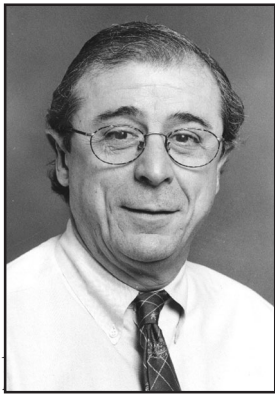


LETTER FROM THE PRESIDENT



President,
Dr. Luciano Dias

I hope that all of you are getting ready for a great summer, but what is more important I hope you are planning to come to Orlando in September for our annual meeting. Dr. Barry Russman and his committee have put together a great program. Knowing that the strength of our Academy is diversity, the program offers great courses and papers of interest to all specialties. The three courses on specialty day are outstanding. Just to mention one, Diane Damiano is doing a course on "promoting strength and physical activity in CP."

If you go to our website you will be able to see the Basic Science Symposium as well as the issues to be discussed on "Point and Counter-point"; always the highlight of our meeting. The "Breakfasts with the Experts" and the Instructional Courses will cover a multitude of topics. To add even more fun to this meeting, Dr. Russman has put together a golf event on Friday afternoon. We are also planning to transmit the meeting to Latin America again this year. Likely sites include, Mexico, Brazil, Colombia and Argentina.

The weather should be great, Disney World and all other Orlando attractions are just around the corner. Come to the meeting and bring your family too.

I hope you all have a great summer.

Thanks for reading,
Dr Luciano Dias

2005 ANNUAL MEETING

Plans for the annual meeting are well under way. The program Committee has selected some new and exciting presentations, and at the request of members, there will be two concurrent free paper sessions instead of three. This will allow attendees to hear more presentations. Sessions will include; orthopaedic surgery and gait, ADHD and sleep, orthopaedics and spasticity, epidemiology, drug therapy and bone density, measurements and assessments, and quality of life issues.

There will be the usual 32 instructional courses; some requested repeats and some challenging new presentations. Specialty Day will include orthopedics, the management of epilepsy and seizures in special needs children, and promoting physical activity. There will also be 10 Breakfasts with the Experts.

This year, you will have more time to visit the exhibitors. Besides the opening reception, 45-minute breaks have been planned to showcase the posters and give the attendees more time with the exhibitors. Please be sure to visit as many exhibitors as you can. The exhibitors provide a valuable service to attendees by showcasing their most recent products. We are grateful for their support.

(Continued on page 4)

WATCH FOR SURVEY...

Your Board of Directors has been looking at ways to provide a broader menu of services for the dues you pay. We have been examining changes to our relationship with MacKeith Press, who publishes our Journal, *Developmental Medicine and Child Neurology*. We would like to know your relationship to the Journal and what you would think of some of the changes we are considering.

You will be receiving a survey soon. Please be sure and respond.

NEWSLETTER EDITOR'S REPORT

From March 17-19 The Strategic Planning Committee and Board of Directors met in Chicago. Given the near completion of tasks generated by the last Strategic Planning Committee, the current committee was charged with defining the vision and mission of the AACPDMD based on agreed upon organizational values, and from these, set the priorities and strategic initiatives for the up coming years.

After extensive discussion, including break-out groups with multidisciplinary perspectives, the following were proposed:

Vision – Leading the way to optimal quality of life for children with cerebral palsy and other developmental disabilities.

Mission – Promote interdisciplinary professional education and research in cerebral palsy and other developmental disabilities.

These statements are based the on the following four key organizational values: collaborative, innovative, family centered, and excellence. Many other appropriate and positive organizational values were discussed, but when asked to limit the list to four, these were chosen as the most important.

Four top priorities were chosen to direct the future of the academy: 1) financial development, 2) journal and management fees discussion, 3) electronic, local, and regional educational enhancement striving for 24/7 access for academy member education, and 4) membership recruitment and retention.

All though the least favorite topic of discussion, financial viability is critical to sustaining any organization. The last decade has enabled the academy to enhance its revenue and holdings including a board designated fund and the start of an endowment fund. In recent years, efforts to promote and facilitate international education and stimulate member research interests have been made. However, the projection is that the academy will not be able to financial keep up with such lofty goals given its revenue and costs. Simply increasing membership dues is not considered and acceptable answer and may hurt academy efforts through a decrease in membership. A Financial Development Committee has been established to search for other sources of revenue. The allocations of current academy costs will be scrutinized.

