
Scientific Session & Abstracts

March 14, 2019



International Conference on
Pediatrics & Neonatal Healthcare

March 14-15, 2019 | London, UK

International Conference on
PEDIATRICS & NEONATAL HEALTHCARE

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Neonatal Sepsis in the Emergency department

Katelyn Hicks, Maria Perez, Sanja Ryan and Alan Spotts
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Sepsis and infection in neonates have been one of the largest contributors to infant mortality. The information from the 2016 neonatal sepsis guidelines recommends antibiotic administration within sixty minutes. The issue of neonatal sepsis compliance was found through chart audits in the emergency department. These audits are done to satisfy compliance with the county board for EDAP, emergency department approved for pediatrics, standards. It was found that each month for the last year (2017) the neonatal sepsis compliance has consistently been zero percent. The nursing staff was given increased re-education on the topic of neonatal sepsis in all staff meetings and daily shift huddle. A new standard of work was formed to create a step-by-step guideline for care of the neonatal sepsis

patient. Each staff member was signed off after a one-on-one education to the standard of work. After education the data showed an increase in compliance in antibiotic administration within 60 minutes of arrival to the emergency department. There was a decrease in the average time from arrival to triage as well as an increase in compliance with triage within ten minutes for all patients under 60 days old.

Speaker Biography

Katelyn Hicks is currently obtaining her DNP in the focus of Family Nurse Practitioner at Loma Linda University, USA. Her doctorate is expected to be completed June, 2019. She is currently working as a registered nurse in an emergency department in Southern California.

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Blood product transfusion and postoperative outcome in Pediatric Neurosurgical patients

Claudine Kumba, Taright H, Terzi E, Telion C, Beccaria K, Paternoster G, Zerah M, Bustarret O, Jugie M, Rubinsztajn R and Treluyer JM

Necker Enfants Malades University Hospital, France

Background: Intraoperative and postoperative Morbi-mortality factors are multiple in pediatric patients. Studies in pediatric cardiac surgery and intensive care patients have identified transfusion one factor among others. This study was undertaken to investigate whether transfusion was a risk factor of postoperative outcome in neurosurgical pediatric patients.

Objectives: To identify Morbi-mortality risk factors in intraoperatively transfused and not transfused pediatric neurosurgical patients.

Design: Retrospective observational descriptive pediatric cohort study.

Setting: Monocentric pediatric tertiary center, Necker Enfants Malades University Hospital Paris, from 1 January 2014 to 17 Mai 2017.

Patients: 206 patients with a median age of 60 months [13.25-135.75] were included. Inclusion criteria were the presence or the absence of transfusion in the intraoperative period in neurosurgery patients. Exclusion criterion was transfusion in the postoperative period until discharge from hospital.

Main outcome measures: Primary outcome was mortality and secondary outcome was morbidity in transfused and non-transfused patients. Mortality was assessed by deaths occurring intraoperatively or postoperatively during the entire hospitalization. Morbidity was assessed by intraoperative,

postoperative complications, repeat surgery, length of stay in the intensive care unit, in the hospitalization ward, total length of stay in hospital and length of mechanical ventilation.


Results: ASA score status (odds ratio 2.49; p-value <0.01) and transfusion (odds ratio 1.33; p-value 0.03) were predictive risk factors for complications. Emergency surgery (odds ratio 6.8; p-value 0.03) was a predictive risk factor for repeat surgery. ASA score, transfusion and emergency surgery were predictive risk factors for length of stay in the intensive care unit, total length of stay in hospital and length of mechanical ventilation (p-value<0.0001)

EC Anaesthesia 2018; 4(8): 288-298.

Speaker Biography

Claudine Kumba graduated as a Medical Doctor in 2001 and completed her specialization in Anesthesiology in 2006 at the Free University of Brussels (ULB, Université Libre de Bruxelles). She has a Paediatric Anaesthesia specialisation graduation since 2010 from the University of Aix-Marseille, Marseille, France. She has a Critical Care Medicine specialisation graduation since 2014 from the University of Montpellier 1, Montpellier, France. She is a paediatric anaesthesiologist in Necker Sick Children's University Hospital, in Paris, France. She has 12 publications and 17 citations. She is a member of the European Society of Paediatric Anaesthesiology (ESPA), the French Society of Anaesthesia and Critical Care (SFAR, Société Française d'Anesthésie-Réanimation) and the French Association for Paediatric Anaesthesiologists and Intensivists (ADARPEF, Association d'Anesthésistes et Réanimateurs Pédiatriques d'Expression Française) and the Belgian Association for Paediatric Anaesthesiology (BAPA).

