



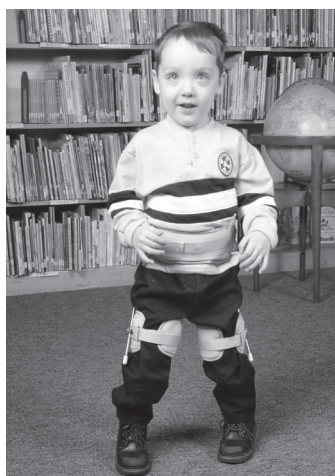
# allard<sup>USA</sup>



## S.W.A.S.H.<sup>®</sup>

**Sitting Walking And Standing Hip orthosis**

- Prescription Required
- Single Patient Use Only.
- The product must be fitted by or under the supervision of a Certified Orthotist-Prosthetist, Certified Orthotist or equivalent medical professional.



# MANUAL

## Clinical





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## *Acknowledgements*

*To Dr. Paul Meyer of Cambridge, England who took the time and the effort to design a way to help his daughter, Rebecca, and children everywhere with cerebral palsy.*

*To Bertil Allard, Past President and CEO of Camp Scandinavia AB, whose vision, commitment and perseverance have made the SWASH® available around the world.*

*And especially to the children with physical disabilities, whose love, enthusiasm and enduring spirit are an inspiration to all of us.*



# HISTORY OF DEVELOPMENT

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In 1984, a four-year old girl with dystonic cerebral palsy developed subluxation of her left hip. She had been able to sit, stand and walk with support (albeit with scissoring). A fixed abduction brace was recommended to stabilize her hip, but her father was concerned about the negative side effects such a device could impart on "normal" function.

He researched medical literature published on use of hip orthotic devices, and concluded the "ideal" brace for his daughter must permit:

- Independent hip flexion
- Maximum abduction during hip flexion
- Minimum abduction - just enough to prevent scissoring during hip extension and weight-bearing
- Normal anatomical movement as the orthosis moves from minimum abduction with hip extension to maximum abduction with hip flexion

Based on the findings in available literature, the father concluded a device was required that:

- Would allow the child to pursue a more normal range of activities with reduced risk of hip dislocation
- Would further enhance acetabular modeling and development of the hip joint complex.

With this in mind, he set about to design his daughter a brace that uses the rotation of leg bars about an inclined pivot to achieve abduction which was continuously variable according to the degree of hip flexion. The result of this effort is the SWASH® (Sitting, Walking And Standing Hip) Orthosis.

The first commercial use of the SWASH® began in 1992. Since then, thousands of children and some adults worldwide with varying degrees of disabilities have been able to realize the functional and psychological benefits offered by the assistance of this innovative orthotic intervention.

## Primary development goals of the SWASH®

1. Increase abduction and stretch hip adductors to improve hip alignment
2. Prevent excessive adduction during sitting, standing and walking
3. Optimize sitting and standing posture
4. Achieve the above goals with an automatic transition from neutral (walking, standing) to abduction (sitting)

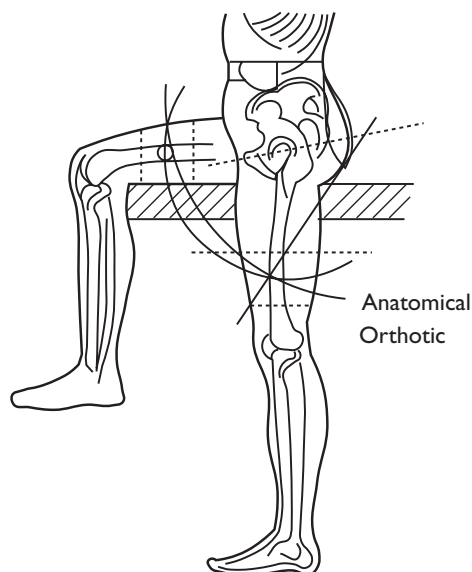
# BIOMECHANICS OF SWASH®

## A Major Biomechanical Engineering Accomplishment

The SWASH® appears to be a relatively simple device, but looks can be deceiving. From the distal tip of one upright to the distal tip of the other, there are a combination of twenty-one (21) joints and angles in the SWASH®. Changing one angle affects the function of the other twenty.

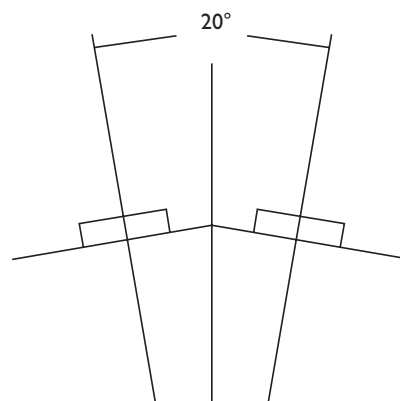
## Anatomic vs. Orthotic Pathways of Motion

At first glance, it appears that the orthosis should cause significant "pistoning" of the thigh cuffs on the thighs, as the wearer moves from standing to sitting. The orthotic hip joints do not approximate the location of the anatomical hip joints. The orthotic joints are actually positioned closer to the sacroiliac joints than they are to the hip joints.



