Torticollis

Agusnadi M, Sjabaroeddin Loebis

(Department Of Child Health, Medical School, University of North Sumatera, Medan)

ABSTRACT We report a case of 12 years old girl with acquired torticollis caused by juvenile rheumatoid arthritis. The main complaint are the head inclined to the right and the pain of the right neck. We established the working diagnosis based on the history and typical clinical pictures. After having physiotherapy and drug therapy with acetosal, the patient become better with the head and neck is in normal condition again. The importance is to treat cases of torticollis as soon as possible, before there is a contracture of the muscles of the neck. [Pediatr Indones 1995; 35:110-112]

Introduction

Torticollis or wryneck describes a tilting of the neck and head towards one shoulder, where the head flexion is to same side of affected side and rotation of the head to the opposite side. This maybe the result of irritative, mechanical, or neurological lesions, or by soft tissue contraction involving the sternocleidomastoid muscle and its sheath, and rarely by some underlying congenital anomaly of one or more of the cervical vertebrae. In most cases in infants torticollis is caused by a tumor-like thickening of the sternocleidomastoid muscle and is frequently preceded by a breech delivery. There are two types of torticollis, congenital torticollis (infantile torticollis) and acquired torticollis (spasmodic torticollis) which are caused by inflammation like rheumatoid arthritis, trauma, neurologic, and drug reactions. The aim of this paper is to report one case of spasmodic torticollis caused by juvenile rheumatoid arthritis in a 12 years old Indonesian girl.

Case Report

A 12-year old Indonesian girl was admitted to Pediatric Division of Tembakan Deli Hospital, Medan on April 6, 1994, with the chief complaint of pain on the right neck and the head inclined to the right starting from five days prior to admission. At first the pain and the inclined head were not clear. The pain was exaggerated when she looked to the right. Several weeks before she had fever and pain on right knee. The history of trauma was denied.

She was delivered spontaneously, aided by midwife at home, on March 18th, 1982. Birth weight was 3700 gram and birth length 48 cm. She was the third of five siblings, the siblings were healthy. Her father was 43 years old, worker, and her mother was 37 years old, house-wig.

Physical examination showed an Indonesian girl, 12 years old, with body weight of 39 kg and body height of 137 cm; the temperature was 37.9°C. The general condition was good, no anemia, no jaundice, no dyspnea, and no edema.

The head was tilted to the right. Eye examination disclosed normal external eye and normal light reflexes. The ears, nose and mouth were normal. The neck was tilted to the right, painful on movement; there was no palpable mass.

The chest was normally shaped, symmetrical, and no evidence of retraction. The heart rate was 80 per minute, regular, while the respiratory rate was 24 per minute, regular. Heart and lungs examination disclosed no abnormality.

The abdomen was soft. The liver and spleen were not palpable. On auscultation the peristaltic were normal.

Examination of the extremities disclosed painful on movement of the right knee, but there was no signs of arthritis. The physiological reflexes were normal, and there was no pathological reflexes.

The laboratory findings showed hemoglobin content of 12 g/dl, the blood sedimentation rate was 15 mm/hour, the white blood cell count was 9000/µl with normal differential count.

Rontgenographic of head and neck. The patient was put on aspirin 500 mg 3 times daily, and she was consulted to the Physiotherapy Division of Tembakan Deli Hospital, for physiotherapy treatment. The physiotherapy of the head and neck was performed every 2 days regularly. After 6 times of physiotherapy and two weeks therapy with acetosal, the head and neck was not tilted anymore and was in normal position; the patient could rotate her neck without pain.

Discussion

In infantile torticollis the clinical pictures shortly after birth are not clear, where the infant holds his or her head at an angle, or that there is a firm swelling on one side of the neck. Palpation reveals the typically olive-shaped, firm tumour in the lower third of the sternocleidomastoid muscle. The head is inclined towards the affected side, but the face looks towards the opposite side, and the chin is rotated and risen towards the opposite shoulder.

