Management in infancy (0–12 months)

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At this age treatment falls into two categories: that directed at - major functional issues as for neonatal care and that directed at skull surgery in cases of craniosynostosis. same; however, there is the possibility of surgery to advance the mandible in the severely retrognathic patient. This can be used to obviate the need for a tracheostomy or to allow for early decannulation. The most e ff ective technique is distrac tion osteogenesis (or distraction histogenesis), which utilises the same basic principles as in limb lengthening. The bone is cut and a device placed across the osteotomy site; after a short latent period the bone ends are gradually separa ted, dis tracting the callus. In the mandible, unlike the long bones, it is not necessary to limit the bone cut to the cortex (corticotomy) and a complete osteotomy is used. The technique allows for a lengthening of approximately 1 /uni00A0 mm/day , after which ther retention period to allow for consolidation of the callus. Craniosynostosis results in premature fusion of one or more of the skull sutures. The conditions may be isolated or part of a syndrome. This can result in abnormalities of both the skull and, particularly in syndromic cases, the facial skel eton. In 10–20% of single-suture cases and a higher propor tion of syndromic multisuture cases the infants develop raised intracranial pressure, which presents as episodes of distress, listlessness and disturbed sleep . This may be associated with papilloedema and, untreated, can lead to visual failure. The diagnosis is confirmed with intracranial pressure monitoring. Some congenital lesions may obstruct the vision of one or both eyes and this type of problem needs to be addressed to minimise the chances of amblyopia developing. An example of this would be the development of a large true haemangioma of the eyelids threatening to obscure the child’s vision out of one eye.

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