are no longer receiving an alternative programme.

I know that some departments will have written policies with regard to these matters, and when you draw yours up, I would suggest some liaison with your Trust solicitor. I am sure that the key to dealing with this issue in a sensitive and efficient way lies in good communication, firstly with parents and then with therapists from other agencies.

I am meeting with the editorial board later this week, and will pass your letter on for the Editor to consider publishing it in the next *APCP Journal*.

Yours sincerely

E A Hardy

Chair APCP



## LETTERS

Joanne Coxhill  
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Jane James  
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Physiotherapist  
Gateshead Health  
NHS Trust  
Dunston Hill Hospital  
Whickham Highway  
Gateshead NE11 9QT  
Tel. 0191 482 0000  
Fax: 0191 402 6408

Dear Mrs Robinson

I have recently taken up a post in a Child and Adolescent Mental Health Unit. I wonder if you have a database which would let me know of any other physiotherapists working in this area. If so could you let me know as I would be interested in contacting them. Please could you send the information to : 13 Clifton Drive, Morecambe, Lancashire LA4 6SR.

Yours sincerely

Joanne Coxhill  
MCSP

Dear Editor

As representative of the Northern Paediatric Interest Group, could I ask you to ask the membership if any areas have programmes or protocols for treatment of Downs Syndrome and Juvenile Chronic Arthritis. We would also like to hear from anyone who has put together leaflets of advice, specific to physiotherapy, for these conditions.

Does anyone have any evidence-based research on either, or both conditions that we can access?

We will be very happy to share our information once collected with other areas.

Please reply to the undersigned.

Yours sincerely

Jane James

Copy for the  
**JUNE 2000 JOURNAL**  
must be with the editor by  
**1<sup>st</sup> MAY 2000**

The editorial board reserve the right to edit all material submitted

# THE JOURNAL (Newsletter) IN THE LAST MILLENNIUM

## ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

**CHAIRMAN** Miss M.P. Gilbertson,  
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32 Mount Mod Rd,  
London S.W.16.

**Hon. Assistant F.R.C.** Miss M. Hutchinson,  
111 Hayes Lane,  
Timperley,  
Altrincham, Cheshire.

### NEWSLETTER No 1 July 1974.

As an official Association we are in fact only three months old having held our first Annual General Meeting in April of this year. The Association was formed as a specific interest group within the Chartered Society of Physiotherapy following a meeting of Paediatric Physiotherapists in Birmingham on December 2nd 1972. Great interest was shown from all parts of the country and an inaugural meeting was arranged at the Hospital for Sick Children, Great Ormond St. on February 22nd 1973. More than a hundred enthusiastic participants attended this lively meeting, and elected a committee has set on five-year terms its objectives with the following objectives:

- I) To maintain a Register of Physiotherapists engaged in the profession.
- II) To improve the training status of such persons, promote and advance a variety of post registrative courses.
- III) To promote by whatever means, conferences, lectures, general work of the Association, to collaborate with the authors affecting the Association.
- IV) To improve communication between the various authors for paediatric physiotherapy.
- V) To do anything incidental arising out of these objectives.

### Post Graduate Training

A working party has set the structure of a post graduate syllabus. The following to serve on this working party:  
Dr Kenneth Holt  
Dr Margaret Griffiths  
Dr Peter Rosenblum  
Miss Pat Addington

## NEWSLETTER No. 1

July 1974

3 sheets of foolscap paper

## ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

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Brighton.

**Hon. Treasurer**  
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Hospital for Sick Children,  
Great Ormond Street,  
London, W.C.1.

**Hon. Secretary**  
Miss C. Mason,  
43 Exotic Grove Road,  
Leyton,  
LONDON, E.15

**Newsletter Editor**

## NEWSLETTER No. 11

May 1979

The first A5 Booklet

## ASSOCIATION OF PAEDIATRIC

## CHARTERED PHYSIO



## NEWSLETTER

## NEWSLETTER No. 30

May 1984

The first 'Pink' Newsletter

## ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

JOURNAL

## ISSUE No. 72

August 1994

The Newsletter goes glossy and becomes the Journal of today.

AUGUST 1994

PRICE 50p



# NEWSLETTER No. 1 July 1974

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## ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

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Department of Physical Medicine,  
Hospital for Sick Children,  
Great Ormond St, London W.C.I.

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Princess Margaret School,  
53 Middleway,  
Taunton,  
Somerset.

Hon. Secretary  
Miss D. Woods,  
Meikle Cottage,  
Church Lane, Bicton,  
Shrewsbury, Salop.

Hon. P.R.O.  
Miss F.A. Birkett,  
Flat I,  
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Birmingham 13.

Hon. Assistant P.R.O.  
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- I) To maintain a Register of Chartered Physiotherapists engaged in the practice of paediatric physiotherapy.
- II) To improve the training, education and professional status of such persons, and in particular, to promote and advance a curriculum for the obtaining of post registration qualifications.
- III) To promote by whatever means possible e.g. by conferences, lectures, and public meetings, the general work of the Association and in particular to collaborate with the parent Society in all matters affecting the interests of the Association.
- IV) To improve communication and understanding between the various authorities responsible for paediatric physiotherapy.
- V) To do anything incidental and conducive to the carrying out of these objects or any of them.

## Post Graduate Training

A working party has been formed to look into the structure of a post graduate course and to draw up a syllabus. The following people have kindly agreed to serve on this working party:--

Dr Kenneth Holt	
Dr Margaret Griffiths	Paediatricians
Dr Peter Rosenbloom	
Miss Pat Waddington	Physiotherapy Teacher
Miss Moyna Gilbertson /	Physiotherapist in
Miss Ann Grimley	a children's hospital
Mrs Mary Hazlewood	Physiotherapists in
	a Special school.
Mr G. Halcrow	University lecturer
	experienced in setting up
	post graduate courses.

They will meet for the first time on July 6th.

## News from the Regions

South West Regional representative Miss J. Hawes,  
II Blenheim Rd, Redland, Bristol 6.

The members of this area organised the first Day Congress in Bristol on September 22nd 1973. This was a very successful event attended by eighty members who heard about two differing approaches to the management of Cerebral Palsy.

In July an informal evening meeting will be held in Tyndalls Park Childrens Centre when a buffet supper will be served and it is hoped that members can get to know each other better.

A Day course is planned for September 1975, the subject being Special Education.

Midlands Regional representative Mrs M. Hazlewood.  
19 Devonshire Rd, Handsworth Wood,  
Birmingham B20 2PB.

Two conferences have been held in Birmingham, one on subnormality, and the other on Cystic Fibrosis, both were well attended. Their next meeting will be held on October 12th at Thieves Wood School, Mansfield, when Miss R. Dawson's film on Cerebral Palsy will be shown.

Wales Regional representative Mrs E. K. Weber,  
7 Caynham Ave, Penarth, South Wales.

