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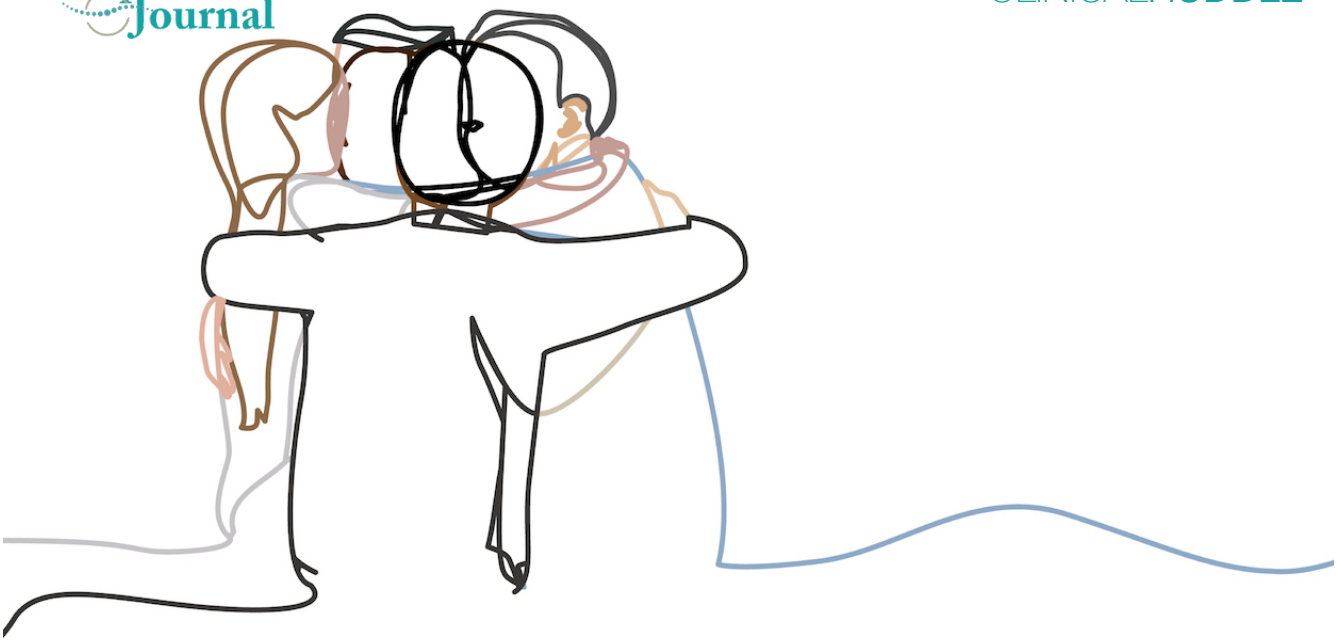

Caring for the pediatric patient and their unique challenges: A Clinical Huddle.

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Abstract: A conversational style is used by the authors to provide an overview of the pediatric consultation in Gonstead-style chiropractic practice. The matters of instrumentation diagnostic imaging are addressed with a conclusion that they provide relevant clinical information to guide the least level of therapeutic intervention. A short pediatric case is given as an example..

Indexing Terms: chiropractic; Gonstead Methods; pediatric; instrumention.

Introduction

As I was checking a patient last week he mentioned, '*Hey Doc, I heard something cool on the radio that I didn't know. When we are infants, we have about 300 bones in our body and then as we get older they fuse together so we end up with less. So you can still check and adjust babies the same as you work on me, right?*'

The short answer to his question is yes. As Gonstead chiropractors, we use the systematic approach that Dr. Gonstead laid out for us on the pediatric population. Not only is this approach thorough, but it also allows for consistent analysis and correction each visit. But there are times, especially when not as experienced with a pediatric patient base, that the doctor might have concerns about how to seamlessly integrate this systematic approach. A good portion of that concern comes from small anatomy coupled with the unpredictability of children. The chiropractor should be skilled in the art and

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analysis, and modify their approach as needed to accommodate for tiny patients.

Let us look at each component of the Gonstead system and how certain modifications might be needed for a patient, specifically one year and younger. It is important to note that one should be mindful of the system, and use it in its entirety as much as possible.

I. History

Every child should have the opportunity to have their spine and nervous system checked. Some parents might come in with specific concerns, others might bring them in because they want they want their child evaluated as early as possible. Either scenario, the leading questions the chiropractor asks are important. The pediatric history is going to be different from a symptomatic adult patient and thus it is even more important for us to guide the conversation with parents.

Topics to focus on which might provide helpful insight include, but not limited to: description of birth process, any medical concerns, sleep schedule, sleep position, formula or breastfeeding, dietary preferences (older children), feeding positions, bowel habits, where child is most comfortable, and temperament. Not only do the questions help guide the chiropractor, they also are powerful education tools for your families under Chiropractic care.

II. Visualization

Visualization starts from the moment you see the child. Pediatric patients should be assessed wearing only their diaper. Older children can be shirtless or gowned. It might be more comfortable for the infant to remain clothed, but will limit the observation of the doctor. An infant only in their diaper also prepares for instrumentation. It is best to keep a warm blanket around them when possible for warmth and security.