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Beyond the NICU-borders

Van Hoestenbergh MR

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Developmental delay is a high risk for prematurely born children and has great consequences on their later quality of life. Working at the NICU for a longer time, one understands the great burden and stress parents undergo by the premature birth and how it effects their interaction with the child. Since good parent-child interaction is an important contributor to the infant's neurological development, we continue the parental support post-discharge by using an informative web-application. This application is offered to the parents until the corrected age of 2 years. We study the parental stress, the support they seek and whether the web-application has an impact on them and on the child's development until the corrected age of 5

years. We also study the difficulties in using the application and hope to open perspective to other digital systems that could optimize the support of these fragile children and families.

Speaker Biography

Van Hoestenbergh MR has completed her medical and pediatric studies in July 1992 at the Catholic University of Louvain, Belgium. She is certified in neonatal intensive care and is working in the NICU of Ziekenhuis Oost-Limburg in Genk since 1993. She is the actual head of the NICU and member of the Belgian governmental college "Mother and Child". She has a special interest in sustained parental support beyond the NICU by using an age-adapted web-application and participated in the SCENE-group research concerning parental closeness in the NICU.

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Transfusion and postoperative outcome in Pediatric Abdominal Surgery: Is transfusion a morbidity factor in Pediatric Abdominal surgical patients?Claudine Kumba, Querciagrossa S, Blanc T and Tréluyer JM
Necker Sick Children's University Hospital, France

Background: Intraoperative and postoperative Morbi-mortality factors are multiple in pediatric patients. Studies in pediatric cardiac surgery and intensive care patients have identified transfusion as one independent factor among others. This study was undertaken to investigate whether transfusion was an independent factor of Morbi-mortality in pediatric abdominal surgical patients.

Objectives: To identify Morbi-mortality risk factors in intraoperatively transfused and not transfused pediatric abdominal surgical patients.

Design: Retrospective observational descriptive pediatric cohort study.

Setting: Monocentric pediatric tertiary center, Necker Enfants Malades University Hospital Paris, from 1 January 2014 to 17 Mai 2017.

Patients: 193 patients with a median age of 27.5 months [1.0-100.5] were included. Inclusion criteria were the presence or the absence of transfusion in the intraoperative period in abdominal surgery patients. Exclusion criterion was transfusion in the postoperative period until discharge from Hospital and non-abdominal surgical patients.

Main outcome measures: Primary outcome was mortality and secondary outcome was morbidity in transfused and non-transfused patients. Mortality was assessed by deaths occurring intraoperatively or postoperatively during the entire hospitalization. Morbidity was assessed by intraoperative, postoperative complications, repeat surgery, length of stay in the intensive care unit, in the hospitalization ward, total length of stay in hospital and length of mechanical ventilation.

Results: Transfusion was the independent predictive risk factor for postoperative complications (odds ratio 1.14; p-value 0.02) and an independent predictive risk factor for repeat surgery (odds ratio 1.11; p-value 0.01). Emergency surgery was an independent predictive risk factor for repeat surgery (odds ratio 5.63; p-value 0.01). Transfusion, age, emergency surgery and ASA score status were independent predictive risk factors for length of stay in the intensive care unit, total length of hospital stay and length of mechanical ventilation (p-value<0.01).

Conclusion: Transfusion was identified as an independent morbidity risk factor among others in this pediatric population. Identifying these factors in order to implement improvement measures can upgrade patient postoperative outcome. One of these measures is to implement transfusion protocols in which blood product administration is guided by point of care devices such as viscoelastic methods which can contribute to reduce transfusion intraoperatively in potential hemorrhagic surgical interventions.

Speaker Biography

Claudine Kumba graduated as a Medical Doctor in 2001 and completed her specialization in Anesthesiology in 2006 at the Free University of Brussels (ULB, Université Libre de Bruxelles). She has a Paediatric Anaesthesia specialisation graduation since 2010 from the University of Aix- Marseille, Marseille, France. She has a Critical Care Medicine specialization graduation since 2014 from the University of Montpellier 1, Montpellier, France. She is a paediatric anaesthesiologist in Necker Sick Children's University Hospital in Paris, France. She has 12 publications and 17 citations. She is a member of the European Society of Paediatric Anaesthesiology (ESPA), the French Society of Anaesthesia and Critical Care (SFAR, Société Française d'Anesthésie-Réanimation) and the French Association for Paediatric Anaesthesiologists and Intensivists (ADARPEF, Association d'Anesthésistes et Réanimateurs Pédiatriques d'Expression Française) and the Belgian Association for Paediatric Anaesthesiology (BAPA).