In severe and long-established cases there is retarded development of the face on the affected side, the forehead ap-
pears flattened and the axes of the eyes are rotated.2

The important diagnostic features are the history, typical clinical pictures, and laboratory examination.2,4

Treatment consists of physiotherapy, either postural or active, which is designed to stretch and elongate the affected sternocleidomastoid muscle.1,2 In the congenital torticollis if it persist until the second year of life the shortened muscle is divided at its sternal and clavicular origin by the small operation (tenotomy). And after the operation the patients wears a light plastic collar for a number of weeks to accustom he or she to the normal new position of head.7 For acquired torticollis the treatment are physiotherapy and depending on the underlying disease.8,9

The prognosis of infantile torticollis generally is good, when the treatment has been done on the first year of life. When it persists until the second year of life, the prognosis is not good. If the operation is carried out in time, the secondary deformities of the face and spine disappear spontaneously.12,5

The diagnosis of torticollis is based on the history of the disease, and typical clinical pictures.4,5 In this patient the clinical pictures were clear with inclined of the neck and the head to the right; there was no history of trauma. Physical examination supported the diagnosis of acquired torticollis.

The underlying condition in this case was juvenile rheumatoid arthritis (acquired torticollis-spasmodic torticollis).8

The treatment consists of physiotherapy and depending on underlying disease.12

In this case, the treatment are active physiotherapy and acetasol as a analgetic drug for rheumatoid arthritis. After 6 times of physiotherapy and several days with drug therapy, the patient showed improvement. She could look to the posterior without pain on her neck.

The prognosis of this patient is good, because the treatment is soon started and also determined by the underlying disease.1,3,5

References

Unrecognized Human Immunodeficiency Virus Type 1 Infection in a Cohort of Transfused Neonates: A Retrospective Investigations


Objective. To retrospective identify unrecognized human immunodeficiency virus type 1 (HIV-1) infection among a cohort of children transfused as neonates before donated blood was routinely screened for HIV-1 antibody.

Methods. Records at a large, private, metropolitan hospital were reviewed to identify children who were transfused as neonates between January 1980 and March 1985 and discharged alive from the hospital. Multiple data sources were used to locate these children. Parents or guardians were contacted, and their children were offered HIV-1 antibody testing and physical examination.

Results. Of the 775 children identified as having received transfusions during the project period, 644 (83%) were located, and 443 (69%) were evaluated for HIV-1 infection. Among those evaluated, 33 (7%) had antibody to HIV-1, including 14 whose infections had not been previously diagnosed. At the time of enrollment, 13 children infected with HIV-1 were asymptomatic an average of 63 months after transfusion.

Conclusion. HIV-1 antibody testing should be considered for all children, regardless of clinical status, who were transfused before routine blood donor screening was implemented in March 1985, particularly in areas with a high incidence of acquired immunodeficiency syndrome during those years.

The Hair Collar Sign: Marker for Cranial Dysraphism


Objective. To call attention to a cutaneous marker for neural tube closure defects of the scalp, the "hair collar" sign. This finding consists of a ring of long, dark, coarse hair surrounding a midline scalp nodule.

Methods and Results. Four children with small congenital scalp nodules and the hair collar sign were studied from the standpoint of clinical findings, radiologic scans, and histology of the excised nodules. All four had an overlying vascular stain in addition to the hair collar. Patients 1 and 2 were found to have encephaloceles, and one had heterotropic brain tissue. The fourth family refused surgery, but the clinical and radiologic findings were consistent with a diagnosis of atratic encephalocele. One infant had agenesis of the corpus callosum and a Dandy-Walker malformation as associated findings.

Conclusions. The "hair collar" sign should alert the pediatrician to the possibility of ectopic neural tissue in the scalp and/or underlying central nervous system malformations.

Infantile Colic: Child and Family Three Years Later


Objective. To assess differences in family functioning or child-rearing attitudes within families with previously colicky infants and to