But in fact, the pathways of motion of the SWASH® thigh cuffs do mimic the pathways of motion of the femurs. This is designed into the orthosis through a combination of the angle of the pelvic band in the sagittal plane, and the angle of the hip joint assemblies in the transverse plane. Also contributing are the angles of the uprights through the hip joints, and the planes on which the angles on the uprights themselves are shaped.

The result of this tri-plane engineering is that "pistoning" of the cuff on the thigh is minimized.



## Center of Gravity

Upon seeing the SWASH® orthosis, one would expect that the center of gravity would be posterior to the trunk. The joints are posterior, leading to the expectation that the center of gravity would also be posterior.

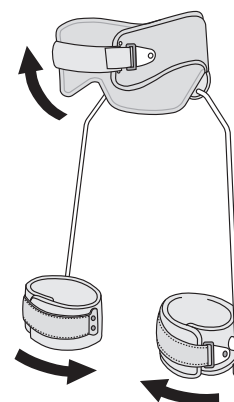
In fact, however, the tri-plane engineering again utilizes all the angles described previously to bring the center of gravity just anterior to L2, through the center of the trunk. Of most significance is the 20° angle in the transverse plane designed into the posterior section of the pelvic band. This angle moves the center of gravity from posterior to mid-trunk alignment.

## Proximal Transfer of Adductor Tone

High adductor tone affects posture of the entire body. It drives the feet into pronation, internally rotates the lower limbs, and has a flexion influence on both the knees and the hips. This lower extremity reaction to adductor tone influences the trunk into a slouched posture.

It is theorized that as SWASH® overcomes adductor tone, two things happen. First, the biomechanical effect of the tone is reversed.

It exerts an external rotary influence on the lower limbs (without twister cables), the knees and hips are influenced more towards extension, and the trunk stands more erect. Second, as the SWASH® reaches its limit for adduction, it transfers adductor force proximally, assisting anterior rotation of the pelvis to help achieve a more erect postural position.



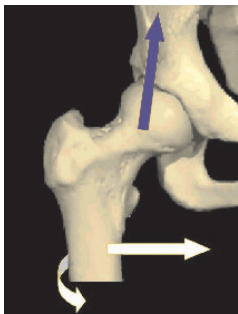
NOTE: Preliminary results of a 10- patient study reports there is no increase in adductor tone associated with the use of a SWASH®.

# HIP STABILIZATION

The most visible benefits of the SWASH<sup>®</sup> are improvements in sitting and standing posture and stability, and for the ambulatory user, improvement in gait. The benefits can be immediate and are often dramatic. Continued improvements may be seen after the wearer has become acclimatized to the orthosis.

Given the visible benefits, perhaps the most important benefit the SWASH<sup>®</sup> offers is its influence on hip stability. The very nature of high adductor tone places dislocating forces on the hips. The internal rotation and adduction forces leave hips at risk. Data shows that ambulatory children with CP have a 30% incidence, and non-ambulatory children have a 60% incidence of hip subluxation requiring medical intervention.

Excessive adduction with internal rotation causes a posterior dislocating force, which is opposed by the SWASH<sup>®</sup> variable abduction brace. Although this may be expected to reduce the risk of hip dislocation, ongoing studies to document this benefit have not yet been completed.

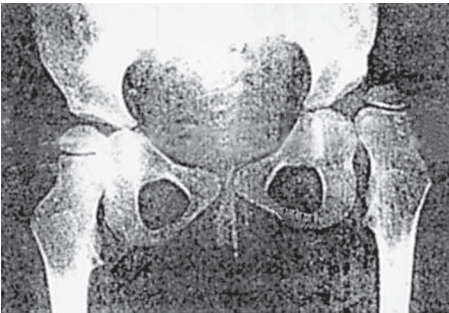


ADduction  
Internal Rotation  
Unstable Alignment



ABduction  
External Rotation  
Better Alignment

This case example offers some insight into the effects of SWASH<sup>®</sup> to help prevent hip displacement over an extended period of time.



In this before fitting x-ray, pelvic obliquity and (R) hip subluxation are readily evident. The acetabulum is shallow and does not cover the femoral head.



At year two post fitting shows further improvement of the femoral head within the acetabulum.



One year post fitting shows improvement in pelvic angle and hip subluxation. Approximately 80% of the femoral head is now covered.



Three years post fitting shows normal pelvic angles and closer to normal hip development.



# FUNCTIONAL INFLUENCE



## Sitting Posture & Stability

Many individuals with neuromuscular disorders are very unstable during sitting due to spastic adduction leading to a narrow base of support. This is demonstrated by a typical slouched posture during sitting, along with the need for external assistance or the use of hands for "touch balance". While it is common to refer to one's "envelope of function", this type of sitting instability might be described as limiting one to a "cocoon of function", as hands are functionally tied down to the sitting surface.

When in the sitting position, SWASH® abducts the hips to create a wider tripod base for sitting stability. This wider base of support, combined with the spinal and pelvic support of the pelvic band, often provides sufficient postural assistance to open a whole new world for the user who otherwise is unable to sit without external assistance. Harnesses, wedges, and bolsters may often be considerably reduced if not eliminated.