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Developmental and Behavioral Pediatrics: A Psycho-cultural approach**Augustin Mubiayi Mamba**
University of Kinshasa, Congo


Talking Pediatrics refers to the welfare of the newborn, taking into consideration his behavior and his development. It is worth to emphasize and mention that we cannot talk of Pediatrics without having a glance to how the mother of the newborn survived the pregnancy period and how the birthchild was handled. These elements play an important role to figure out how the growth of the newborn will be. The development and behavior of a newborn is affected positively or negatively by the behavior of the mother, the one we think does not live in a sole network but in a socio-cultural network which impacts on the birth child, the health of the pregnant woman and the pediatrics considerations in general. A mother, who spent a pregnancy period in harmony with the family (society, environment) is expected to go through well-balanced parturition, in the absentia of infections or programmed complications. This is why a global approach is envisaged in the care to be given to the newborn in order to attain successful pediatrics management. Let us consider a nutrition aspect picking the case of breast-feeding, for example. We may notice that, not only the milk that comes out of the mother's breast is crucial for the baby. On a psychological point of view, the fact that a baby remains in the chest of the mother, sucking the breast even if no milk is coming out, increases the attachment and the affectivity of the newborn to the mother. This is an

expression of libido of Sigmund Freud. While advising and campaigning on the breastfeeding for a newborn, the emphasis should not be put only on the chemical or biological nutriment but also on the psychic nutriment, which contribute to the total care and development of this newborn and build his behavior tomorrow. In our research on psychological accompaniment to complicated childbirth's, we considered the problem of childbirth as a node containing several facets, which facets could be treated in synergy between several specialties. It is this holistic view of the problem that, amongst other things, has led us to believe that the mother as well as the newborn does live not in a social and cultural vacuum, but rather in a network of social and cultural relations. This society waits from the newborn, in terms of potential, will occupy status and plays roles in this society and change the environment.

Speaker Biography

Augustin Mubiayi Mamba is an associate professor at the Faculty of Psychology and Educational Sciences of University of Kinshasa. He is the Chairperson and founder of Centre for consultations and Psychological Cares, Psych Clinic of Kinshasa-DRC and Chair of Psychological Care Commission at the Ministry of Public Health. His book publication: *Cure d'âme ou cure psychologique*, Kinshasa 2013 and Articles: *Etude de l'Etat Psychoaffectif des albinos victime de l'agression social*, *Complicated Childbirth Protocol Inspired by Luba-Kasai Therapeutic Practice* etc.

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A Retrospective Descriptive Cohort study of Preoperative, Intraoperative and Postoperative Management of children in Scoliosis Surgery**Claudine Kumba**

Necker Sick Children's University Hospital, France

Background: What is already known: Scoliosis surgery in children is a common intervention in pediatric tertiary centers. These patients depending on the type of scoliosis, idiopathic or neuromuscular or congenital have also severe comorbidities which necessitate management in specialized centers. Blood and fluid loss can be important issues in this setting. Scoliosis surgery has a high rate of postoperative complications. Data exist concerning the importance of goal directed fluid therapy and hemodynamic monitoring to minimize postoperative morbidity in moderate to high risk adult patients undergoing moderate to high risk surgery. Evidence has shown that blood transfusion protocols (based on viscoelastic methods, erythropoietin and iron supplementation) can reduce blood product exposure in this setting. It is known that transfusion is a predictive factor of negative postoperative outcome in children. Rapid enhanced protocols have shown to reduce length of hospital stay and complications in adults. In children these protocols are beginning to develop. What is not known: The impact of intraoperative fluid and hemodynamic goal directed therapy on postoperative outcome in pediatric surgery in general is not known. Objective: The primary objective of this study was to identify postoperative negative outcome predictors in pediatric scoliosis surgery which could be improved by implementing protocols based on existing evidence. Main outcome measures of postoperative negative outcome were complications and transfusion.

Methods: Medical records of children admitted for scoliosis surgery were retrospectively analyzed from 1 January 2015

to 8 December 2017 in Queen Fabiola Children's University Hospital, Brussels. Forty-one children with an average age of 13.15 ± 2.79 years were included. Main outcome measures were postoperative complications and transfusion. XLSTAT 2018.3 software was used for statistical analysis.