The first conference was concerned with the emotional factor in the handicapped child, and the second, held on May 18th in Cardiff, with Spina Bifida - A Review of Allied Problems. The latter was a very successful meeting attended by Physiotherapists, Occupational Therapists, Social Workers and Teachers in Special Education. The next meeting will be a joint meeting with the Cardiff and District Branch of the National Council of Special Education on September 19th, when Mrs Ester Cotton will speak on "Conductive Education for the Cerebral Palsied Child".

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# NEWSLETTER No. 1 July 1974

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London Regional representative Mrs M. Reid,  
12 New End, London NW3.

A very successful one day course was held on Chronic Neurological Conditions and Physiotherapy. A small sub-committee has been formed to organise further activities in the region.

One of the members from this region, Mrs Proper, is representing the Association on the South West Metropolitan Local Board which has chosen "General Paediatrics" as the subject for their Annual Congress. This takes place on Sat: October 19th at Worthing Hospital and applications should be sent to Miss N. Nash, Physiotherapy Dept; Worthing Hospital, Worthing, Sussex.

Despite sterling efforts on Mrs Murdoch's behalf there appears to be a general lack of interest in Scotland. However the second A.G.M. is to be held in April 1975 so it is hoped that this will stimulate local enthusiasm.

North West Regional representative Mrs L. Willescroft  
33 Blord Rd. Prestwick, Manchester.

The first Annual Congress was organised by Mrs Willescroft and Miss Grimley with a splendid attendance of almost two hundred people. It was held at Salford University on April 5th and 6th, the first day being devoted to Cystic Fibrosis and the second to "The Assessment Teams". Both days ended with a forum consisting of the lecturers and some parents.

The first Annual General Meeting was held on April 5th at Salford, when the steering committee was elected as the Executive Committee:-

Members

Mrs M. Biddle,  
43 The Grove, Isleworth, Middlesex.

Mrs M. Walters,  
Ladywood Cottage, Sarratt Lane,  
Rickmansworth.

Miss A. Smith,  
8 Coombe Bridge Ave, Stoke Bishop,  
Bristol B59 2LP.

Miss A. Grimley,  
Manchester Childrens Hospital,  
Pendlebury, Manchester MAN27 IHA.

Officers

As noted at head of newsletter.

Annual Conference of Hon. Branch P.R.Os

Mrs Biddle represented the Association at this meeting and spoke, along with the representatives of the other Special Interest Groups, about the formation of the Association and its work so far.

## The Chartered Society's Film

The Chartered Society have had a recruitment film made entitled simply 'Physiotherapist'. It is a well made film with an unscripted dialogue and covers a wide variety of work. It shows students working in an intensive care unit, outpatient department, wards, hydrotherapy pool etc. You will be pleased to know that the treatment of a CHILD is included. The film gives a good idea of the training and the opportunities open to qualified Physiotherapists, but the educational qualifications required for training, and the career and pay structure are not included.

The 16mm film lasts 30mins, is in colour and available from S.D.C. films, Guild, Sound and Vision Ltd, Peterborough. There is no hire charge.

## Australia

Members will be interested to know that Physiotherapists working with children in Australia have, in the last few months, formed a specific interest group. The main reason for forming the group was concern about the reorganisation of their health system by the government which appeared to be overlooking the needs of handicapped children.

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Unless you are a paid up member this will be the last newsletter we can afford to send you.

## Stop press

Pre-School Playgroups Association Conference. This conference is to be held at Lake Hall, University of Birmingham from 10.00 am on September 21st to 4.00pm on September 22nd. This may interest some members as the topic is The Role of Opportunity Playgroups for Young Handicapped Children and their Families. Booking forms and further information are available from P.P.A. (Opportunity Playgroups) Alford House, Aveline Street, London SE11 5DJ.

## VICTORIA KENT

Senior II, Paediatric  
Physiotherapist

## RACHEL M<sup>C</sup>CONNELL

Senior II, Paediatric  
Physiotherapist

The Newcastle upon Tyne  
Hospitals NHS Trust

## CHORDOMA TUMOURS

### A CASE PRESENTATION

#### Introduction

Newcastle is the Regional Paediatric Oncology Centre for the North of England, taking referrals of patients with brain and spinal tumours. The variety of tumours, patients and neurology is both challenging and fascinating.

This case study describes the management of a child with a rare Chordoma Tumour. It is the purpose of this paper to give a greater insight into chordomas; then specifically to discuss the case history of one child who presented with this diagnosis.

Although the posterior fossa contains the minority of the brain volume, approximately half of all paediatric brain tumours arise in this site. The most common being medulloblastomas, astrocytomas (cerebellar and brain stem) and fourth ventricular ependymomas.

The posterior fossa is formed by the occipital and petrous temporal bones. The clivus is a steep, smooth slope anteriorly which is continuous with the body of the sphenoid bone, posterior to the hypophyseal fossa. The brain stem rests upon the clivus, the medulla passes through the foramen magnum to become continuous with the spinal cord. The cerebellum rests on the floor of the posterior cranial fossa.

Paediatric tumours differ from adult brain tumours in their tendency to be better differentiated and to occupy the posterior fossa. Chordomas are rare dysontogenetic tumours that usually occur in adults (Borba 1996). They are of notochordal cell origin (remnants of the spinal cord) and account for approximately 1-4% of all primary malignant bone tumours (Jallo 1997). Of all chordomas 85% are intracranial (Makhumlov 1998). The Chordoma is a slow-growing tumour with local aggressiveness and has an invasive nature. They are predominantly seen in the sphenoid-occipital and sacrococcygeal regions. Growth begins in midline, however, they often expand asymmetrically into the intracranial cavity.

Al-Mefty (1997) described skull base chordomas as 'challenging, and at times frustrating to treat. Borba (1996) has stated that literature on paediatric patients revealed that clinical presentations, histological patterns and behaviours of chordomas differs greatly, dependent upon the age of the patient (whether they are younger or older than 5). Also that the younger population have a higher instance of metastasis, a wider range of presenting symptoms, a greater prevalence of atypical histological findings and aggressive behaviour.

# CHORDOMA TUMOURS

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Prognosis for patients with a chordoma is related directly to the histological pattern of the tumour. Due to their critical location skull base chordomas pose management challenges. There is a high recurrence rate despite multi-modality treatment.

Clinically most patients develop nasal obstruction, and cranial nerve compression leading to palsies usually follow (they depend on the exact tumour site). The condition is usually well established at diagnosis and patients with chordomas have a poor surgical prognosis.

Al-Mefty (1997), Lawton (1995) and Weber (1994) have all documented that these tumours are best treated with radical surgery (the transfacial approach gives the surgeon wide exposure for resecting skull bone lesions), followed by proton beam irradiation. However, due to their location they are not usually amenable to complete surgical resection. This surgical approach has also been associated with low rates of morbidity and mortality.