It is clear that a substantial majority of academy costs (expenditures of member dues) are journal costs and management fees. There is consensus that having an official journal of the academy is important and we are fortunate to be able to claim ours as **Developmental Medicine and Child Neurology**. The international recognition and academic quality of the journal is unquestionable. The academy and the journal have a long standing, fruitful relationship. However, given the practicalities of the current day, the direct link between journal subscriptions and membership dues must be questioned. Likewise, a review has begun of the relationship of management fees to management services. As the academy moves into the future it is important that management fees and efforts are focused toward most efficiently serving the priorities of the academy.

Education of members, nonmember colleagues, and international professionals remains a critical focus of the academy. A four day meeting once a year is now considered insufficient educational opportunity for members of this academy. The leadership of the academy has decided to strive for 24/7 educational opportunities for its members. This goal can be achieved through web site enhancement, local and regional efforts (such as tutorials), and other internet protocol initiatives.

Ultimately, the academy's viability depends on member recruitment and retention. In this day of busy schedules and decreasing reimbursements the novelty of being a member of a professional organization fades quickly. An academy such as ours must provide a continuing value to membership throughout the year. Education and research opportunities must exist, be effectively promoted, and be within reach of members. When accomplished, this strategy will serve as a stimulus for member retention and for prospective members to join. It is easy to recruit new members when current members are excited and encouraged by what they know academy membership offers. Likewise, members must know that their dues are being effectively applied during these changing times based on the current priorities of the academy and not historical perspectives.

Many more ideas were discussed during the course of the three days. The limitation to the issues above was through the efforts of a professional facilitator who worked hard to focus the group on the highest priorities. Other issues that all agreed were important were,
(Continued on page 6)

EVALUATION OF THE CHILD WITH CEREBRAL PALSY

Barry S. Russman, M.D.
 Professor Pediatrics and Neurology, OHSU
 Director Pediatric Neurology
 Shriners Hospital for Children-Portland

INTRODUCTION

Cerebral palsy is a syndrome of many etiologies. The diagnosis of cerebral palsy (CP) always involves a motor deficit and the usual presenting complaint for which medical evaluation is sought is that the child is not reaching motor milestones at the appropriate chronological age. In most instances, a medical history establishes that the child is not losing function, assuring that the patient does not have a progressive or degenerative disease. This history, combined with a neurological examination establishing that the patient's motor deficit is due to a cerebral abnormality, leads to the diagnosis of CP. Serial examinations may be necessary to assure the diagnosis of CP, especially when the history is not reliable. (This definition of CP will be formerly discussed at the 2004 annual meeting.)

There is agreement that CP is due to a defect or lesion in the developing brain, which may have had its onset in the prenatal, perinatal or postnatal period. (Nelson & Ellenberg 1978) While often a cut-off age for the appearance of symptoms early in life is generally not given, the great majority of children with CP present with symptoms as infants or toddlers, and the diagnosis of CP is made before age 2 years. In some children, symptom onset may be delayed (e.g. dystonic cerebral palsy) whereas in other children the appearance of 'pseudoprogression' of symptoms may occur. Of importance is that affected individuals have similar needs for rehabilitation, education, and medical and social services. (Swaiman KF 1999)

Laboratory tests are not necessary to confirm the diagnosis of CP as it is based on the history and examination. Genetic diseases, brain malformations, infections, and anoxic injury to the developing brain are a few of the many causes of CP. (Miller G 1998) Accurate determination of the etiology of CP has specific implications regarding treatment, prognosis and ongoing medical management of associated conditions. The importance of determining whether there is a malformation, genetic etiology or injury and whether the injury is due to an acquired pre-, peri- or postnatal process has obvious significance from the point of view of assessment of recurrence risk, counseling of

families, implementation of prevention programs and when medicolegal issues arise. Determining causality also helps limit further unnecessary testing. Finally, understanding the etiology of CP has implications for prevention, intervention strategies, and raises concerns about the presence of associated problems. This knowledge will direct further research efforts. **The following review is based on data recently published in a practice parameter on the evaluation of children with cerebral palsy that was sponsored by the American Academy of Neurology and the Child Neurology Society (Ashwal et al. 2004)**

DETERMINING ETIOLOGY

Role of Imaging

The evaluation of the child with CP, once the diagnosis had been established, may start with an imaging study. In neonates, neuroimaging is frequently obtained when there is a history of complications during pregnancy, labor and delivery, when the infant is born very prematurely (<32 weeks), or when neurological symptoms or findings are present on neonatal examination. A practice parameter regarding the value of and indications for obtaining neuroimaging in preterm and term infants has been published. (Ment et al. 2002) If an imaging study has determined the etiology of CP in a particular patient a second imaging study is obviously not necessary

