# Table 3: SUMMARY AND STATUS OF ACTION STATEMENTS FOR THE 2018 CONGENITAL MUSCULAR TORTICOLLIS CLINICAL PRACTICE GUIDELINE

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|  **Action Statement** | **Status** | **Page** |
| **I. EDUCATION, IDENTIFICATION AND REFERRAL OF INFANTS WITH CONGENITAL MUSCULAR TORTICOLLIS (CMT)** |
| **P. Action Statement 1: EDUCATE EXPECTANT PARENTS AND PARENTS OF NEWBORNS TO PREVENT ASYMMETRIES/CMT.** Physicians, nurse midwives, prenatal educators, obstetrical nurses, lactation specialists, nurse practitioners or physical therapists should educate and document instruction to all expectant parents and parents of newborns, within the first 2 days of birth, on the importance supervised prone/tummy play when awake 3 or more times daily, full active movement throughout the body, prevention of postural preferences, and the role of pediatric physical therapists in the comprehensive management of postural preference and optimizing motor development. (Evidence quality: **V**; Recommendation strength: **Best Practice**) | New | 253 |
| **A. Action Statement 2: ASSESS NEWBORN INFANTS FOR ASYMMETRIES/CMT.** Physicians, nurse midwives, obstetrical nurses, nurse practitioners, lactation specialists, physical therapists or any clinician or family member must assess and document the presence of neck and/or facial or cranial asymmetry within the first 2 days of birth, using passive cervical rotation and/or visual observation as their respective training supports, when in the newborn nursery or at site of delivery. (Evidence Quality**: I,** Recommendation Strength**: Strong**)  | Revised and updated | 255 |
| **B. Action Statement 3:** **REFER INFANTS WITH ASYMMETRIES/CMT TO PHYSICIAN AND PHYSICAL THERAPIST.** Physicians, nurse midwives, obstetrical nurses, nurse practitioners, lactation specialists, physical therapists or any clinician or family member should refer infants identified as having postural preference, reduced cervical range of motion, sternocleidomastoid masses, and/or craniofacial asymmetry to their primary physician and a physical therapist with expertise in infants as soon as the asymmetry is noted. (Evidence Quality: **II**, Recommendation Strength: **Moderate**) | Revised and updated  | 256 |
| **II. PHYSICAL THERAPY EXAMINATION AND EVALUATION OF INFANTS WITH ASYMMETRIES/CMT** |
| **B. Action Statement 4: DOCUMENT INFANT HISTORY.** Physical therapists should obtain and document a general medical and developmental history of the infant, including 9 specific health history factors, prior to an initial screening. (Evidence Quality: **II**, Recommendation Strength: **Moderate**) | Revised and updated | 257 |
| **B. Action Statement 5: SCREEN INFANTS FOR NON-MUSCULAR CAUSES OF ASYMMETRY AND CONDITIONS ASSOCIATED WITH CMT.** When infants present with or without physician referral, and a professional, or the parent or caregiver indicates concern about head or neck posture and/or developmental progression, physical therapists with infant experience should perform and document screens of the neurological, musculoskeletal, integumentary and cardiopulmonary systems, including screens of vision, gastrointestinal history, postural preference and the structural and movement symmetry of the neck, face and head, trunk, hips, upper and lower extremities, consistent with state practice acts. (Evidence Quality: **II-IV**, Recommendation Strength: **Moderate**) | Revised and updated  | 258 |
| **B. Action Statement 6: REFER INFANTS FROM PHYSICAL THERAPISTS TO PHYSICIANS IF INDICATED BY SCREEN.** Physical therapists should document referral of infants to their physicians for additional diagnostic testing when a screen identifies: non-muscular causes of asymmetry (e.g. poor visual tracking, abnormal muscle tone, extra-muscular masses); associated conditions (e.g. cranial deformation); asymmetries inconsistent with CMT; or if the infant is older than 12 months and either facial asymmetry and/or 10-15 degrees of difference exists in passive or active cervical rotation or lateral flexion; or the infant is 7 months or older with an sternocleidomastoid mass; or if the side of torticollis changes, or the size or location of an SCM mass increases. (Evidence Quality: **II**, Recommendation Strength: **Moderate**) | Revised and updated  | 259 |
| **B. Action Statement 7.** **REQUEST IMAGES AND REPORTS**. Physical therapists should request, review, and include in the medical record all images and interpretive reports, completed for the diagnostic workup of an infant with suspected or diagnosed CMT, to inform prognosis. (Evidence Quality: **II**, Recommendation Strength: **Moderate**). | Revised and updated  | 260 |
| **B. Action Statement 8:** **EXAMINE BODY STRUCTURES**. Physical therapists should perform and document the initial examination and evaluation of infants with suspected or diagnosed CMT for the following 7 body structures: * Infant posture and tolerance to positioning in supine, prone, sitting and standing for body symmetry, with or without support, as appropriate for age. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Bilateral passive range of motion (PROM) into cervical rotation and lateral flexion. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Bilateral active range of motion (AROM) into cervical rotation and lateral flexion. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* PROM and AROM of the trunk and upper and lower extremities, inclusive of screening for possible developmental dysplasia of the hip (DDH). (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Pain or discomfort at rest, and during passive and active movement. (Evidence quality: **IV**; Recommendation strength: **Weak**)
* Skin integrity, symmetry of neck and hip skin folds, presence and location of a SCM mass, and size, shape & elasticity of the SCM muscle and secondary muscles. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Craniofacial asymmetries and head/skull shape. (Evidence quality: **II**; Recommendation strength: **Moderate**)