## CASE PRESENTATION

### DIAGNOSIS - Chordoma of the Clivus

Patient 'A' was transferred to Newcastle from a District General Hospital in July 1998. This had followed a two year history of morning headaches and vomiting. A few months previously her right eye started turning in (operated on two weeks prior to admission). She had been unsteady on her feet for eight months and was progressively getting worse. In the last few weeks she had started bumping into things and had difficulty concentrating at school.

An MRI Scan showed "probable chordoma" a tumour compressing the brain stem. She had no relevant past medical history.

Following the MRI Scan, on admission to the Newcastle General Hospital 'A' started on long term dexamethasone and ranitidine. Her gait and breathing immediately improved, she no longer had any headaches or vomiting and had a rapid increase in appetite.

A diagnostic transoral biopsy was carried out which confirmed the diagnosis. A double lumen hickman line was inserted and three courses of chemotherapy (Ifosfamide, Mesna, Doxorubicin) administered.

An MRI in October 1998 showed no reduction in tumour size so chemotherapy was discontinued. A second opinion was obtained from a New York consultant, who advised no advantage to proton beam radiotherapy in a tumour of this size. Radical surgery would be more appropriate but probably not curative and she was admitted in January 1999 for staged surgery.



# CHORDOMA TUMOURS

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## SURGICAL MANAGEMENT

Patient 'A's surgery was performed in two stages, two days apart.

First a right retromastoid resection of the tumour was carried out. The V,VII,VIII and IX cranial nerves were preserved along with the vertebral artery. The second stage was a transfacial and transpharyngeal resection. (Both lasted approximately eleven hours each).

Tumours of the clivus can be resected completely through these routes; they provide safe avenues through areas of complex anatomy.

Transfacial disassembly widely exposes the mid-line skull base for visualisation of tumours and critical structures.

Due to the nature of the approach 'A' was left with large amounts of swelling in the mouth and upper respiratory tract. A tracheostomy was carried out during the second stage to ensure airway protection. This was removed after five weeks. Again due to swelling a nasogastric tube was passed to ensure adequate nutrition. In the initial post-op period cranial nerve damage assessment was unable to be carried out.

Patient 'A' required a series of shunts. Initially a lumbo-peritoneal shunt was carried out. This required revision after eighteen days due to increased swelling. A cysto peritoneal shunt was inserted five days later for increased CSF collections in the neck and retromastoid area. Unfortunately ten days later the situation deteriorated further with symptoms suggestive of a communicating hydrocephalus (increased weakness and ataxia), therefore a right ventriculo-peritoneal shunt was inserted.

Six days later an MRI scan showed no effusion/haematoma/abscess but there was suggestion of some oedema of the medulla and S-shaped kinking of the brain stem; probably due to setting of the skull into the vertebrae post-operatively. 'A' was re-started on dexamethasone.

## SHUNTS

A shunt (irrelevant of type) is performed to reduce/prevent hydrocephalus, defined as an increase in CSF volume usually resulting from impaired absorption. CSF is formed at approximately 500 ml per day. It is secreted by the choroid plexus of the lateral, third and fourth ventricles. It flows in a caudal direction through the ventricular system and exits into the subarachnoid space. Absorption occurs through the arachnoid granulations into the nervous system.

Pathologically a raised ICP is seen which clinically gives symptoms of : Headache/vomiting, Papilloedema, Deterioration of conscious level, Impaired upward gaze.

# CHORDOMA TUMOURS

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A shunt insertion is the management of CSF built up. There are three types:

1. Ventricular-atrial (V-A) shunt - the distal catheter is inserted through the internal jugular vein into the right atrium.
2. Ventriculo-peritoneal (V-P) shunt - the distal catheter is inserted into the peritoneal cavity.
3. Lumbo-peritoneal (L-P) shunt - the catheter is inserted into the lumbar theca either directly at open operation or percutaneously through a tuohy needle. The distal end is situated in the peritoneal cavity.

A shunt had three components:

1. Reservoir (permitting first aspiration for analysis).
2. Valve (incorporated in the system. Opening pressures range 5-10 mm H<sup>2</sup>O).
3. Ventricular catheter (inserted through the occipital horn. The distal end location varies upon shunt type).

## RESPIRATORY COMPLICATIONS

MRSA was isolated from sputum at two weeks post-operatively, long term antibiotics were started. 'A' was isolated in a cubicle on the ward.

Shortly after removal of the tracheostomy six weeks post-op, 'A's respiratory status deteriorated. A CXR showed left lower lobe collapse. Bronchial alveolar lavage was carried out via a newly formed tracheostomy.

## DRUGS/ CHEMOTHERAPY

Initially patient 'A' was started on the steroid Dexamethasone. This is used for symptom relief e.g. the management of raised ICP. Steroids help to reduce pain caused by compression and distension due to intracerebral tumours. They generally improve appetite and general well-being. Marked weight gain is common. Other side effects include unpleasant changes in mood and behaviour, gastritis and the rapid alteration of physical appearance. These side effects are often distressing both to parents and child.

Ranitidine is often given with dexamethasone, this can help reduce gastric irritation.

Chemotherapy is the use of cytotoxic agents (drugs toxic to cells). These then interfere with the proliferation of cells and can be an effective and often curative method of treatment for many types of tumour/leukaemia.

The drugs are given either singly or in combination.

Chemotherapy affects normally dividing cells as well as the malignant ones. (The cells that most rapidly divide are those in the bone marrow, gut and hair follicles. As a result these are the areas where the immediate side effects are seen). In this case the following drugs were used :

# CHORDOMA TUMOURS

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Ifosfamide - an alkylating agent. It is not fully understood how the process of alkylation results in cytotoxicity, but it is thought that once cells are exposed to these agents crosslinking and strand breaks in DNA occur which interferes with its integrity causing misreading of the DNA code.

(Is more bladder toxic, but has been overcome by use of MESNA for uroprotection.)

Doxomrubicin - An antitumour antibiotic. Due to the structure of the drug it is allowed to insert itself within the DNA helix. The compounds were originally derived from bacteria and fungi and have both antimicrobial and antitumour activity.

Generally the side effects of this chemotherapy course are :

- Bone marrow suppression.
- Hair loss.
- Bladder irritation.
- Nausea and vomiting.
- Occasionally damage to kidney tubules and fertility.
- Sore mouth (mucositis).

## PHYSIOTHERAPY

This can be separated into 3 main areas :

### **Pre-op**

A baselines assessment was carried out. No problems highlighted with respiratory function.

Independently mobile with mild ataxia.

### **Post-op**

Initially ventilated post-op. 5 days later was transferred to cubicle on the oncology ward with a cuffed tracheostom tube, NG helse & collar in situ. She was fully dependent for all care.