The less involved child, who may be able to sit without external assist but requires use of the upper extremities for touch balance, may be able to sit independently when wearing the SWASH® - freeing the hands for eating, interacting with others, for more active participation in therapy programs, and for playing.

From the mild to the severely involved, the stable base for sitting will result in a more upright sitting posture - certainly

a significant benefit for hip and spine alignment. The opportunity for enhanced upper extremity function may also improve trunk strength and control.

## Standing Posture & Stability

With a successful fitting, SWASH® may offer significant improvements in standing posture. Non-ambulatory wearers will often be better able to stand more upright in their standing frames with reduced external assistance. For the ambulatory wearer, there will often be improvements in trunk posture, reduced scissoring and a wider base of support for standing.

As a result of overcoming adductor tone and its biomechanical consequences, standing frames or walkers will generally need to be adjusted higher to accommodate the more erect posture.

## Proprioceptive Implications

While the biomechanical aspects of the SWASH® may be relatively well understood, it is more difficult to understand the proprioceptive implications. In almost every instance, fitting the SWASH® will result in a decrease in spasticity and improved reach targeting of the upper extremities. The mechanism for this common outcome is not entirely understood.

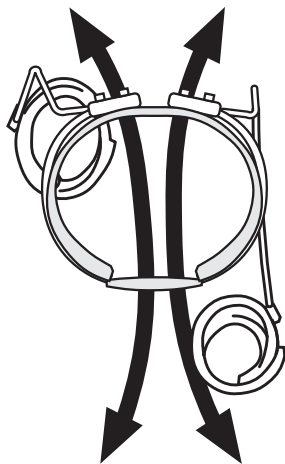


# FUNCTIONAL INFLUENCE

## Gait Dynamics

SWASH® is the only hip orthosis that is designed to offer variable hip abduction - requiring no "unlocking" or other adjustments by the wearer or the caregiver.

For the ambulatory patient, this can offer significant functional benefits. With a successful fitting SWASH® can provide enough abduction to prevent scissoring during standing and gait. As the hips are flexed to the sitting position, the SWASH® uprights guide the femurs to further abduct the hips to create a tripod base for sitting stability and to stretch the hip adductors.



## Respiratory and Speech Functions

The improved posture reduces the compromising of breathing capacity which can be a side affect of slouched posture. Many therapists have reported this improved posture can also have a positive impact on speech as a result of the improved breathing control and since the user can now bring the head and neck (less constriction of the vocal cords) into a more upright position.

Control of scissoring gait, more upright posture, and ability to shift from standing to sitting and sitting to standing with minimal, if any, external assistance can offer numerous benefits for ambulatory candidate:

- They may ambulate with greater independence. Many children who have never taken more than a few steps without someone having to untangle their feet can now walk to the limits of their endurance without scissoring.
- SWASH® may help conserve energy. Without the energy consumed in attempting to stabilize the trunk and untangle scissoring feet, the child is often able to walk more fluidly for greater distances.
- With the ability to walk better and more independently, they will want to walk more, and their distance/walking may improve. Walking now becomes a means of getting from here to there instead of an exercise to be endured during supervised therapy sessions. With better gait biomechanics and greater gait capacity, they will be better able to participate in physical therapy protocols to increase muscle length and reduce tone in the hamstrings and calf group.





# INDICATIONS & CONTRAINDICATIONS

## Indications

- Spastic Hemiplegia
- Spastic Diplegia
- Spastic Quadriplegia
- Risk of hip displacement (both ambulatory and non-ambulatory)
- Low trunk tone (may require customized combination with spinal jacket).
- Post-Botulinum Toxin A (Focal spasticity management)  
A three year, randomized multi-centre trial with concealed allocation to either BTX-A and bracing and/or observation concluded: "Injections of BTX-A combined with SWASH® bracing reduces the rate of hip displacement and delays the need for orthopaedic surgery".
- Post-operative - For stabilization when abduction in both flexion and extension is required.
- Night Splint - This application can be especially useful if the child spends the first two or three hours of the day overcoming muscle shortening that occurred during sleep. It is recommended to first allow the child to become accustomed to wearing the brace during the day.

## Contraindications

- Dislocated hips
- Fixed hip flexion contracture greater than 20°. There are no finite guidelines for use with non-fixed flexion contracture - this generally is dependent on wearer tolerance.
- Adductors so strong they overpower the SWASH® uprights (SWASH® Low Profile has larger diameter and therefore stronger uprights.)
- Adductor length so short it causes discomfort with SWASH® use in the sitting position
- If ambulatory, excessive tibial torsion or foot involvement, without physician assessment of impact SWASH® impacts on these conditions.