 | Revised and updated | 261 |
| **B.** **Action Statement 9: CLASSIFY THE LEVEL OF SEVERITY**. Physical therapists and other health care providers should classify and document the level of CMT severity, choosing one of eight proposed grades (Figure 2), based on infant’s age at examination, the presence of a SCM mass, and the difference in cervical rotation PROM between the left and right sides. (Evidence Quality: **II**, Recommendation Strength: **Moderate**) | Upgraded with new evidence | 265 |
| **B. Action Statement 10: EXAMINE ACTIVITY AND DEVELOPMENTAL STATUS**. During the initial and subsequent examinations of infants with suspected or diagnosed CMT, physical therapists should examine and document the types of and tolerance to position changes, and motor development for movement symmetry and milestones, using an age appropriate, valid and reliable standardized test. (Evidence quality: **II**; Recommendation strength: **Moderate**) | Revised and updated | 268 |
| **B. Action Statement 11. EXAMINE PARTICIPATION STATUS**. The physical therapist should obtain and document the parent/caregiver responses regarding: * Positioning when awake and asleep. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Infant time spent in the prone position. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Whether the parent is alternating sides when breast or bottle feeding the infant. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Infant time spent in equipment/positioning devices, such as strollers, car seats or swings. (Evidence quality: **II**; Recommendation strength: **Moderate**)
 | Revised and updated  | 269 |
| **B. Action Statement 12: DETERMINE PROGNOSIS.** Physical therapists should determine and document the prognosis for resolution of CMT and the episode of care after completion of the evaluation, and communicate it to the parents/caregivers. Prognoses for the extent of symptom resolution, the episode of care, and/or the need to refer for more invasive interventions are related to: the age of initiation of treatment, classification of severity (Figure 2), intensity of intervention, presence of comorbidities, rate of change and adherence with home programming. (Evidence Quality: **II**, Recommendation Strength: **Moderate**) | Reaffirmed and updated  | 270 |
| **III. PHYSICAL THERAPY INTERVENTION FOR INFANTS WITH CMT** |
| **B. Action Statement 13:** **PROVIDE THESE FIVE COMPONENTS AS THE FIRST-CHOICE INTERVENTION.**  Physical therapists should provide and document these five components as the first choice intervention for infants with CMT: * Neck PROM. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Neck and trunk AROM. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Development of symmetrical movement. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Environmental adaptations. (Evidence quality: **II**; Recommendation strength: **Moderate**)
* Parent/caregiver education. (Evidence quality: **II**; Recommendation strength: **Moderate**)
 | Revised and updated | 272 |
| **C. Action Statement 14. PROVIDE SUPPLEMENTAL INTERVENTION(S), AFTER APPRAISING APPROPRIATENESS FOR THE INFANT, TO AUGMENT THE FIRST-CHOICE INTERVENTION.** Physical therapists may provide and document supplemental interventions, after evaluating their appropriateness for treating CMT or postural asymmetries, as adjuncts to the first choice intervention when the first choice intervention has not adequately improved range or postural alignment, and/or when access to services is limited, and/or when the infant is unable to tolerate the intensity of the first choice intervention, and if the physical therapist has the appropriate training to administer the intervention. (Evidence Quality: **I-IV**, Recommendation Strength: **Weak**) | Revised and updated  | 273 |
| **B. Action Statement 15:** INITIATE CONSULTATION WHEN THE INFANT IS NOT PROGRESSING AS ANTICIPATED.Physical therapists who are treating infants with CMT or postural asymmetries should initiate consultation with the infant’s physician and/or specialists about other interventions when the infant is not progressing as anticipated. These conditions might include: when asymmetries of the head, neck and trunk are not starting to resolve after 4-6 weeks of comprehensive intervention, or after 6 months of intervention with a plateau in resolution. (Evidence Quality: **II**, Recommendation Strength: **Moderate**)  | Revised and updated  | 276 |
| **IV. PHYSICAL THERAPY DISCONTINUATION, REASSESSMENT, AND DISCHARGE OF INFANTS WITH CMT** |
| **B. Action Statement 16:**  **DISCONTINUE DIRECT SERVICES WHEN THESE 5 CRITERIA ARE ACHIEVED.** Physical therapists should discontinue direct physical therapy services and document outcomes when these 5 criteria are met: PROM within 5 degrees of the non-affected side; symmetrical active movement patterns; age appropriate motor development; no visible head tilt; and the parents/caregivers understand what to monitor as the child grows. (Evidence Quality: **II-III**, Recommendation Strength: **Moderate**) | Revised and updated  | 277 |
| **B. Action Statement 17: REASSESS INFANTS 3-12 MONTHS AFTER DISCONTINUATION OF DIRECT SERVICES AND THEN DISCHARGE IF APPROPRIATE.** 3-12 months following discontinuation from direct physical therapy intervention OR when the child initiates walking, physical therapists who treat infants with CMT should examine postural preference, the structural and movement symmetry of the neck, face and head, trunk, hips, upper and lower extremities, and developmental milestones to assess for reoccurrence of CMT and evidence of atypical development. (Evidence Quality: **II**, Recommendation Strength: **Moderate**) | Revised and updated | 278 |