ORG B's Reply:

We are beginning work on a Selective Dorsal Rhizotomy Clinical Practice Guideline, with XXXXXX, but the final product is likely two years away.

…for SDR, we typically recommend a four to six week inpatient rehab stay. Patients are flat for three days after surgery, and transfer to a prone cart for the first time just a few hours before flat bedrest restrictions are lifted. Our team completes a pre-rhizotomy rounding on each patient to try to identify which kids might need longer versus shorter stay. Some factors that would influence length of stay include the need for serial casting, poor access to outpatient services (longer stay), access to IP rehab program closer to home (we partner with two facilities, and transfer patients around 2-3 weeks post surgery), relatively low or very high function before surgery (shorter stay). With children who are ambulators, we usually recommend OP PT 5 times per week for the first month after discharge, then tapering to 3 times a week for about two months, then a further decrease. The kids are often seen for a full year, but not always. Restrictions after surgery include no straight leg raise over 30 degrees for 6 weeks, no passive truck rotation for 12 weeks. Ambulatory children typically discharge with a WC from IP, and are only walking in therapies. One of the over-riding principles is that, with normalization of (or closer to normal) tone, there are opportunities to change movement patterns that were not available before. Many children will first complete tone-reduction surgery, then, about one year later, SEMLS, in order to optimize lever arm function.