## Precautions

- In patients with shortening of hamstrings, psoas, adductors, or Achilles tendon, great care should be taken when planning the orthotic and therapy program.
- SWASH® is not a treatment for hamstring tightness. If current therapy protocols include exercises to relieve hamstring tightness, it is important these exercises be continued as hamstrings will not be stretched in the SWASH®. Hamstring tightness should be monitored on a regular basis. Any signs of increased tightness should be specifically addressed.
- SWASH® does not eliminate the need for AFOs. Particularly for the ambulatory wearer, it is important to re-evaluate the AFO design as the needs may change as a result of the new stance and gait patterns that will result from wearing the SWASH®.
- SWASH® does not replace rehabilitation or the therapist. It does help overcome some of the major consequences of high adductor tone and therefore allows more specific and functional rehabilitation.
- Patients with spinal asymmetry or deformity may be unable to wear the SWASH®, or may require that the orthosis be incorporated into a custom body jacket.
- With time, for some wearers, spasticity of the adductors may reduce either due to wearing the orthosis or Botulinum Toxin A (BTX-A) injections. It is important on a regular basis to review the amount of abduction correction needed to maximize hip alignment and functional goals.

## Limitations

- The SWASH® is not a cure-all for all postural problems. New movement and postural motor control patterns will have to be learned and gained. The SWASH® is seen as a device to facilitate these gains.
- If patients cannot walk at all without the SWASH®, it is highly unlikely they will be able to walk with the SWASH®.
- Even with the SWASH® in use, there may be residual internal rotation of the lower extremities. Very often, unless there are internal tibial torsion or metatarsus adductus issues, the medial hamstrings have been seen to exert this internal rotary influence. An aggressive stretching program of the medial hamstrings has been seen to minimize this residual internal rotation.



# CANDIDATE SELECTION

Since its introduction, physicians have prescribed thousands of SWASH® for patients from infants to adults, ambulatory and non-ambulatory, from mild to severe involvement - to protect hip alignment, improve the ability to sit independently or at least with reduced external assistance, improve sitting and standing posture, and for improvement of stepping for patients with scissoring postures.

**The following are guidelines presented by subject area.**

## Age

The following age discussions are intended as a guide only, based on fitting experiences. However, it is important to remember every candidate and level of development varies at different ages, so there will definitely be exceptions in each age category:

### Early Intervention (9 months - 2 years):

Both SWASH® and SWASH® Low profile will fit an infant as young as 9-10 months. SWASH® has been widely prescribed for infants at risk for spastic hip displacement. When properly fitted, SWASH® will not interfere with crawling. For the child that may be able to learn to walk, SWASH® can often help them to better stabilize as they pull themselves up on furniture. For the child who may only be able to sit, the wide abduction base may help them achieve a more stable position.

### 2 - 6 years

This age group will generally adapt to the SWASH® very quickly. They tend to accept quite readily the correction it offers and, with guidance from the physical therapist and caregiver, develop new skills. They usually accept the sitting stability it offers and quite freely start using their upper extremities for function instead of for sitting balance.

### 6 - 12 years

Around this age the child can be slower to adapt. By the time a child reaches 9 or 10, there may also be muscle length issues (contracture), muscle strength issues, and long-standing neuromotor patterns that can be very difficult to overcome. For the child in this age group with strong adductor tone, the SWASH® Low Profile is generally recommended as the uprights in this model are stronger.

## 13 - Adult

The pelvic band of the Classic SWASH® will fit a waist circumference up to 72 cm (28 1/4 inches). SWASH® has been successfully fitted on small adults who fit within this range. Again, due to the increased strength of the uprights, the SWASH® Low Profile may be required to control the adductor tone. A larger size SWASH® Low Profile with longer uprights and larger cuffs is now available.

## Acclimatization Time

Age, cooperation, and the degree of functional involvement all affect the length of time for the wearer to become accustomed to the orthosis. As a general rule, the younger the candidate, the quicker they accommodate to the orthosis. Even those that acclimate quickly, will continue to improve in function as they continue to wear the orthosis. If immediate results are not seen, it is encouraged to allow the candidate to continue to wear the orthosis at least an additional 30 minutes to one hour as it has been observed that given time to relax in the orthosis - they start to realize how they can use its support to sit, stand, or walk better. If no improvement is seen after one hour, it is unlikely SWASH® will be of benefit.

Sometimes improved posture is evident immediately upon application, but then he or she tends to return to the original slouched posture. This is usually indicative that the orthosis will work, but physical therapy and re-training may be required to establish new movement patterns.

Especially children who have always had to use their hands for balance, are scared to "let go" for fear they will topple over. A little "diversion therapy", such as trying to get them to clap their hands or reach for a ball will help them overcome the fear.

# PRODUCT SELECTION



Classic



Low profile



## SWASH® Classic

The original design of SWASH® uses a plastic anterior over-lap pelvic band to secure the orthosis around the waist and maintain its position, resting over the ASIS, just below the navel. In the back, the pelvic section extends from L2/L3 to the distal margin of the sacrum, providing maximum pelvic support. Children with low trunk tone and/or very limited trunk control strength may benefit from the increased posterior and lateral support this design offers. The thigh cuff closure is a double-lock strapping system to reduce the chances of unwanted removal by children. Pelvic band and thigh cuff padding are removable for laundering.

The uprights are 6mm (size I) and 7mm (sizes 2-4) diameter. The smaller diameter uprights on the size I allow more "spring", permitting less restriction of movement. This is often desirable for the developing infant.