### **Rehabilitation Phase**

This was commenced one week post second stage of surgery.

### **Problem List**

- 1) Neck pain
- 2) Lower limb weakness
- 3) Low tone right upper limb
- 4) Dependent for transfers
- 5) Unable to sit independently

# CHORDOMA TUMOURS

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## **Treatment**

- Passive/active assisted movements in variety of postural sets upper and lower limb)
- Early sitting and standing (supported) to ensure alignment to key points and encourage extensor activity.
- Transfer work, progressing from hoisting to assistance of 2 and later to assistance of 1.

After 3 days 'A' was able to mobilise independently around the cubicle.

## **Problem List :**

- 6) Falling to right below midline orientation
- 7) Trunkal/mild lower limb ataxia
- 8) Reduced hip and knee Control
- 9) Low tone upper limb
- 10) Difficulty with communication

## **Treatment**

- Mid-line orientation work.
- Weight transference in standing.
- Facilitation of pelvic tilt.
- Selective hip and knee activities in supine/high perch sitting/standing.
- Working with Occupational Therapist addressing upper limb early to increase activity and function.
- Liaison with Speech Therapy and Occupational Therapy re light writer.
- Wheelchair assessment - longer periods sat in chair encouraged.

Initial progress was excellent. However, respiratory and neurological deterioration led to 'A' returning to theatre for VP shunt revision and change of tracheostomy tube. 1 week later active rehabilitation was recommended.

## **Further Problems:**

- 11) Very low mood, poorly motivated and very frustrated (remains MRSA positive and isolated in cubicle).
- 12) Marked lower limb weakness and wastage, reduced co-ordination.
- 13) Bilateral low tone upper limbs. Reduced selective activity, unable to write (wastage of thenar and hypothenar eminences).
- 14) Nil independent sitting, reduced head control, poor mid-line orientation.
- 15) Requiring hoisting for all transfers.

## **Treatment Plan:**

- Close work with Multi-Disciplinary Team (MOT). Outing - trying to give some independence back.
  - Bilateral night resting splints to prevent shortening of TA's.
  - Continued sitting work.
-

# CHORDOMA TUMOURS

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- Liaison and joint treatment sessions with Speech Therapist and Occupational Therapist.
- Supported sit, high perch sit and periods of wheelchair sitting.
- Progress to standing, including standing transfers once safe.

Discharge planning began after a further 2 months of rehabilitation as 'A' became more medically stable. A case conference was held involving all members of the MDT at both Newcastle and local hospital. Following this meeting a more thorough physiotherapist to physiotherapist handover was given which also allowed 'A' to meet her new Physiotherapist.

7 months after surgery 'A' was returned to her local District General Hospital.

### **Continuing problems on Discharge were :**

1. Reduced tone throughout both upper limbs. Slight active movement distally more than proximally. Right > left, nil functional movement.
2. Bilateral lower limb weakness (right > left).
3. Reduced head control. Only able to maintain head unsupported in midline for short time.
4. Dependent for all transfers and only tolerating up to 1 hour in chair before having back pain.
5. Limited communication - uses light writer but very slow and frustrating. Tends to rely on mouthing words.
6. Respiratory - much more stable. Frequent suction via tracheostomy with positional changes. Chest remains clear.
7. Remains MRSA positive at tracheostomy site.

1 week following discharge was readmitted to NGH with a 2 day history of confusion and raised CO<sub>2</sub>. A chest X Ray revealed left lower lobe collapse. 'A' required reintubating on PICU. Routine chest physiotherapy and passive movements for joint protection was carried out. She was extubated a day later and transferred back to the district general 13 days later as medically stable.

2 months later she was readmitted from the district general hospital for a routine MRI Scan.

### **Much progress had been made :**

1. Communication via speaking tube on tracheostomy for short periods improved mouthing of words, as a result more positive and motivated.
2. Much improved movement of lower limbs. Power increased to Grade 4 with good selective hip movements.
3. Improved active movement of upper limbs. Able to make gestures with hands and remove Swedish nose from trache and throw across room!

# CHORDOMA TUMOURS

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4. Sitting independently and able to maintain head control.
5. Maintain head control in standing for short periods. Still requiring a lot of support but increased use/power of lower limbs.
6. Able to go home for weekend stays.
7. Receiving hydrotherapy at local hospital.

Close contact with local physiotherapists remains. 'A' is now able to get in/out of car with assistance of I. Further neurosurgery is planned within the next month in the hope of gaining further improvement.

This patient had a very complex and interesting condition. Working with her and her family proved to be stimulating, challenging and very rewarding.

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# ARTICULATING ANKLE FOOT ORTHOSES ENCORPORATING NEUROPHYSIOLOGICAL FOOTPLATE RECTIFICATIONS

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## A CASE STUDY

MARTIN MATTHEWS

Dip. Ort, MBAPO

### Abstract

An orthosis function criteria was established based on the hypothesis that the function of the orthosis should, firstly, improve the quality of gait by using an orthosis of a configuration that would allow for inter relationship of movements between limb segments and secondly reduce as far as possible the sensory stimulatory effect of the orthosis on sub cutaneous structures.

The design modifications to the orthosis are as follows :-

The posterior calf section was windowed removing contact between the orthosis and the muscular-tendon interface of Gastrocnemius and the Tendon-Achilles reducing the possibility of an orthokinetic response. Fuchs *et al* (1950). The orthosis was articulated using flexura ankle hinges to permit progression of the tibia over the stance phase foot whilst maintaining full foot ground contact. Gage *et al* (1991). The toes were held in extension to reduce the tonic reflex response. Bronkhurst *et al* (1987).

The calcanium was secured by the application of pressure below sustentaculum-tali. Carlson *et al* (1970). The metatarsal heads were unloaded to reduce toe grasping. Hylton (1989). A foot counter balance eversion force was established. Shamp (1989).

### Introduction

The Ankle Foot orthosis (A.F.O.) is thought to adversely affect the tonic reflex responses in children with cerebral palsy. Ford *et al* (1986), reducing the quality of ambulation.

This single case study reports on a design protocol of an ankle foot orthosis to reduce the tonic reflex response and restore the gait pattern to a more acceptable level.

### Presentation

The subject is an eleven year old female with a left side hemiplegia. On examination she displays rigidity around the pectoral girdle with elbow and wrist flexion. The pelvic girdle displays a left side elevation obliquity. The left knee hyper-extends during loading response and maintains this attitude during the entire stance phase period. The foot is plantar-flexed with medio-lateral instability of the calcaneus, the sub-talar joint is maximally pronated and the fore-foot is abducted through the transverse tarsal axis. On standing, the subject displays a high toe plantar grasp reflex response which causes painful cramps that interrupt sleep patterns.