Data from 782 children with CP who had CT scans found abnormalities in 77% (range 62% to 93%). The yield from CT scans varied depending on the type of CP (hemiplegic > ataxic > mixed > diplegic > quadriplegic > hypotonic > dyskinetic) with the percent abnormal in those with dyskinetic CP being much lower than in other forms of CP. Data from studies involving 682 children with CP who had MRI scans found abnormalities in 89% (range 68% to 100%). For the two prospective studies (n= 98), 92% of children had abnormal scans, as did 89% of children in the retrospective study (n=562). The yield on MRI depended on the type of CP that was present (dyskinetic>quadriplegic> hemiplegic> diplegic> ataxic) and was somewhat different than that reported using CT. MRI was helpful in determining whether the injury was prenatal, perinatal or postnatal in onset.

(Continued on page 6)

2005 ANNUAL MEETING, *continued from page 1*

Opening in October of 2004, the Omni Orlando Resort at ChampionsGate is surrounded by acres of well-preserved wetlands and two world-class golf courses designed by Greg Norman. Each of the 730 luxurious guest rooms are lavishly decorated and offer complimentary high-speed wireless Internet access and free local phone service. You can enjoy a fully equipped health club, the 850-foot lazy river pool and a variety of restaurant options. Room rates are \$150 plus tax. The \$10 resort fee has been waived for AACPDM attendees, so be sure let the hotel know you are with AACPDM. Walt Disney World is 5 miles from the hotel, which offers free daily shuttles. Discount tickets to the parks will be made available. Busch Gardens is 66 miles away and the Kennedy Space Center Visitor Complex is 70 miles. Car rentals can be made through the concierge desk, or hotel taxis are available. The hotel is not located near any commercial area, but a 10-minute walk will take you to a mini-mall where there is a drug store, several fast food restaurants and other services. We recommend staying at the host hotel due to its location.

There are several restaurant options at the hotel: Trevi's for a taste of Italy, Zen's menu features pan-Asian dishes, Croc's is a pool-side bar and grill, David's Club offers casual dining in a sports bar atmosphere, and the Broadway Deli offers a wide array of sandwiches, pizza, and snacks. A cash lunch cart will be available in the exhibit hall during lunch breaks.

Also available is a kids' camp, a kid's activity bag, kid-themed menus in the restaurant and a nighttime children's snack. Camp Omni is a unique childcare opportunity for convention attendees and guests. Camp Omni is a specially designed facility for children 2 1/2 years old through 14 years old, who are completely potty-trained. There are a variety of video



*Rendering of Omni Orlando Resort at Champions Gates
Courtesy of Omni Orlando Resort at Champions Gate.*

games, board games, arts and crafts and other recreational activities to choose from. Hourly rates will apply. For information call the hotel and ask for extension 6569.

On Friday there will be a golf tournament to benefit the AACPDM Endowment Fund, which helps support research. Attendees can also participate in a 9-hole tournament or a Fun Run/Walk. Details can be found in the preliminary program, which will be posted on the website the first of June. This will be an outstanding meeting. Please plan on attending.

Sheril King, Executive Director

AVAILABLE ONLINE...

There is an full-color version of the newsletter on the secure part of the member page of the web site. Visit www.aacpdm.org.

If you would prefer to receive the newsletter via e-mail, instead of by mail, contact Melody Raymond at raymond@aaos.org.

INTERESTING WEB SITES

The Department of Health and Human Services has launched "I Can Do It, You Can Do It," a program aimed at inspiring the 6 million disabled children in the U.S. to be more physically active. Visit www.hhs.gov/od to learn more about this effort and how you can become a mentor.

The National Council of Disability (NCD) has launched a new listserv that will provide critical information on issues affecting people with disabilities. To subscribe to the listserv go to <http://listserv.access.gpo.gov/>. Online mailing list archives, then select NCD-News-L and click on Join or leave the list.

NCD's report "Livable Communities for Adults with Disabilities" articulates the elements of a livable community, highlights existing examples of livable communities in the United States. Visit www.ncd.gov/newsroom/publications/2004/LivableCommunities.htm

NCD's report "Righting the ADA (www.nck.gov/newsroom/publications/2004/righting_ada.htm) provides an analysis of the problematic court rulings, and describes the resulting impact on people with disabilities.