## SWASH® Low Profile

SWASH® LP uses a padded iliac extension that can be positioned in one of two places: it can be fit immediately above the iliac crest between the crest and the inferior angle of the costal flail, or it can be fit between the ASIS and the greater trochanter. The latter is used to minimize any influence towards lumbar flexion when sitting. The double strap front closure allows for symmetrical application. In the back, the padded metal posterior frame extends from approximately L2/L3 to S1/S2. The metal offers positive non-slip contact for the abduction control joints, and includes clear markings to monitor abduction settings. The joints are tapered downward to accommodate most walker styles. The thigh cuff closure is a simple double Velcro fold-back closure for easy donning and doffing. The pelvic band cover and thigh cuff padding are removable for laundering. The uprights for all sizes are 8mm diameter. This increase in diameter offers added strength to manage very high tone, plus it allows cuffs to be completely interchangeable between all sizes.

## Guidelines for Product Selection

The following are offered as general guidelines only. When possible, it is recommended to try each style on the patient to best assess which offers optimum function.

### SWASH® Classic

- When maximum trunk control is required, i.e., for the candidate who lacks muscle strength or upper body control to sit upright.
- When patient is primarily non-ambulatory (GMFCS IV-V).
- When a smaller diameter (6mm) uprights on the size I are desired to permit less restriction of movement.
- When the greater pelvic coverage area triggers more desirable neuro-sensory motor response.

### SWASH® Low Profile

- When the primary goal is to control scissoring gait and the posterior joints on the SWASH® Classic interfere with posterior walker, and a new walker is not an option.
- When wearer has limited space between the iliac crest and the rib cage.
- When maximum upright strength is required to manage adductor tone.
- When candidate and/or caregiver acceptance of "bracing" is an issue, the Low profile is more cosmetically acceptable to some.

# PRODUCT SELECTION

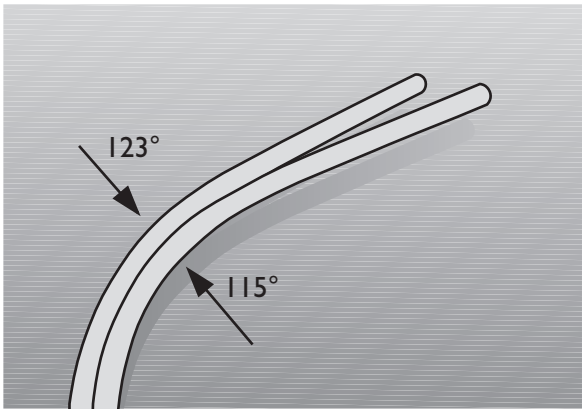
## 115 or 123 Degree Uprights?

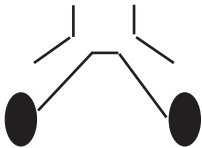
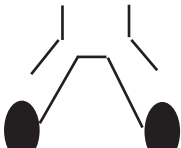
SWASH® is available with either 115° or 123° uprights. This refers only to the fixed angle of the most proximal visible curve in the uprights – it does NOT refer to the exact degree of abduction obtained while wearing the orthosis.

Standing and walking functions of both uprights are very similar. Generally the differences between the two are related to sitting function, with the 123° uprights creating greater amounts of abduction and the 115° uprights creating relatively smaller amounts of abduction.

NOTE: In sitting, the 123° uprights will have a greater influence towards posterior pelvic rotation, thereby increasing the flexion influence on the trunk.

The selection of the 115 or 123-degree uprights does have an effect on the postural outcome of the fitting. The following are offered as guidelines:



 <p><b>123 Degree - Wide Sitting Base</b></p> <p>When the greatest amount of adductor muscle lengthening in the sitting position is desired.</p> <p>When more trunk lumbar flexion influence is desired when sitting.</p> <p>When more lumbar extension is desired during gait.</p>	 <p><b>115 Degree - Narrow Sitting Base</b></p> <p>The wearer is primarily chair mobile and the 123° uprights would be too wide in the sitting position for the child to fit in the chair or car seat is not an option.</p> <p>Adductors are too tight and the amount of abduction when sitting in the 123° uprights would be impossible or painful.</p> <p>When less trunk flexion influence is desired when sitting.</p>
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# PRE AND POST-FITTING FUNCTIONAL EVALUATIONS

## Pre-Fitting Functional Evaluations

A pre-fitting assessment should be done and documented with a team consisting of at least a physical therapist and the orthotist. It is also desirable to have the primary caregiver present during this assessment. Each person brings to the evaluation their own areas of expertise and observational skills. Don't be surprised if the primary caregiver sees more than the rest of the medical team! Their observations and comments can be surprisingly insightful.

The assessments should be oriented toward assessing the hip stability/displacement and overall function as opposed to individual components of function. Carefully observe function or limitations of the adductors, hamstring, and hip flexors. Be aware of and document symmetries found during the evaluation. Some facilities are using videotape as one of the ways to document the before and after effects of the SWASH®. Clinically proven assessment methods such as Gross Motor Function Measure (GMFM), or the Peabody Developmental Motor Scales (PDMS), among other tests will add validity and proven repeatability to the assessment process.