View the global positioning of the infant. Do they stay completely contracted and have difficulty opening into extension when prompted? Is the head turned or tilted a certain direction? When you hold them upright, what direction do their legs and feet stay in, or is their a shortening of one leg compared to the other? Observe for any skin changes, whether in color or texture. Does the infant have hair patterns on their back? What sort of birthmarks or “stork bites” might be present? Everyone loves a chubby baby, but those rolls can actually be helpful in identifying an asymmetry. Is there an unusual cleft or dimpling in the sacrum? Further investigation of spina bifida might be necessary.

III. Instrumentation

Instrumentation can often be overlooked for pediatric patients. Granted it is not always fully reliable and other components such as palpation might give the doctor a better indication of where to adjust, but still provides important insight into the case. The laxity of the infant’s skin can make running the scope difficult. Going slower and holding the skin taut in areas can make the task easier. Skin around the diaper can be somewhat moist from the heat the diaper traps causing the instrument to jump rather than glide. In those scenarios, dotting the spine with the instrument can be beneficial. Fossa readers are also an influential tool when evaluating the condition of the upper cervical spine.

A significant modification of instrumentation is the position of the patient. Children as they get older can easily sit in a cervical chair, sometimes with assistance by a parent. But with infants, other positions would be more ideal. They can be scoped held against a parent’s chest, the doctor holding the infant themselves, prone across a parent’s lap, or prone laying across the pelvic bench. The younger the patient, the more involved you want the parent in the process. This will make the task easier for the doctor, but also provide comfort for the infant and parent.

IV. Palpation

Palpation is a highly utilized component when determining the segment to correct on the pediatric patient. The key is to be light and be adaptable. Infants can squirm quite a bit. With a parent holding the child, the doctor can expend less energy in trying to neutralize the infant's movement, and devote more concentration to what they are palpating. Static palpation should be focused on heavily, but when motion palpation is necessary positioning modifications can be helpful.

For motioning the pelvis/sacrum, the infant might be placed prone across a parent's lap or on the pelvic bench. Gentle lifting of the legs to isolate movement in the pelvis can be utilized. An infant can sit on a parent's leg with the parent stabilizing the torso and head, allowing the doctor to palpate very similarly to how we would on an adult patient. In the lumbar and thoracic spine, gentle P-A pressure through a specific segment can be insightful. Observe the infant's reaction as you palpate, squirming or excessive movement can indicate discomfort in the area. For the infant's cervical spine, palpation can be approached with them in the seated position with parent stabilization, or with the parent holding them upright with the head above their shoulder. No matter the approach, the doctor needs to be adaptable to the infant's movement, and modify which finger contacts they use to best fit the anatomy of the patient.

V. Spinography

The use of spinographs is under-utilized in the pediatric population. This does not mean we need to start radiating every pediatric case we have, but we need to be mindful of situations. When imaging is necessary, first a conversation with the parent(s) must be had. Provide the parent with reasoning, address any concerns they might have, and walk them through the x-ray process. Ideally, a cassette will be placed on the floor and the infant will lay on that supine, and then on their side. It is necessary to have the parent participate to hold the child and have them aware they will be receiving a small amount of radiation as well.

In our office, we utilize an upright stationary bucky. For us to take the AP film of a pediatric patient, we have them stand upright with a parent holding their arms/head for support. For the lateral film, we have the patient stand (ideally) while they face their parent and the parent holds the infant's hands. If they can not stand, the infant sits on a stool and the parent holds the infant's hands in front of them. These situations are not common, but when necessary, the imaging can provide valuable information for the doctor.

Katherine: Pediatric Case

Katherine has been receiving chiropractic care since she was two months. On one visit when she was 11 months old, she presented with palpable spasm in her thoracolumbar region, cried if she moved her body into extension, was content if she could stay seated, slightly flexed, and the parent's could not identify a mechanism of injury. After scoping and palpating Katherine, I located subluxation findings at L1 and the S4 sacral tubercle. After deliberating, I spoke with the parent and expressed my need for radiographs.

Once I reviewed her films, I had conviction to adjust the sacral segment. I adjusted S4 tubercle prone across her mother's lap. By the next visit 3 days later, her spasm had decreased markedly. On this visit, I applied gentle P-A pressure at L1, essentially no lift of the segment due to its posteriorly wedged position. At 7 days from her initially coming in with the injury, Katherine was able to crawl rather than only scoot on her bottom. After further direct questioning, it was identified that Katherine was placed in a walker for sometimes up to two hours per day. The parents were advised to avoid the walker, as well as do their best to avoid rotation of her spine during diaper changes. These changes, in conjunction with her scheduled chiropractic visits, allowed the area to heal.

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Mission of Dr Sedar's Clinical Practice:

To offer the absolute best in Chiropractic Care;

To perpetuate the Gonstead System of Chiropractic thru education;

To assist man, woman, and child in receiving an opportunity for optimal health, if they choose to pursue it;

To encourage a natural way of living, a life of proactive vocation and action, and a life driven not out of fear, but purpose and direction;

Thru chiropractic lifestyle, nutrition, education, love, and laughter;

This is our mission: One adjustment at a time!