



The Child Development Center of Colorado Springs, Inc. Newsletter

Summer 2009 Issue

Torticollis

At **The Child Development Center** we are dedicated to providing **high quality** and effective treatment for children with torticollis. The incidents of torticollis are reported to be .3% to 2% of all live births.

It is the third most common congenital musculoskeletal anomaly after dislocated hip and clubfoot. True congenital muscular torticollis is a condition caused by unilateral fibrosis of the sternocleidomastoid muscles. The true etiology of sternocleidomastoid fibrosis is unknown. There are theories relating it to direct injury, ischemic injury based on abnormal vascular patterns, rupture of muscle tissue, infective myositis, a neurogenic injury, or hereditary factors.

One out of five children presenting with torticollis have a non-muscular etiology with either soft tissue involvement or boney involvement.

Clinical features of congenital muscular torticollis:

- Laterally flexed head with rotation of the head and neck toward the non-involved side.
- Decreased neck range of motion.
- Tight banding of the sternocleidomastoid muscle or the tumor like tissue.
- Plagiocephaly or flattening of the occipital and parietal areas.
- Fascial Hemihypoplasia: flattening of the face on the affected side and orbital dystopia.

Clinically we have also observed children with the sternocleidomastoid contractures may also develop craniofacial asymmetries, scoliosis (most prominent in the upper thoracic region), shortening of other neck muscles (anterior/posterior regions of the neck), delayed large motor development, gait abnormalities, as well range of motion limits and delayed function on the involved side upper extremity. Feeding problems have also been noted.

At the Child Development Center of Colorado Springs we carry out a thorough and **comprehensive evaluation and develop a family centered intervention program specific to the evaluation findings.**

At the time of the first evaluation, risk and benefits of the therapy intervention are discussed with the family and home programming is initiated.

The **treatment management** of congenital muscular torticollis includes: soft tissue releasing, strengthening, range of motion, positioning, handling, and facilitation of postural correction and reactions, postural control, and developmental facilitation.

Treatment Duration: Many times, the length of treatment is an initial question from the family. The **length of treatment varies with the initial presentation**, the degree of tightness or fibrosis

within the sternocleidomastoid muscle, the degree of the range of motion limitations, and clinically correlates with the degree of restriction of cervical rotation to the involved side.

The **research indicates the earlier the initiation of treatment, the more successful the outcomes.** Children with sternocleidomastoid mass required longer treatment regardless of severity of the range of motion restrictions; an average of 6.9 months. The average treatment duration has ranged from 3-12 months. Fewer than 16% of children treated conservatively before one-year of age will require any surgical intervention. **Follow up** is recommended through independent ambulation, the achievement of full passive neck range of motion, documentation that there is no regression with growth spurts, and that all long-term goals are achieved.

Torticollis may reoccur or “reappear” depending upon the initial clinical severity, the degree of the fibrosis, and the child’s growth patterns. The involved sternocleidomastoid is oftentimes unable to maintain a normal growth rate or lengthening.

Consultation with specialists is generally recommended if:

1. The clinical exam reveals possibilities of spinal congenital anomalies.
2. Full neck range of motion is not achieved over the age of 12-months and/or after six months of aggressive intervention, development of fascial hemihypoplasia, and progression of cranial deformities.
3. Oftentimes an ophthalmological consult is recommended if there is continuation of a head tilt with full or near full neck range of motion over the age of 12-months or if visual tracking is asymmetrical and does not improve in the first months of intervention..
4. If there is absolutely no response to neck range of motion or no improvement by four- to five-months of age.

Outcomes: Outcomes based on treatment supports manual stretching with **reported good success rates varying from 61 to 85%.**

An **excellent outcome** is with no facial asymmetry and full neck range of motion. A **good outcome** would be mild head tilt, mild facial asymmetry, and/or mild limitations in neck range of motion. A **fair/satisfactory outcome** would include mild facial asymmetry, sternocleidomastoid hypoextensibility. **Poor outcome** would include persistent contracture of the sternocleidomastoid muscles, moderate to significant facial asymmetry, and moderate to severe range of motion limitations.

If you have questions regarding your patients with torticollis or evaluation and treatment, please do not hesitate to contact Banba Swicker-Lipton, PT at the Child Development Center of Colorado Springs, Inc. at 574-8300

Experience Counts!

We've Been Making a BIG Difference in Little Lives since 1988

3090 N. Academy Blvd., Colorado Springs, CO 80917
(719) 574-8300 Fax (719) 574-9547

**** NEWS ****

We've just installed 1000 sq. ft. of cushioned, high-performance, multi-functional sport floor in our dedicated Sensory Integration gym.

This will increase our patients' safety and enjoyment while participating in different activities during treatment sessions.

Also, in the next few weeks we will be installing a professionally designed indoor climbing wall in our Sensory Integration gym. This will help facilitate greater gains in balance, strength, and coordination of our patients.



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of

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WEB SITE:
www.cdcpedsrehab.com

Who is at the Child Development Center of Colorado Springs, Inc.?

We are Occupational, Physical, and Speech/Language Therapists who specialize in treating children age birth to 18. We provide one-on-one rehabilitation programs for children with torticollis, developmental disabilities, autism, sports injuries, orthopedic injuries, cerebral palsy, muscle disorders, speech or language disorders, feeding disorder, learning disabilities, sensory integration and sensory processing disorders just to name a few!

INSURANCE

Do you have questions about your patient's insurance coverage? Call us! Our friendly and knowledgeable billing staff will be happy to help you

Occupational Therapists:

Tami Lamphere, OTR,
Cindy Stroup, OTR
Kirsten Brandt, MOTR
Tamie Saiki, OTR

Physical Therapists:

Banba Swicker-Lipton, PT
Allyson Kelley, PT
Nicole Norris, DPT
Georgia Pauls, PTA

Speech Pathologists:

Julie Nelson, MS, CCC-SLP
Shannon Younkin, MA, CCC-SLP
Sarai Granados, MA, CCC-SLP
Amber Schroeder, MS, CCC-SLP
Carmen M. Heitzer-Winer,
MS, Ed, CCC-SLP

You can also send an
E-mail with your question to:

info@cdcpedsrehab.com

The Child Development
Center is a provider for most
major insurance companies.

Specialized Sensory Integrative Treatment Offered:

Interactive Metronome (IM) -

IM is a brain-based assessment and training program developed to directly improve the processing abilities that affect attention, motor planning, and sequencing.

Brain Integration – Brain

Integration Therapy includes exercises and repatterning methods to promote coordinated use of all the senses.

Therapeutic Listening Program –

TLP is an auditory modality that uses electronically altered sounds to impact the nervous system.

Wilbarger Deep Pressure

Technique – The Wilbarger Technique is a protocol that incorporates use of a soft surgical brush and joint compressions completed as part of an intensive home program. The purpose of this technique is to improve the child's overall ability to respond appropriately to the various sensory events in his/her life.

Hours: Monday: 8 a.m. 6 p.m. Tuesday – Friday: 8 a.m. – 6:30 p.m.

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