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tween GMFCS and WeeFIM subtypes according to subtypes, all parameters were correlated at the level of $p < 0.01$ like MACS. There was no difference in MACS between age groups of 4-7, 8-11 and 12-15 yrs ($p > 0.05$). It is concluded that both the use of GMFCS and MACS in practice and research area will provide easy, practical and simple classification of the functional status of children with CP.

GOOD PRACTICE IN REHABILITATION OF CHILDREN – IN PRACTICE, IN THE REAL WORLD

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The objective is to implement good practice in rehabilitation of children and young, as defined by specialists and societies. The subjects are 15 local groups of rehabilitation specialists all over Finland and six national societies. The specialists represent health and social care, education, day care and families of children and young with special needs. They will be trained by Vajaaliikkeisten Kunto ry-society. From each local group two project workers will make a plan how to organize rehabilitation in their own district. Results and conclusions: 1) the good practice in rehabilitation of children and young will be in use in the whole of Finland; 2) special needs of each district will be taken into rehabilitation plan and practice; and 3) the local framework forms the basis for individual planning. The framework makes the individual rehabilitation planning quick and easy and preserves its individual character.

RELIABILITY OF UKRAINIAN VERSION OF GROSS MOTOR FUNCTION CLASSIFICATION SYSTEM

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Gross Motor Function Classification System (GMFCS) is a standardized system for describing and classifying the severity of movement disability among children with cerebral palsy. The aim of this study was to develop the Ukrainian version of the GMFCS and to test its reliability. Translation and back translation of the GMFCS has been made, the differences were fixed by consensus. Two physicians trained to use GMFCS classified patients after reviewing video recordings of their motor functions. The sample of 108 children with cerebral palsy aged 1-12 years was under study. Children were divided

into 4 age subgroups and 5 GMFCS level subgroups. The sample was "balanced" by age and GMFCS levels, so each of 20 subgroups had approximately 5 children. Inter-rater reliability was assessed with Cohen's unweighted Kappa. Kappa was also calculated for each age and level subgroup. Calculated overall Kappa coefficient was 0.76 (95% CI=0.66-0.85). Cohen's Kappa coefficient is a statistical measure of inter-rater reliability. Kappa values from 0.61 to 0.80 can be interpreted as a good strength of agreement, and values from 0.81 to 1 as very good. The indices of agreement were lowest for the 1-2 year age group: Kappa equaled 0.64 and for the pair of levels III and IV levels Kappa was 0.62. The results of the study suggest that the Ukrainian version of the GMFCS can be used reliably to classify patients with cerebral palsy and is suitable for application in research studies and clinical practice. The Ukrainian version of GMFCS has been already introduced into everyday practice at several rehabilitation institutions in Ukraine.

EFFECTS OF STANDING PROGRAMS WITH ABDUCTION IN CHILDREN WITH SPASTIC DIPLEGIA

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Hyperactivity of the adductor muscles is typical in the majority of children with spastic diplegia. The delay in weight-bearing on standing and poor muscle balance in the legs can lead, with time, to hip dysplasia. The purpose of this study was to show long term benefits of the use of a standing device in abduction on hip development, muscle alignment and functional gait. Seven children aged 14-17 months and diagnosed with spastic diplegia were selected in the early intervention department for this study. The children demonstrating a scissors stepping pattern and requiring assistance for standing balance began the standing program using a standing device in abduction (made individually with plaster). The degree of abduction varied in each case (55°-70° of abduction). The children used the standing device for 45 minutes a day at home until the age of five. The hip migration percentage was measured once a year with x-ray. Muscle alignment was assessed by goniometric measurement of the hip adductor range of motion. The hip migration percentage remained within the normal limits in all cases (13%-21%) at the age of five. The adductor muscles did not lose the capacity of the range of motion. There was widening of the base of support with improved functional step. At the age of five, we compared radiological study results of these seven children with another seven children that did not use the standing program in abduction, also diagnosed with spastic diplegia and selected at random in different centers.