This reply and brief review is first and foremost to acknowledge, thank, and congratulate the author, Pragnesh Nathavat, BPT, NDT Trained. In this article, the author shared his experience, which in my informed clinical opinion, communicates an appropriate viewpoint concerning the rigid use of GMFCS levels as a major guide in planning appropriate activity-based and participatory goals. Some therapists may use this system to demonstrate progress, and yes, it is more likely that one would more easily and realistically assist a child with cerebral palsy to move from Level II to Level I. However, to the best of my knowledge, this system was intended primarily for purposes of communication, potential research, and to track demographics within the population of children with cerebral palsy.

The NDT approach is committed to evaluate, examine, treat, and manage all children with cerebral palsy regardless of GMFCS level, degree of severity, and age. This may very well be the heart of NDT, geared to the improvement of quality of life for each child and family. This moving report is also exemplary of the author’s ability to select participation outcomes including sleeping, a decrease in the frequency of constipation, improved nutrition, family guidance, and support, including the family’s provision of an adapted chair that allowed for visual exploration of the environment, people, and interesting toys and objects.

Of interest was the description of the author’s conversation with an orthopedist who commented that one cannot ever move a patient out of Level V and could not understand why the author would spend so much time treating MH. While it is informative to learn that the GMFCS is being utilized universally, it would seem that the orthopedist should be made aware of the author’s astute ability to select appropriate goals. Of greater importance would be that he recognizes that the author’s use of NDT includes not only gross motor skills but addresses both primary and secondary impairments and sensory processing/integration strategies. Along these lines, the intervention included the prevention and/or slowing down of the development of secondary
musculoskeletal impairments such as muscular contractures, bony deformities, and osteoporosis. For this reason, I hope the author will be able to continue his treatment of this patient. It also seems feasible that the author’s use of handling strategies may have, or will have, a positive impact upon the child’s pulmonary function through positioning and on the practice of standing for MH’s ability to sustain weight bearing through his lower limbs in preparation for activities such as participating in transfers.

In conclusion, I would like to share with the author that I was personally moved by the article and reminded of the importance of viewing the child as a whole and treating appropriately selected challenges. My highest regards for your article certainly include the reported insights from the patient’s mother. Congratulations, and again, thank you for sharing your important message.

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REFERENCE