Paediatrics & Child Health, 2024, **29**, 189–192
https://doi.org/10.1093/pch/pxae003
Position Statement

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Care for children and youth with cerebral palsy (GMFCS levels III to V)

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ABSTRACT

Cerebral palsy (CP) is the most common physical disability in Canadian children. The comprehensive care of ambulatory children with CP functioning at Gross Motor Function Classification System (GMFCS) level I and II was covered in a previous practice point. This companion document focuses on the care of children with CP functioning at GMFCS levels III to V. Children functioning at GMFCS level III and IV mobilize using devices such as a walker, canes, or powered mobility, while those functioning at GMFCS level V require assisted mobility, such as a manual wheelchair. An overview of key concepts in early detection, rehabilitation services, and therapeutic options for children with CP at these levels is provided, along with practical resources to assist health surveillance for paediatricians caring for this population.

Keywords: Anticipatory guidance; Cerebral palsy; Early detection; Surveillance.

EARLY DIAGNOSIS AND MOTOR PROGNOSTICATION

An accurate diagnosis of cerebral palsy (CP) is often possible to make in infants, based on a combination of findings from a physical examination tool (e.g., notably the Hammersmith Infant Neurological Examination [HINE]) and magnetic resonance imaging (MRI) (1). CP subtype and future ambulation status can also be predicted (1) on this basis. At-risk newborns, such as those born preterm or with hypoxic ischemic encephalopathy, should receive close monitoring as part of their neonatal follow-up program. For these at-risk infants, a CP diagnosis can be predicted accurately before 6 months based on a motor function assessment (e.g., Prechtl's General Movement Assessment) combined with HINE and MRI findings (1).

Guidelines recommend early intervention with task-specific motor training for infants with (or at high risk for) CP, to harness neuroplasticity and improve long-term motor and cognitive outcomes (2). Early detection and prompt referral for intervention services will support caregiver well-being (1). Whenever possible, interventions should occur in a natural environment, like the child's home, and with caregiver assistance, such that therapies can be tailored to meet infant tolerance, needs, and family-centred goals (1).

When a diagnosis is made, parents often ask paediatricians about future skills. By age 2, a gross motor trajectory can be established and the GMFCS is helpful for predicting motor outcomes (3). It is rare for individuals to move more than one level up or down on the GFMCS (4), and most of a child's motor development has been achieved by 5 years of age (5). Despite these facts, paediatricians should continue to encourage children with CP to develop independent adapted mobility, and promote lifelong participation in motor activities throughout life (5).

For all prognostic conversations, maintaining a strengths-based approach and focusing on a child's independence and abilities (rather than what they cannot do) are important. Use positive phrasing. For example, "We're going to focus on helping your child to move independently, which may include an assistive device, like a walker," or "Encouraging kids to explore the world and move when and where they want to—as independently as possible—is really important for their overall development," will be more positively received than "Your child won't be able to walk independently". Providing hope and an optimistic outlook, while managing parental expectations, is crucial for maintaining relationships with families and supporting them throughout their child's journey.

Received: May 6, 2022; Accepted: March 31, 2023

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