The Partnership for Prescription Assistance is a coalition of health care practitioners, pharmaceutical companies and advocates that aim to improve access to needed prescription medications. The Partnership offers a single point of access to more than 275 public and private patient assistance programs. In April, the Partnership initiated an awareness program. To find out more visit www.pparx.org.

Those interested in inclusive recreation can visit these websites: National Recreation and Parks Association (NRPA, www.nrpa.org), BlazeSports USA (www.blazesports.com), and Wilderness Inquiry (www.wildernessinquiry.org).

MEETINGS OF INTEREST

AusACPM Conference Conference 2006
Australasian Academy of Cerebral Palsy & Developmental Medicine
Hilton Hotel, Adelaide * 10-12 March 2006
The call for abstracts is available at www.dccconferences.com.au/aacpdm2006

Key note speakers are Associate Professor Annette Majnemer and Dr. Jan Willem Gorter

The 1st International Convention on Cerebral Palsy Rehabilitation is being held on November 1-2, 2005 in Patna, India. For information contact Dr. AK Varma, cpr2005@rediffmail.com or by e-mail ajitvarma592@yahoo.com.

The 10th International Child Neurology Congress website is now "live." Please visit the site at: www.icnc2006.com for more information on the congress. Dates are June 11-16, 2006 in Montreal, Quebec, Canada.

TUTORIALS

Registration is still open for:

"Assessment & Early Intervention of Autism Spectrum Disorders" being presented by Larry W. Desch, MD June 27-28, 2005 in Chicago.

"Evaluation & Treatment of the High Risk Infant" being presented by Andrew Morgan, MD on July 28, 2005 in Peoria, Illinois.

"The Orthopaedic Management of Cerebral Palsy" presented by Hank Chambers, MD August 25-26, 2005 in San Diego.

For information contact Shari Centrone (centrone@aaos.org). Information is also on the web page (www.aacpdm.org).

If you would be interested in giving a tutorial at your institution, please contact the AACPDM staff (centrone@aaos.org). The next tutorials will be given in the spring and summer of 2006. Tutors will be reimbursed for their expenses. This is a wonderful service for the membership of AACPDM. It gives the tutors a chance to show off their facilities and the attendee to have an up close learning experience. Evaluations have been very positive.

NEWSLETTER EDITOR'S REPORT,

continued from page 2

encouragement and facilitation of member research initiatives, a review of academy governance, and the creation of strategic initiatives to encourage students and young professionals to consider a career in specialties related to cerebral palsy and development medicine.

The academy is yours and functions best when you participate fully. I would encourage *all* of you to call or send your ideas and comments to any member of the board.

Joseph Dutkowsky, MD
Newsletter Editor
jd352@columbia.edu

EVALUATION OF THE CHILD WITH CP,

continued from page 3

Metabolic Testing

Metabolic or genetic causes for CP occur infrequently (i.e., 0-4%). However the true incidence is unknown as there have been no prospective studies that have examined this issue. In almost all such cases, there are atypical complaints, features in the history of a progressive rather than a static encephalopathy, findings on neuroimaging that are representative of certain genetic or metabolic disorders, or a family history of childhood neurologic disorder with associated CP. Neuroimaging studies have shown that 7-11% of children with CP will have a brain malformation suggesting additional risk for genetic and possibly a metabolic etiology.

Coagulopathy Testing

Patients with hemiplegic CP frequently have suffered a prenatal or perinatal cerebral infarction. Data from three CT studies listed in Table 1a (n=196) found cerebrovascular occlusion, usually in the middle cerebral artery distribution, in 13%,(Chen 1981) 32%,(Taudorf, Melchior, & Pedersen 1984) and 37%(Molteni et al. 1987) of individuals. There are insufficient data concerning the incidence of cerebral infarction or other causes of cerebrovascular compromise in children with other forms of CP.

ASSOCIATED PROBLEMS

Epilepsy

Given the higher frequency of epilepsy in children with CP, EEG is often considered during the initial

evaluation.(Zafeiriou, Kontopoulos, & Tsikoulas 1999) The utility of EEG for establishing an etiology in this population has not been prospectively investigated. The vast majority of papers on EEG and CP are retrospective studies or case reports that describe the frequency and types of seizures in children with different forms of CP.