The subject displays a low startle reflex response tolerance initiating full global extensor spasticity. The subject had been supplied with a fixed angle, ankle foot orthosis to maintain plantar-grade foot position relative to the tibia. The primary function of the orthosis was to maintain foot ground clearance during swing phase and through the fixing of the ankle angle maintain a small angle of knee flexion during the stance phase period. The orthosis was also required to maintain a stable base of support, medio-

# ARTICULATING ANKLE FOOT ORTHOSES ENCORPORATING NEUROPHYSIOLOGICAL FOOTPLATE RECTIFICATIONS

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lateral calcaneal stability, reduce excessive sub-talar joint pronation, Brown *et al* (1987), re-orientate the transverse orientation of the forefoot and reduce the potential for contracture of the tendo achilles. The need to modify the existing orthotic management regime was determined by an increase in the level of synergistic muscular activity by the use of the fixed angle orthosis. All parties concerned felt that the orthosis was a predominating factor in the higher levels of spasticity around the pectoral and pelvic girdle. Fuchs *et al* (1950). A hypothesis was formulated suggesting that the orthosis was functioning in a detrimental fashion in two distinct areas; firstly the orthosis was preventing small but significant movement of the foot and ankle complex that accommodate movements generated elsewhere within the body; and secondly that the contact interface between the orthosis and the skin sense organ was stimulating sub-cutaneous sensory activity that results in the initiation of muscular activity. Fuch *et al* (1950). In the non disabled population either of these factors could be compensated for in firstly, fine motor modification to postural and ballistic inter relationship between body segments, and secondly a cognitive realisation that the subcutaneous stimulation of muscle activity could be accommodated. In the cerebral palsied subject the fine motor activity required for postural and ballistic control is compromised and the cognitive abilities depleted. Brown *et al* (1994).

## Results

Although the subject initially experienced difficulty in donning the orthosis due to the high tonic reaction to stimuli of the process of application this was overcome by investigation on the subjects experimentation. The elbow and wrist flexion showed signs of easing at the first application and became quite placid on later review. The pelvic girdle obliquity initially showed little change but on review three weeks later this had shown a lesser degree which improved as the subject continued with the orthotic regime. The hyper extension of the left knee and the neutral positioning of the subject's sub-talar joint were controlled. The cramps that disturbed the sleep pattern no longer occurred indicating a reduced plantar grasp response. After the initial orthosis acceptance few skin problems were experienced. The gait pattern was improved to allow "normal" follow through to be initiated with minimal reliance on the non affect side. On later review the angle of dorsiflexion obtained at the ankle was increased as was the ease of attainment.

## Summary

The use of this design protocol has shown that mechanical advantage can be used together with neurophysiological stimuli to enable an orthosis to function and improve the gait pattern of the high tone hemiplegic child.



# ARTICULATING ANKLE FOOT ORTHOSES ENCORPORATING NEUROPHYSIOLOGICAL FOOTPLATE RECTIFICATIONS

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## AFO WITH NEUROLOGICAL FOOTPLATE



Fig 1.  
Shows the ribbed reinforcement, posterior cut out section and the neurological rectification to the footplate from a postero-medial aspect.



Fig 2.  
Shows the plantar aspect of the footplate showing the neurophysiological rectifications.

# ARTICULATING ANKLE FOOT ORTHOSES ENCORPORATING NEUROPHYSIOLOGICAL FOOTPLATE RECTIFICATIONS

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The Development work was carried out at the Jenny Lind Paediatric Physiotherapy Department at the Norfolk and Norwich Hospital, Brunswick Road, Norwich, Norfolk, Great Britain.

The orthosis was manufactured with the assistance of Camp Manufacturing, Sheffield.

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## HELEN BUSWELL

Project Manager  
Occupational  
Therapist

### PROJECT SUMMARY

Following a recent request for national feedback on the issues of transition to inform a project in Plymouth, this summary is being distributed to respond to the overwhelming feedback received and to acknowledge that the project has now been completed.

The aim of this project was to identify the clinical issues in transition between paediatric and adult health services across both Plymouth Community Services NHS Trust and Plymouth Hospitals NHS Trust, identifying training needs.

The focus has been maintained on identifying the clinical issues from the point of view of professions allied to medicine although knowledge had to be gained of how other health professionals and agencies (particularly Education, Social Services and the Careers service) manage transition.

Overwhelming feedback has been obtained from professionals nationally and this information together with clear guidance identified within key pieces of legislation, has led to the identification of best practice in response to the clinical needs identified.

A number of seminars have been held to raise awareness of the issues around health service transitions and it has been clear how timely this project has been, in the volume of responses received and how it has initiated thought amongst many professionals.

A clear set of recommendations has been proposed as a result of this six-month project. Positively a working group has been formed who not only have taken 'ownership' of the needs but also are actively working on elements of the recommendations. A multi-agency steering group has also resulted from discussions and will link with future HAZ funded projects across agencies in order to pursue these recommendations further.

Data obtained from clients clearly indicates that the lack of involvement, support and advocacy for the young person is the main issue in transition. Coupled with the main need for accurate service information for professionals and other agencies it is becoming clearer to see how transition can have a profound and lasting effect on individuals' futures in terms of inappropriate placements and lack of emotional support which needs 'mopping up' in young adult life.

It is strongly felt health services need a greater role in enabling education to support individuals at this time to ensure needs are appropriately identified and met. Transition teams it is felt would add to the confusion at this stage, in this area, and what is needed is an informed flexible approach whereby all individuals are empowered (the client, parents, carers and

## TRAINING FOR TRANSITION

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professionals) in terms of knowing where to go, the options and what is available for all aspects of their life i.e. home, work and leisure, in order to access appropriate help when it is wanted/needed.

Advocacy has emerged as an important element of providing this flexible service.

If you have any queries please contact the project manager. Helen Buswell (Occupational Therapist), at : Challenging Behaviour Service, Freedom House, 31 Greenbank Terrace, Plymouth, PL2 2PQ; OR: the projects lead advisor, Anneliese Barrell (Superintendent Physiotherapist), at: Learning Disability Service, Westbourne Unit, Scott Hospital, Beacon Park Road, Plymouth, PL2 2PQ.

### CHILD SEXUAL ABUSE

#### INFORMING PRACTICE FROM RESEARCH

David P H Jones and Paul Ramchandani

Radcliffe Medical Press Ltd., Oxon.

1999. (ISBN 1 85775 362 3) 119 pages

Price unknown.

This book on Child Sexual Abuse was written by the authors, with a grant from the Department of Health, to try and fill the gap between research findings which are currently available on the child protection process and the problems which face practitioners on a day to day basis.

Each chapter in the book opens with questions and issues, followed by a text of key relevant findings from appraised research. The authors continually emphasise an evidence based approach to the way forward and there are clear implications not only for practitioners but also for managers, planners and commissioners of services. At the end of each chapter there is a comment section by the authors which presents their own views on the research findings, implications for practice and links with other research.