Below is a guide of areas to assess posture and function PRIOR to SWASH® fitting:

### SITTING (90/90 position)

- Overall sitting height from sitting surface
- Time no touch sitting
- Reaching distance capacity
- Ball catch capacity
- Sit to stand functional performance
- General stability and posture
- Hip adduction
- Pelvic tilt posture due to hamstring tightness

### STANDING

- Overall stance height
- Foot position and alignment
- Reaching capacity with extrinsic support
- Reaching capacity without extrinsic support
- Stand to squat functional performance
- General posture
- Femoral alignment

### WALKING

(with normal ambulatory aid and with normal AFOs if used)

- Incidence of scissoring and scissoring posture
- Transverse plane alignment both sides (one limb rotated more than the other?)
- Stride length
- Stride base width
- Heel to toe utilization during gait
- Speed
- Distance capacity

## Primary & Secondary Goals

Based on above assessment, establish primary and secondary goals for the orthotic intervention. For example: Hip alignment? Stretch adductors? Increase walking capacity? Improve sitting posture? Appropriate product selection (Classic or Low Profile, 115° or 123° uprights) and proper fit are highly dependent on knowing these goals.

## Post-Fitting Functional Evaluations

During this process, simply repeat the evaluations accomplished in the pre-fitting evaluation. Note any changes in functional capacity that are measured or observed.

### Please consider the following:

#### Age

The younger wearer typically adapts to the orthosis and shows more immediate improvements than the older wearer.

#### Acclimatization Time

While some differences are usually apparent immediately after fitting, many more changes will become apparent after days, weeks, or months in the SWASH®. It may take some time for the wearer to acclimatize to and to trust the orthosis. Many children will demonstrate a more erect and stable standing posture. It may take some time to become acclimatized to this new posture and elevation. Cervical hyperextension and spinal rotation should diminish as pelvic stability increases. Improvements in standing balance and stability may be demonstrated after a few hours or days.

#### Walker, Standing Frame, Crutch Adjustment

Be certain that the height of any standing or walking assistance device is evaluated with the child wearing the SWASH®. It will often need to be raised to accommodate to the new stance height of the child.

#### Abduction Adjustment

In initially setting up the orthosis, it is difficult to judge the amount of abduction required to provide optimum hip stability and achieve established goals. If ambulatory and scissoring is still hindering gait, abduction angles will need to be re-adjusted by the fitter.





# PROTOCOLS AND PROPER FIT GUIDELINES

## Protocols

### Wearing time

The number of hours the orthosis is to be worn should be determined by the physician. This time will vary depending on the degree of involvement of the pathology, the goals of the rehabilitation program, and the tolerance of the wearer. While up to 24 hour use may be indicated, the recommended wearing time is at least six hours per day, usually during periods of highest activity (sitting, standing, and stepping). The SWASH® may also be prescribed to be worn at night to control night time scissoring.

### Fitting over / under clothing

The orthosis should ideally be fitted under clothing to optimize the control it has over hip alignment. This also facilitates the child who is managing their own toilet.

### Liner care instructions

The liner in the SWASH® Classic and the cover of the SWASH® Low Profile are removable. Both may be removed, hand washed in cool water with mild detergent, and dried flat. Replacement liners and covers are available through your orthotist.

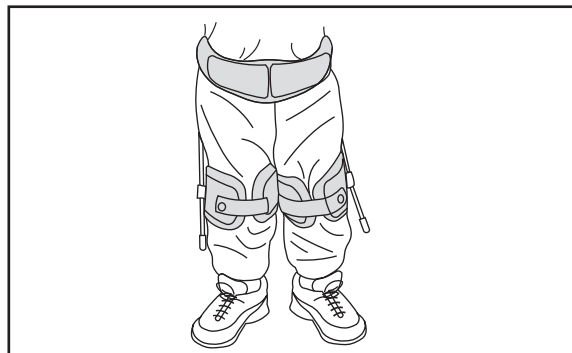
### Skin care

Red marks that appear as a result of wearing the orthosis should disappear within 30 minutes of removing the orthosis. The most persistent red marks are usually on the inside part of the thigh under the thigh cuff. Consult your orthotist if the red marks do not disappear within 30 minutes after removing the orthosis.

### Orthotist Follow-Up

A one-to-two week post-fitting check-up is recommended to assure the integrity of the orthosis and caregiver fitting technique. The primary purpose of this follow-up is to check for the need to adjust hip abduction to assure proper hip alignment.

## Proper Fit Guidelines



### Pelvic Band

Location:

SWASH® Classic - Immediately over the ASIS.

SWASH® L.P. - The waist band should rest comfortably on the ASIS. It should be contoured to the shape of the waistline and extend no more than 2 inches / 5 cm toward anterior midline.

### Symmetry

For both orthoses, make certain the orthosis is applied as symmetrically as possible. The orthosis should NOT be rotated on the wearer as this can result in loss of control of hip alignment.

### Tightness

You should be able to insert the fingers of one hand between the padding and the abdomen.

