

Cerebral Palsy and the Treatment Associated with it

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Editorial

There is no known cure for cerebral palsy, but supportive treatments, medication, and surgery may help many individuals. This may include physical therapy, occupational therapy, and speech therapy. Medications such as diazepam, baclofen, and botulinum toxin may help relax stiff muscles. Often, external braces and other assistive technology are helpful. Some affected children can achieve near normal adult lives with appropriate treatment. A number of potential a group of permanent disorders of the development of movement and posture, causing activity limitation, that are attributed to non-progressive disturbances that occurred in the developing fetal or infant brain” is how the condition of cerebral palsy is defined. Though movement problems are the primary feature of CP, there are often problems with thinking, learning, feeling, communication, and behavior as well.

For example, 28% of people with CP have epilepsy, 58% have trouble communicating, at least 42% have trouble seeing, and 23-56% has learning disabilities. Muscle contractions in people with cerebral palsy are commonly thought to be the result of over activation. Cerebral palsy is characterized by abnormal muscle while the orthopaedic manifestations are secondary and progressing, the primary neurological lesion is permanent. Bone and joint deformities are the result of uneven growth between muscle-tendon units and bone in cerebral palsy. Deformities are initially dynamic. Joint contractures and deformities tend to become static over time [1-3]. Deformities in general and static deformities in particular (joint contractures) cause increasing difficulties with gait, such as tip-toeing and scissoring gaits caused by Achilles tendon tightness. Among the most common gait abnormalities in children with cerebral palsy are these patterns.

The effects of cerebral palsy fall on a continuum of motor dysfunction, which may range from slight clumsiness at the mild end of the spectrum to impairments so severe that they render coordinated movement virtually impossible at the other end of the spectrum. Although most people with CP have problems with increased muscle tone, some people with CP have normal or low muscle tone. Additionally, crouch gait (excessive knee flexion gait) is prevalent among children who possess the Spasticity or dystonia can cause high muscle tone. Babies with severe cerebral palsy frequently have abnormal posture. They may have very floppy or very stiff bodies. Occasionally, CP is accompanied by birth defects such as a curvilinear spine, a small jawbone, or a small head. As a child grows older, symptoms may appear or change. Typically, cerebral palsy (CP) is diagnosed when a baby reaches the developmental stage at 6 to 9 months and begins to mobilize, exhibiting preferential use of limbs, asymmetry, or gross motor developmental delay.

Babies born with CP do not immediately present with symptoms. Most children who are born with cerebral palsy have more than one risk factor associated with CP. While in some cases there is no identifiable cause, typical causes include problems in intrauterine development (e.g., exposure to radiation, infection, fetal growth restriction), hypoxia of the brain (thrombotic events, placental insufficiency, umbilical cord prolapse), birth trauma during labor and delivery, and complications around birth or during childhood. In With better resources, many

cases of CP in Africa could be avoided [4,5].

Various gait patterns can be observed in patients with spastic diplegia or hemiplegia, but only complex gait analysis systems can describe the exact form of these patterns. A straightforward description of the gait pattern is helpful in order to facilitate interdisciplinary communication among those affected, doctors, physiotherapists, and orthotists in the interdisciplinary team. In 2001, J. Rodda and H. K. Graham described how CP patients' gait patterns can be more easily recognized and classified into gait types that they compared. The Amsterdam Gait Classification was developed at the free university in Amsterdam, the VU medisch centrum, based on their description of how gait patterns can change with age. This classification is unique in that it can be used for CP patients with only one leg or both legs affected because it makes different gait patterns easy to identify. The Amsterdam Gait Classification identifies five distinct types of gait. The patient is viewed visually or through a video recording from the side of the leg that is being evaluated in order to assess the gait pattern. On the one hand, the knee angle and foot contact with the ground are evaluated when the leg to be viewed is in mid stance and the leg not to be viewed is in mid swing.

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