The literature review is comprehensive and uses both published and unpublished material to produce key findings for professionals both in child protection issues and also in the psychological treatment of those who have been sexually abused.

The authors clearly document the strengths and limitations of the book pointing out that some important omissions, such as learning disability, were

not addressed thoroughly by much of the research and they were unable to discuss these fully even though their importance in the child protection process is acknowledged. The appendices give further information on Department of Health funded projects, summaries of studies on child protection and a glossary of terms.

This book is written primarily for social workers and mental health practitioners but Elizabeth Butler-Sloss (Royal Courts of Justice, London) who wrote the forward suggests the book should have much wider reading, including judges, barristers and solicitors engaged in family law.

This well written and easy to read book would be of interest to any Paediatric Physiotherapist who wants to know more about the Child Protection Process, implications for practice, and the effects child abuse has on children and their families, using an evidence based approach. However, this may be a book Physiotherapists could borrow from social work colleagues rather than have in their own library.

**Adare Brady BSc, MCSP.**

## PROFILE

### YOUR NEW EDITOR

### SALLY BRAITHWAITE



Sally qualified in 1978 from RAF Halton and The Joint Services School of Physiotherapy where she was a civilian student. She had an interest in paediatrics from the very start of a career which has ranged over a wide area of paediatric experience in both acute and community services. She spent the early days working in various parts of East Anglia where she built up a basis of knowledge for working with children.

Married and settling down in Birmingham with three step children, now grown and embarked on careers of their own, a continuing career with children on a full time basis was still the order of the day. Working in a special school much community experience was gained. The job just evolved, changing vastly in nature over the years, it was like a regular job move because it always offered such different experiences. Finally with a move in employing authority, co-ordinating the service for children with motor problems in mainstream schools is the current and stimulating and often difficult task.

She developed an interest in APCP about seven years or so ago, initially as a West Midlands regional committee member. This led naturally on to being course organiser for the region, and a while later chairman. During this time the region hosted APCP conference when an interesting time was had by all. For the last year as West Midlands Regional Representative associations with APCP have strengthened still further and the prospect of editing the journal although a bit daunting is very exciting.

Her hobbies are wide ranging when the time allows. Foreign travel and choral singing topping the list, with gardening following closely behind (when the weather is fine), along with reading twentieth century fiction. Time is precious with the family, of which the cat is an important member.

### MINIMUM STANDARDS OF HEALTHCARE IN CHILDREN WITH CEREBRAL PALSY

In August last year the Chartered Society of Physiotherapy invited representatives from APCP, BABTT (British Association of Bobath Trained Therapists) and PPIMS (Paediatric Physiotherapy Managers Group) to a meeting with Judy Mead and Gwyn Owen from the CSP and a representative from a company called Bell Pottinger. I attended on behalf of APCP.

We understood that the purpose of the meeting was to discuss the development of standards of healthcare in children with cerebral palsy.

It soon became evident that a document, entitled as above, had already been produced in draft form by Bell Pottinger and copies were distributed to us. Contributions to the document had been made from members of a "CP Working Group".

Essentially the company wanted the CSP to support the recommendations made within the document.

Many issues were raised at the meeting including concerns about the completeness of the content and extent of consultation prior to producing the document. As representatives from the above groups were then given very limited time for wider discussion before a formal response was made to the CSP.

Following as wide a discussion as we could manage in the time available the formal response from APCP to the CSP was that we were not able to support the document. Our objections covered three areas: concerns about the provenance of working group, lack of consideration of specific provisions, and inappropriate weight of other treatment modalities, particularly botulinum toxin.

Gwyn Owen produced a very clear and detailed reply to Bell Pottinger which is best summarised in the Conclusion section of the document which is as follows:-

"The Society welcomes the principle of developing minimum standards of healthcare for children with cerebral palsy. The current draft, however, does not provide a comprehensive picture of the services required for the child with cerebral palsy: it appears to reflect the interests of members of the working group and the sponsors of the project.

It is hoped that wider consultation will enable the working group to review the standards that should reflect the healthcare needs of children with cerebral palsy in a broader context. The physiotherapy specific statements need placing in a wider context: and further details adding to reflect what is current good practice.

Given these concerns, the Society is unable to endorse the document in its current format".

The Document has since been distributed but I do not have any copies. However, if you would like copies of the comments made on behalf of APCP or the full response by the CSP I will be happy to let you have this. My address is listed under publications sections.

EILEEN KINLEY  
National Committee Member and Publications Officer

## WORKING TOGETHER PARENTS AND PHYSIOTHERAPISTS

It is hoped that by now all NHS Trusts in England and Wales who have a Paediatric Physiotherapy service will have received a copy of this publication.

Just establishing which Trusts have Paediatric physiotherapy services was a major undertaking in itself; as a result I know that the list we submitted to SCOPE cannot have been accurate.

However, packages were sent out to Managers of Paediatric Therapy Services and if your service has not received a copy in the first instance approach your head of service and then contact SCOPE who may be able to supply a copy.

The publication is the result of joint working between APCP and SCOPE. It is hoped that it will enable parents to have a better understanding of the purpose of physiotherapy and to help them play a more active and central role in their child's physical management programme. It should also raise the expectation that standards for care should be the same across the country.

It is intended that this document will become a working document for each Paediatric Physiotherapy department in the country.

Please read the contents and then discuss how best to let families have access to them. You may choose to help parents and carers to start a working document for themselves by photocopying the contents and encouraging them to keep their own folder to which they can add local information, reports, treatment programmes etc. throughout their child's life. Your service may wish to finance a copy for every family who use your Child Development Team. Some parents may want to buy one themselves and use it in their own way. Copies can be ordered from the SCOPE library at a cost of £10 plus £1 p&p.

The success of this project will, in the first instance, depend upon you making it available to the families you see. You will see that we have used language aimed at the non-professional person; any of the authors will be pleased to discuss and explain the rationale behind concepts and ideas discussed in the document.

Some members have already suggested that it might be useful for one or more of the authors to attend an APCP study day in order to explain it and answer questions. Please contact us if you would find that helpful.

We are grateful to SCOPE for facilitating this project, for producing it in this format and for funding it so that it could be provided to all NHS Trusts who provide Paediatric Physiotherapy services in England and Wales. However the document is the result of a truly collaborative partnership between two organisations - a strong collaboration that we want to support being developed between parents and physiotherapists.

Please feed back your comments and experiences of using the publication, good or bad, and also whether you think we will need to approach SCOPE for a reprint.

JILL BROWNSON

Authors can be contacted at the addresses shown in the publication with the exception of Jill Brownson who can now be contacted at St.Mary's Hospital, Praed St. London W2 1NY.