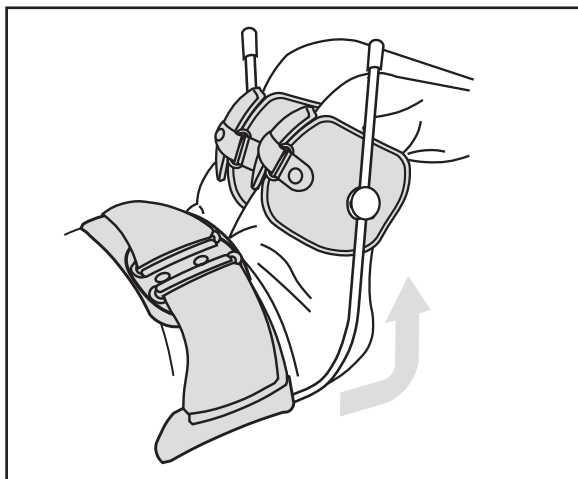
### Amount of abduction

The abduction setting varies considerably from patient to patient, depending on primary and secondary goals for the orthosis. For both non-ambulatory and ambulatory wearers, the "ideal" is to adjust abduction to provide appropriate hip containment and knee clearance.

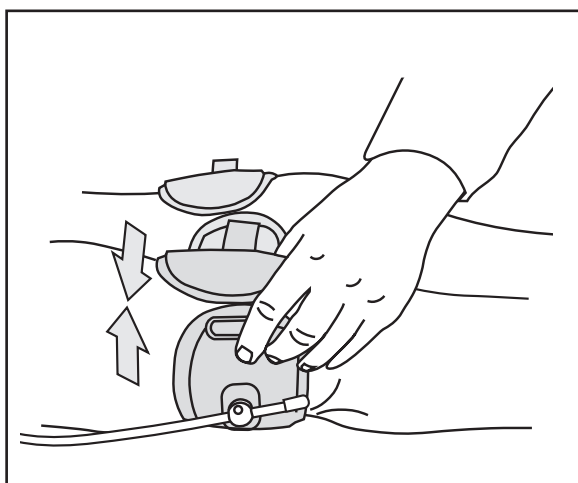


# PROTOCOLS AND PROPER FIT GUIDELINES

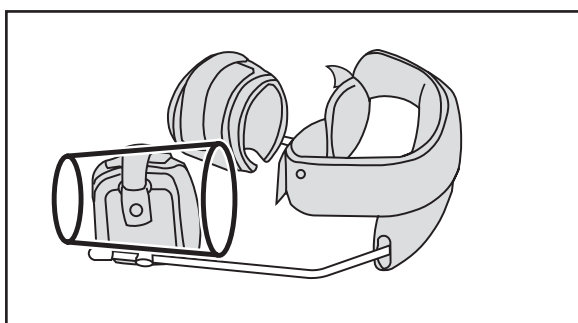
## Cuffs



**Location** - Usually as distal as possible without interfering with popliteus, but may be located up to distal 2/3 of femur if flexion influence is present.

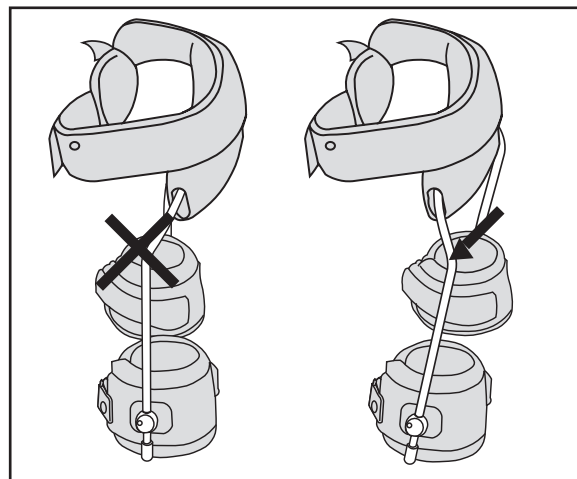


**Closure Gap** - There should be no more than 2 inches / 5 cm gap gap between the medial and lateral sides of the plastic. **Tightness** - Comfortably snug - never so tight as to cause red marks or compromise circulation.

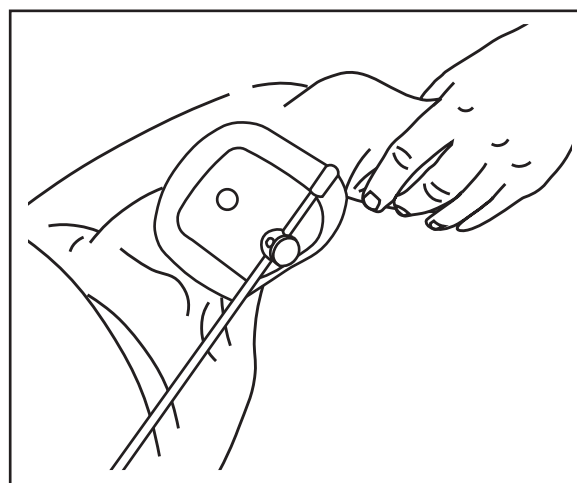


The cuffs are conical shape. They should be fitted so the greater circumference is proximal.