Results: Length of postoperative hospital stay (LOSHOSP) was predictive of postoperative complications and transfusion with an odds ratio of 1.337 [1.048-1.705], $p=0.019$. Cobb's angle ($p=0.002$), length of surgery ($p<0.0001$) and length of postoperative $\alpha 2$ agonists infusion ($p<0.0001$) were independent predictive factors of postoperative transfusion.

Conclusion: Implementing improvement protocols aiming to reduce length of hospital stay such as fluid, hemodynamic, transfusion goal-directed therapies and enhanced recovery pathways may upgrade postoperative outcome in pediatric scoliosis surgery.

Speaker Biography

Claudine Kumba graduated as a Medical Doctor in 2001 and completed her specialisation in Anaesthesiology in 2006 at the Free University of Brussels (ULB, Université Libre de Bruxelles). She has a Paediatric Anaesthesia specialisation graduation since 2010 from the University of Aix- Marseille, Marseille, France. She has a Critical Care Medicine specialisation graduation since 2014 from the University of Montpellier 1, Montpellier, France. She is a paediatric anaesthesiologist in Necker Sick Children's University Hospital, in Paris, France. She has 12 publications and 17 citations. She is a member of the European Society of Paediatric Anaesthesiology (ESPA), the French Society of Anaesthesia and Critical Care (SFAR, Société Française d'Anesthésie-Réanimation) and the French Association for Paediatric Anaesthesiologists and Intensivists (ADARPEF, Association d'Anesthésistes et Réanimateurs Pédiatriques d'Expression Française) and the Belgian Association for Paediatric Anaesthesiology (BAPA).

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Ensuring hemodynamic stability in Neonates requiring Continuous Renal Replacement Therapy

Suzan R Miller-Hoover

Rady Children's Hospital San Diego, USA


Small children and neonates requiring continuous renal replacement therapy (CRRT) are some of the sickest patients in the ICU. These patients, who are already hemodynamically compromised, may become increasingly unstable during CRRT initiation and circuit changes. Using normalized blood for priming filters in unstable patients reduces the risk of increased hemodynamic instability, especially when the extracorporeal volume is 10% or greater. Exposure to stored blood increases the patient's risk of complications, especially when filter changes are routinely done every 72 hours. Using an alternative

method for filter changes reduces or eliminates the need for stored blood usage.

Speaker Biography

Suzan R Miller-Hoover is a pediatric critical and acute care clinical nurse specialist. She has been a nurse in critical care for over 40 years. During the past 10 years, she has been a mentor for evidence-based implementation and research projects. She is a published author and has presented both poster and podium presentations. Providing evidence-based best practices for patients of all ages is her passion.

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Impact of 2018 earthquakes to Pediatric population in North Lombok Field Hospital, West Nusa Tenggara, Indonesia**¹Melissa Ronaldi, ¹Ida Bagus Gde Suwibawa, ²Kurniawan Taufiq Kadafi, ²Nurhandini Eka Dewi, ²Jaya Ariheryanto Effendi, ²Aman B Pulungan**¹North Lombok General Hospital, Indonesia²Indonesia Pediatric Society, Indonesia

Background: Three devastating earthquakes hit North Lombok within a 28 days period in 2018. North Lombok has limited disaster preparedness system and it gave a great challenge to the health systems. So, this study aims to characterizes diseases in pediatric population at North Lombok Field Hospital and examine the implications for planning deployment in future similar disaster.

Method: This is a prospective observational study of pediatric population presenting to a field hospital in North Lombok for a period of 28 days following the earthquake on August 5, 2018. Demographic and clinical information was prospectively registered for all patients in the systematic emergency registry and nutritional status was based on weight for age.

Result: There are 836 children were treated in the field hospital for 28 days. Children under five were the highest proportion every week (52%). Most of them were male (54%) and had normal nutritional status (72%) and 96 children (11%) had

severely wasting. There were 56 children (7%) with trauma and 780 children (93%) with no trauma. From 56 children with trauma, 4 children were died because multiple trauma. Respiration tract infection was the highest disease on the first and second week. Gastrointestinal tract infection became the highest disease on third and fourth week. This study found there is no correlation between age, sex, and nutritional status with prominent disease children after earthquake ($p > 0,005$).