Data from studies involving 1918 children have found on average that 43% (range 35 to 62%) of children with CP develop epilepsy. In none of these studies was there evidence that the EEG was useful in determining the etiology of the child's CP. Data from one prospective study compared patients with CP and epilepsy to those with epilepsy alone.(Kwong, Wong, & So 1998) Factors associated with a seizure-free period of one year or more in epileptic children with CP include normal intelligence, single seizure type, monotherapy, and spastic diplegia. Similar findings have been observed by other investigators in the studies listed in and are summarized in the review by Wallace.(Wallace 2001) Children with CP who have abnormal neuroimaging studies are more likely to have epilepsy.

Mental Retardation

Cognitive and neuropsychological functions in children with CP are commonly impaired. In general, there is some but no absolute relation between the type of CP and severity of cognitive impairment. Children with spastic quadriplegia have greater degrees of mental impairment than children with spastic hemiplegia. Motor deficits of children with spastic CP appear to correlate with the severity of cognitive deficits in contrast to those children with dyskinetic CP where this relation is lacking.(Fennell & Dikel 2001) Children with different forms of CP may be difficult to assess because of the motor deficits and in some forms of CP (e.g. spastic diplegia) the differences between performance and verbal intelligence test scores actually increase with age.

Ophthalmologic Impairments

Visual impairments and disorders of ocular motility are common (28%) in children with CP. There is an increased presence of strabismus, amblyopia, nystagmus, optic atrophy, and refractive errors.(Schenk-Rootlieb et al. 1992)

Speech and Language Disorders

Because of bilateral corticobulbar dysfunction in many CP syndromes, anarthric or dysarthric speech and other impairments related to oral-motor dysfunction are common. For example, articulation disorders and impaired speech intelligibility are present in 38% of

EVALUATION OF THE CHILD WITH CP,

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children with CP.(Clarke & Hoops 1980;Love, Hagerman, & Taimi 1980)

Hearing Impairment

Hearing impairment occurs in approximately 12% of children with CP. This occurs more commonly if the etiology of CP is related to very low birth weight, kernicterus, neonatal meningitis or severe hypoxic-ischemic insults.

CONCLUSIONS

There is insufficient evidence to recommend the optimal sequence of tests to determine the etiology of CP, taking into account diagnostic yield and potential treatability. Obviously, all children should undergo a detailed history and physical examination. It is important to determine that the child's condition is due to static and not a progressive or degenerative neurological disorder. It is also important to classify the type of CP as this has diagnostic implications as well as implications regarding associated problems. In order to establish an etiology and prognosis in children with CP, neuroimaging is recommended, with MRI preferred to CT. However, if neuroimaging performed in the perinatal period provided an etiology of the child's CP, it may obviate the need for later study. Metabolic and genetic studies should not be routinely obtained in the evaluation of the child with CP. If the clinical history or findings on neuroimaging do not determine a specific structural abnormality or if there are additional and atypical features in the history or clinical examination, metabolic and genetic testing should be considered. 'Because the incidence of cerebral infarction is high in children with hemiplegic CP, diagnostic testing for a coagulation disorder should be considered, although, how one should respond to a positive finding is unclear.

Because children with CP commonly have associated mental retardation, ophthalmologic abnormalities, hearing impairments, speech and language disorders and disorders of oral-motor function, screening for these conditions should be part of the initial assessment. An EEG is recommended when there are features suggestive of epilepsy or a specific epileptic syndrome.

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Goiania October 4th, 2004

Dear Dr. Dias,

This is to thank you and **The American Academy for Cerebral Palsy & Developmental Medicine (AACPD)** Board of Directors for the opportunity to transmit by teleconference the 2004 AACPD meeting to our country. We are very happy for the opportunity.

The AACPD teleconference was great! We had 162 participants from Goiania and Brasilia and another states in our facilities. This was the opportunity for many people here to participate at this very important meeting. The scientific program was very good and our multidisciplinary team learned very important new information.

We would really appreciate if there is opportunity to have this event again next year.

Thank you very much again!

Very Sincerely,
Joao Alirio Teixeira Silva Jr., MD
Medical Director

Sergio Daher, MD
Executive Superintendent
CRER – Rehabilitation Center

IN MEMORIUM

Dr. Sedgwick Mead, former chief of neurology at Kaiser Permanente Medical Center in Vallejo, California and past president of AACPD died November 21, 2004. He was 95. He devoted most of his long medical career to working with patients with cerebral palsy and developmental disabilities. He is survived by his wife Abbott and two sons, Sedgwick Mead, Jr. and Marshall Mead.

59th Annual Meeting

Sept. 14 – 17, 2005

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