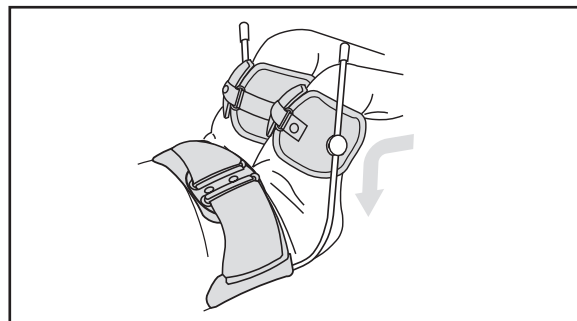
## Uprights



**Left and Right** - There is a left and right for the uprights. When standing the 1st curve from the distal end should angle to the posterior. If it doesn't, it is on the wrong side.



**Length** - The distal end of the upright should be in line with the distal end of the cuff padding.



**Hip Clearance** - The uprights should be as close as possible to the greater trochanters without impinging on them when the hips are flexed.



# BENEFITS AND OUTCOMES

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## Benefits

- Limits or controls adduction when sitting, standing and walking to prevent scissoring
- Provides additional abduction for muscle lengthening and sitting stability
- Provides support throughout the day
- Limits adduction during the night
- May reduce hip displacement caused by strong adductors
- Improves hip alignment
- Can prolong effects of other treatment modalities
- Maintains muscle length
- May delay the progression to surgery

## Outcomes

- Improved ambulation when wearing the orthosis. "Gait scores showed improved pelvic symmetry, better knee clearance, and progression in functional walking scales in most cases"
- Longer walking distances using less energy is reported by some parents
- Vertical positions and dynamic walking are associated with improved respiratory, bladder and kidney functions
- Improved trunk control facilitates upper body function for enhanced stretching and other exercises to improve muscle control and coordination skills
- Improved sitting balance means the possibility of using both hands to perform tasks such as eating, playing, manipulating objects, and interacting with others instead of holding the sitting surface for touch balance
- Neutralizing the dislocating forces secondary to high adductor tone may arrest or reduce hip displacement
- Clinically observable impact on the function of the proprioceptive response. This can generally be seen in the
  - a) Reduced tone of the adductors
  - b) Improved posture of the trunk and
  - c) Enhanced coordination of the upper extremities resulting in better reach targeting
- Often helps the wearer overcome pathological movement patterns
- Early mobilization may also reduce subluxation and dislocation of the hips
- Improved respiratory function as a result of the more upright posture



## FREQUENTLY ASKED QUESTIONS ABOUT SWASH®

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### **Is the SWASH® usually worn over or under clothing?**

The SWASH® is generally fitted under clothing to optimize the control the device has in enhancing hip alignment.

### **What about toileting?**

Generally SWASH® must be removed for toileting because the orthosis interferes with easy donning and doffing of underwear and diapers.

### **Will using SWASH® strengthen adductors?**

The opposite is true because the SWASH® serves to stretch the adductors and cause them to clinically present with lower tone.

### **When will patients progress to not needing the SWASH®?**

The SWASH® helps manage the consequences of high adductor tone. While there may be some carryover in lessened adductor tone after use of the SWASH, it is not known if it will return if SWASH® use is totally discontinued.

### **Will AFOs still be necessary?**

The SWASH® does not alter the need for AFOs. It may, however, change the design criteria for some patients. Because the SWASH® has a significant influence over transverse plane rotation of the lower extremities, AFOs will generally need to be set up in relatively neutral position relative to rotation.

### **How long should the patient wear the SWASH® each day?**

The SWASH® is generally worn at least six hours each day. It can also be very appropriate for use as a night splint.

### **Are there any side effects to using the SWASH®?**

Pressure marks may be evident on inside thigh where the SWASH® overcomes the forces of abnormal adductor tone. These marks should disappear within 30 minutes of removing the SWASH®.

### **The patient still seems to sit in too much spinal flexion. Can anything be done about that?**

115° uprights tend to minimize this problem. Adding a sitting wedge (thicker part under seat, narrow part under legs) can also help to minimize the negative postural effects of tight hamstrings. If the problem persists, return to the orthotist for further adjustments.

### **How long before a child will "outgrow" his or her SWASH®?**

SWASH® will usually fit a child for 2-3 years. Components are sold separately, so it is possible for the orthotist to adjust up to a larger cuff or longer uprights should that be necessary.



# INITIAL FITTING ASSESSMENT

Patient ID# \_\_\_\_\_ Date \_\_\_\_\_

Physical Therapist \_\_\_\_\_ Ortotist \_\_\_\_\_

Physician \_\_\_\_\_

	WITHOUT SWASH	WEARING SWASH
<b>SITTING</b> (90/90 position)		
Hip adduction		
Pelvic tilt posture due to tight hamstrings		
Sitting height from sitting surface		
Time no touch sitting		
Reaching distance capacity		
Ball catch capacity		
Sit to stand functional performance		
General stability and posture		
<b>STANDING</b>		
Femoral alignment		
Overall stance height		
Foot position and alignment		
Reaching capacity w/extrinsic support		
Reaching capacity w/o extrinsic support		
Stand to squat functional performance		
General Posture		
<b>WALKING</b>		
Incidence of scissoring		
Transverse plane alignment both sides (one limb rotated more than the other?)		
Stride Length		
Stride Base Width		
Heel to toe utilization during gait		
Speed		
Neuromuscular control (jerky? fluid? balance issues?)		
Distance capacity		









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