Conclusion: Respiration and gastrointestinal tract infection became the highest disease in children at North Lombok Field Hospital after earthquakes.

Speaker Biography

Melissa Ronaldi has completed her MD from Christian University of Indonesia. Now she is serving in North Lombok General Hospital, West Nusa Tenggara, Indonesia as rural doctor and an intern of Department of Pediatrics. She believes that children are the future of the nations. So that, she also believes that a healthy nation starts from healthy children. That's why she is so passionate in pediatric.

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Joint care model between Rural Paediatric Setup and Tertiary Care Centre for children with special needs: Indian experience

Asish Bhakta

Apollo Gleneagles Hospital, India

Introduction: India currently enjoys the bottom most position in World Inequality Global Index 2018¹. This is pronounced in the care delivery of children with special needs. According to WHO, one in every 4 to 5 children is a child with special needs. An environmental factor (e. of ICF) like urban rural divide pronounces as this health care access especially for these children. We share our successful experience of collaborating with tertiary care centre using Kolkata development model.

Methodology: We report five cases.

Results: The outcome was splendid and exemplary. All the five cases showed remarkable improvement in their cognitive and mental development, by virtue of which they have become functioning enough regarding self-care and communication with others.

Conclusion: According to the 'World report on disability' about 15% of the world's population lives with some form of disability, of whom 2-4% experience significant difficulties in functioning. The global disability prevalence is higher than previous WHO estimates, which date from the 1970s and suggested a figure of around 10%². Estimates suggest that there are at least 93 million children with disabilities in the world, but numbers could be much higher. They are often likely to be among the poorest members of the population. They are less likely to attend school, access medical services, or have their voices heard in society. Their disabilities also place them at a higher risk of physical abuse, and often exclude them from receiving proper nutrition or humanitarian assistance in emergencies.

Updated: 2 October 2017³Unicef. As per the Census 2011,

In India out of the 121 Cr populations, 2.68 Cr persons are 'disabled' which is 2.21% of the total population. • Among the disabled population 56% (1.5 Cr) are males and 44% (1.18 Cr) are females. In the total population, the male and female population are 51% and 49% respectively. • Majority (69%) of the disabled population resided in rural areas (1.86 Cr disabled persons in rural areas and 0.81 Cr in urban areas). In the case of total population also, 69% are from rural areas while the remaining 31% resided in urban areas. This is mainly due to existing Health Inequity in the rural population caused by lack of awareness, information and access to proper health care facilities. We have successfully implemented our pioneering concept of bridging this gap through the tie-up of our rural paediatric setup with a city based tertiary care centre utilising the "Kolkata Development Model" which has already proved successful among the children with special needs by establishing their genuine right to education and grow up with equal social and family importance.

Speaker Biography

Asish Bhakta was born in the year 1957, he was reared at his village Mahishadal, Purba-Medinipur, West-Bengal and had been nurtured at Mahishadal Raj High School till he passed the Higher Secondary examination in 1973 with National Scholarship. In the year 1974, he qualified for MBBS course at R G Kar Medical College; under University of Calcutta and passed out in 1981; he did House-physicianship in Paediatrics in his mother institution. Thereafter, he devoted himself to serve the paediatric population in his native place as a doctor. Later in 2013, he met Dr Anjan Bhattacharyya, the renowned Developmental Paediatrician in the Child Development Center, Apollo Gleneagles Hospital, Kolkata. That was the turning point in his life. He was inspired to pursue post-graduate studies under the mentor-ship of Dr Anjan Bhattacharyya and achieved the prestigious qualifications: DCH/IPPC (Sydney University) in 2014 & DCH (U.K) -RCPC (UK) in 2018.

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The “Kolkata Developmental Model” works in both resourced crunched and resourced settings**Jewel Chakraborty**
Apollo Gleneagles Hospital, India

Introduction: Children with developmental disabilities can lead a rich and rewarding life, yet as a group, are among the more vulnerable within our community. Early intervention for children with developmental disabilities involves timely provision of an optimal nurturing and learning environment that aims to maximize developmental and health outcomes and reduce the degree of functional limitations. There is evidence that effective early intervention can positively alter the child's longer-term trajectory, achieve significant savings and potentially reduce the risk of secondary health and psychosocial complications. This aspiration is currently emboldened by the recent refining of the Early Detection tool of General Movements (GM) Assessments. GM Assessments has now become the practice standard from 2017 (Novak et. al. JAMA 2017) Objectives: Early intervention follows early identification of developmental problems. When developmental problems are identified, a comprehensive assessment and diagnosis gives us concrete picture of the functional abilities, developmental diagnoses, health conditions and other factors likely to influence future outcomes and wellbeing. The Kolkata Development Model makes these principles work in reality for best outcome in the both resourced-crunched and resourced settings within India and proposes that the same Standard Operative Procedure can achieve most favorable outcome in children of all ages with Special Needs.