# A.P.C.P. MATTERS

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## PHOTOS FROM CONFERENCE

Birmingham October 1999



**The National Committee**



**The Organising Committee – London Region**



2000

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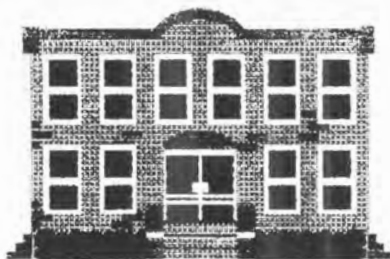
Julia Graham, 3 Railway Cottages, Station Road, East Tisted,  
Nr. Alton, Hampshire, GU34 3QX

# **APCP Conference 2000**

## **REMINDER**

**PARTNERSHIP FOR CHANGE**

**THURSDAY 4TH - 6TH MAY**



**UNIVERSITY OF THE  
WEST OF ENGLAND, BRISTOL**

**CLOSING DATE FOR APPLICATIONS  
14TH APRIL 2000.**

**CONTACT : JULIA GRAHAM,  
3 RAILWAY COTTAGES, STATION ROAD, EAST TISTED,  
NR. ALTON, HAMPSHIRE, GU34 3QX**

\* Would you like more information about funding for research? The CSPs quarterly Research Bulletin is primarily about funding possibilities - and it's free - just contact the CSP and ask to be put on the mailing list.

\* For information about literature searching, website addresses and many other topics relating to research, see what the CSPs Information Resource Centre (IRC) publications have to offer. They are listed on pages 622-623 of your November *Physiotherapy Journal* and are free on request.

\* A new website, known as PEDRO, looks very promising and is accessible free via your home computer. It is a database of abstracts of randomised control trials (RCTs), i.e. high level research, of physiotherapy topics.

The address is : <http://www.cchs.usyd.edu.au/pedro/>

I got through successfully and found a good selection of abstracts re : CP - it has to be easy!

\* For anyone who would like a copy of the executive summary of the systematic review of "Health Promoting Schools and Health Promotion in Schools", which was commissioned by the NHS, please send me a S.A.E. The conclusions are, broadly, that the 'Health Promoting Schools' approach looks promising and that 'Health Promotion in Schools' can have a positive effect on children's knowledge but that their behaviour, attitudes etc. are much harder to change. More investment and evaluation is recommended.

Carrie Jackson  
Research Officer

### THE GARNER PROJECT

#### Scoping Information Management Needs in Occupational Therapy and Physiotherapy

July 1999

This joint project between the CSP and COT (College of OTs) was undertaken by Ruth Garner in the six months to May 1999, and investigates the understanding and the use of information technology within the professions. National policies on information management (IM) were being published around this time thus providing the framework for the professions. The working definition of IM 'being concerned with how information is generated, interpreted, used and distributed', was used to ensure that the practical purposes of IM were emphasised. Three levels of information exchange were identified as a taxonomy for linking national policy and the needs of the therapist. Then consultation and consensus exercises were carried out - you may remember being invited to participate via *Physiotherapy* and *Frontline* - and the findings used to draw up seven key recommendations.

It is envisaged that the project will progress through two further stages and at present the next stage of dissemination is in progress.

As we are all going to be using information systems at work soon, and, as the report suggests, 'IM is the key to knowledge development, clinical governance, effective practise and lifelong learning', I would recommend reading it. It can be used as a reference document both of those managing services and for clinicians.

If you would like a copy of the report, price £5, or a free copy of the executive summary, write to : Sara Waters, PA Dept., CSP, 14 Bedford Row, London WC1R 4ED or phone 0171 306 6621/22

Carrie Jackson  
Research Officer

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## REGIONAL REPORTS

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### NORTHERN IRELAND

In November, Dr Peter Watson came to talk to us on "Seating", it was a very interesting evening and we would like to thank him for coming and speaking to our group.

The AGM will be held in February this year, we are looking forward to the talk following the AGM on "Head injuries", the speaker is Carrie Spence.

Sadly we have lost three members from the committee this year, I would like to thank Liza Lindsay, Mary Parker and Lynn Trewin for all their valued help and support on the committee.

I would like to remind everyone of the next evening meeting on Monday 13th March 2000, "A Pharmacology Update", Dr Elaine Hicks will be the speaker.

We are hoping to organise a Respiratory Course later in the year in conjunction with the Belfast Branch.

JUDITH MORRISON

### SOUTH EAST

We are looking forward to our next Study Day on Monday 27th March, 2000 on 'Paediatric Manual Handling'. It will be at Aylesford Priory, near Maidstone, Kent. Our course tutor is Pat Alexander. Enquiries and application forms to Carol Dooley, Physiotherapy Dept., Valence School, Westerham, Kent, TN16 1QN. Tel 01959 562156. This subject should be of interest and importance to all of us - please support your region.

The AGM will be at 1.00 pm, at this Study Day. There will be vacancies on the regional committee and we would be delighted for any enthusiastic new members to join us. There's always a need for new blood and people with ideas to ensure that the committee are giving members what they want from their region. A list of all committee members will be given in the next journal.

I hope you've all received our spring newsletter. If not please do contact me. I look forward to seeing many of you in March.

SARAH CROMBIE

### WEST MIDLANDS

Your committee have been very busy recently organising the Congenital Developmental Co-Ordination Course which took place at The Children's Hospital in Birmingham on 4 and 5 February. This course led by Michelle Lee was fully subscribed and everyone learnt a great deal.

The West Midlands AGM will be held at Victoria School, Northfield, Birmingham on Wednesday 29 March 2000. The lecture is yet to be confirmed due to a last minute cancellation by Dr Peter Farndon, but it will be followed by a buffet supper and a chance to chat to all your colleagues. Don't forget that if you have any nominations for the regional committee they need to arrive with myself or Liz Bubb regional secretary before the day of the meeting.

A programme of Study Days and evening lectures is currently being assembled and details of these should reach you shortly.

SALLY BRAITHWAITE

### EAST ANGLIAN

The committee met in January to plan and finalise this year's Study days.

The A.G.M./ Study Day on the 4th March at Cambridge will be the Update and Issues of Erb's Palsy, Talipes, and Torticollis. The speaker is Jeanne Hartley of G.O.S.

Thanks to Linda Fisher for organising this.

Preparation for a joint C.F. Study Day with A.C.P.C.F. in June at Bury St. Edmunds is in hand.

## REGIONAL REPORTS

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The speaker and date to be confirmed. More details later.

We are planning to run a Week-end course on 22/23 September in Cambridge; the topic is S.C.B.U. and the programme will include –

- acute/respiratory management;
- handling and positioning;
- screening and follow-up.

The speakers will be Chris Hawley from Ipswich and Judy Hough of G.O.S.

More details later in the year.

We hope as many as you is possible can make it to these Study days and we look forward to seeing you then.