Methods: Children with developmental disabilities, aged 0 to 19 years are benefited, by and large, at any point of time, given their degree of impairments. Families of these children

get oriented by structured parent training program after initial contact at Child development Centre. Children are screened with preliminary and cost-effective screening tools (PSC, M-Chat etc.) followed by detailed developmental history sessions to capture the child's overall background and their current functionality. Preliminary screening determines the necessity and degree of multidisciplinary standardized assessment and intervention. Children undergo generic therapeutic regime based on clinical observation before final diagnosis is established. Goal settings and targeted intervention are jointly carried out with parental involvement along with structured feed-back sessions. Parents are regularly exposed to therapeutic sessions to modulate Home Base Program later on in the due course of treatment process. This approach of Universal Care Model in all children with Special Needs and Disability is proving to be ace in terms of extraordinary clinical gain.

Speaker Biography

Jewel Chakraborty, Master of Physiotherapy (MPT), has specialization in Neurology, is working in the field of Physiotherapy and disability for last 15 years. He is certified in Ayer's Sensory Integration Therapy from University of Southern California; USA. He is trained and certified in Advanced GM assessment. He is also certified in Mulligan Concept Manual therapy under guidance of Dr. Brian Mulligan. He is presently working as a Pediatric Physiotherapist and a team member in the Child Development Center, Apollo Gleneagles Hospital Kolkata lead by internationally famed Dr. Anjan Bhattacharya. He formerly worked with the prestigious The Doon School of Dehradun as a Sports Physiotherapist for seven years. He also worked at NIEPVD (National Institute for the Empowerment of Persons with Visual Disabilities) Dehradun as a visiting lecturer. He is an academian and External examiner of HNB Garhwal National University, Uttarakhand for undergraduate physiotherapy course. He has publications in journals like "Developmental Medicine & Child Neurology" (DMCN).

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Integrity of multidisciplinary team members/treatment in Kolkata Developmental Model**Asimayan Nandi**

Apollo Gleneagles Hospital, India


Children with special needs (Developmental delays, Cerebral palsy, Autism spectrum diseases) require timely, comprehensive multidisciplinary evaluation and treatment. The purpose of multidisciplinary evaluation is to find out the nature of child strength, difficulties and purpose of multidisciplinary treatment are to optimize functional ability to lead near normal life in the society.

Speaker Biography

Asimayan Nandi has done his Masters of Physiotherapy and Bachelors of Physiotherapy degree from Sri Ramachandra medical college and Research Institute, Chennai. He has completed his Basic Neuro Developmental Therapy from South African Neuro Developmental therapy Association, Johannesburg, Republic of South Africa and has been trained as a Neuro Developmental Therapist [NDT] with Dr. Gillian Saloojee, Senior SANDTA tutor. He is a Paediatric Neuro Developmental Therapist working in Child Developmental Centre in Apollo Gleneagles Hospital, Kolkata. He is a trained

NDT therapist [BOBATH Method] who is specialized in the subject of Paediatric physiotherapy. Asimayan, while working in CDC, AGH, got interested in normal movements of a normal child from neonatal period to the first year of life and how it differs with an atypical child. So later, he has completed advanced level – II NDT courses on Movement Analysis and Facilitation of Athetosis child from Senior Bobath tutor Jean Pierre Maes (Bobath Centre, London). He has also completed his advanced upper extremity management and treatment training for children from Neuro Developmental Treatment Association, USA conducted by Lezlie Adler OT, Kate Blain OT Advanced course Instructors. He is trained in assessing children with Bayley Scales for Infant and Toddler Development, trained by Betty Hutcheon UK Bayley Trainer at Addenbroke's Treatment Centre, Addenbroke Hospital, Cambridge, UK. He is a Certified Sensory Integration Therapist from University of Southern California/WPS. He is trained and successfully completed Basic and advanced training in Prechtel method of Qualitative assessment of General Movements with neonates/babies. He is trained and certified in DIR floor time techniques for children with sensory issues and Autism Spectrum disorders.

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