TRICIA BROSNAN

### SCOTLAND

#### Course Information

- 1) Please note the MOVE Study Day Friday 24th March 2000 will be held at Ayrshire Central Hospital, Irvine, Ayrshire. The A.G.M. will be prior to the lunch.
- 2) The Scottish Neonatal Nursing/Multidisciplinary Interest Group are hoping to run a 2 day conference in Edinburgh this October on "Developmental Supportive Care and Follow up of the Neonate". Kathy Jorgenson, a neonatal nurse specialist from the USA will be the guest speaker. Dates, Venue and Programme to be confirmed.

In conclusion, The Introduction to Paediatrics Course which was held in Glasgow, June 1999, the committee are pleased to report that all those who submitted a case study have passed.

LESLEY SMITH

### LONDON

The London Committee had a very busy but rewarding year arranging the A.P.C.P. Congress which was

incorporated with other C.I.G.'s and held at the Birmingham Conference Centre. Congratulations to all those involved.

A very successful 'Riding for the Disabled' study day was held in the Autumn. Study days for this coming quarter will be feedback from Eva Bower Research Project and the A.G.M. combined with complementary therapy approaches to be held at Guys Hospital on Thursday March 2nd. Please contact Regional Representative for more details on 0181 444 3355.

We welcome Sarah Beasley, Fiona Jackson and Sam Challends who have recently joined the London committee.

ANN SHANKS

### NORTH EAST

The AGM and Study Day for Saturday 4th March 2000 has now been changed to 11th March 2000. The topic is now 'Orthotics' by Dr David Pratt. The venue is at St James Hospital, Leeds. We are hoping for a good turnout!

Hopefully, we will soon have confirmation of speakers and venue for our June Study Day on JCA.

We have secured the services of Dr Margaret Mayston, Bobath Centre for our November Study Days. See details on recent Flyer.

There has been a disappointing response to our request for titles for a video library. This will be discussed in depth at our AGM where a decision will be made on whether or not to go ahead with the project. A considerable amount of money will be needed to set up the library and we will need to be convinced that it will be used sufficiently to warrant such an outlay.

Don't forget there is still time to apply for the Annual Paediatric Conference on 4th May 1999 at the University of the West of England, Bristol. Closing Date: 14th April 2000.

MARY HARRISON

## REGIONAL REPORTS

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### SOUTH WEST

The Orthopaedic Study Day in Taunton was excellent; thank you to Ruth and her team for organising it. It was well attended and it was particularly good to meet members from Devon and Cornwall. The AGM/Study Day on Syndromes on 4 March 2000 is at Salisbury but we would like to have another day further west later in the year. Please send me suggestions or offers of venues.

The Wessex Workshops continue and the next one planned will be at Basingstoke (North Hampshire Hospital) on Wednesday 5 July, 1.30 - 3.30 pm. The subject is "CP or Not CP?" and there will be a talk by Dr Pleydell-Pearce on the differential diagnosis of CP and metabolic disorders. Please contact me nearer the time if you would like to attend or would like more details.

Don't forget that the APCP Conference is in the South West region this year, at Bristol, so I hope to meet lots of SW members there.

PAM EVANS

### WALES

1999 was a successful and happy year for APCP WALES! Our membership continued to make positive progress, all Study Days were well attended and everyone appeared to be happily satisfied!

On March 17th, we're holding a Manual Handling Study Day, in conjunction with the AGM, at Trinity Fields Special School, with Pat Alexander. And because it's such an important topic, we've decided not to charge members for this day!

We've arranged an afternoon on May 17th for a talk on the current issues on the management of spinal problems in children, with Paul Davies, Consultant Orthopaedic Surgeon and that will be at Llandough Hospital, Cardiff.

On June 16th, there will be a Study Day on Muscular Dystrophy with Marianne Maine from the

Hammersmith, at the brand new Royal Glamorgan Hospital, just off the M4, near Bridgend.

And then, it's the "big one" - Introduction to Paediatrics Cymru 2000! - at the Jury's Cardiff Hotel from November 6th - 10th. We've already started drawing up a programme and we'll hopefully utilise local expertise as much as possible. We're also thinking about arranging a midweek social night, possibly with a Welsh theme, as an optional extra! Very exciting stuff!!

I'm still hoping to start a newsletter following the next AGM and it would be good to set up a video library. Apart from that, no other news - just to remind you about the APCP Conference in Bristol in May, and if you have any suggestions/ideas for future courses etc., please contact me! Diolch!

SIAN HOWELLS



# APPLICATION FORM FOR APCP PUBLICATIONS

TITLE	PRICE	QUANTITY
Serial Splinting in Hemiplegic Cerebral Palsy by Margaret Jones (2nd Edition)	£3.50	
The Children Act 1989 'A Synopsis for Paediatric Physiotherapists'	£2.50	
Dyspraxia - A Handbook for Therapists by Michelle Lee and Jenny French	£5.50	
Guidelines for Calculating Caseloads	£1.00	
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Human Postural Reactions - Lessons from Purdon Martin by Dr. John Foley	£5.00 (incl. of P&P)	
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**Eileen Kinley, Superintendent Physiotherapist,  
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**APCP WALES**

**INTRODUCTION TO  
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**6th - 10th NOVEMBER 2000**

**JURY'S CARDIFF HOTEL**

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*For further details, please contact :*

SIAN HOWELLS  
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## Notes for Contributors

The Editorial Board welcomes research material; referenced articles and evaluations of physiotherapy practice; informal articles.

Manuscripts should be sent to Mrs Sally Braithewaite, 531 Church Road, Yardley, Birmingham, B33 8PG.

Copy to be submitted should be typed on one side of the paper, double spaced and with ample margins. All pages should be numbered consecutively.

**Manuscripts** should provide the title of the article and the author(s) name(s) and full postal address for correspondence.

**References** should be given in the Harvard System.

In text Author(s) name and initials followed by the date of publication. Use a,b, to indicate more than one publication in the same year. Where there are 3 or more authors use first name followed by et al.

For books Laszlo, J. & Bairstow, P. (1985) *Perpetual Motor Behaviour* (Rinehart and Winston)

For chapters within books

Morley, T.R. (1992) Spinal deformity in the physically handicapped child, in : G.T. McCarthy (Ed). *Physical Disability in Childhood* (Churchill Livingstone)

For articles Scott O.M., Hyde S.A., Goddard C.M., Dubowitz V., (1981a) Prevention of deformity in Duchenne muscular dystrophy. *Physiotherapy* 67(6), 177-80.

## Tables and Figures

The approximate position of the tables and figures should be indicated in the manuscript.

Keys to symbols should be included.

Tables should be numbered by Roman numerals and figures by Arabic numerals.

Figures should be supplied in a finished form, suitable for reproduction. Figures will not normally be redrawn.

Proofs will be sent to authors if major alterations have been made to the text.

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**The Journal in the  
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**The First Newsletter**

**Chordoma Tumours**

**Hinged AFO**

