Children's Health Ireland

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Torticollis

Link to Torticollis Flow Chart

Aim

To provide an evidenced based guide to assist in the emergency department management of children presenting with **acute** onset torticollis.

Definition of terms

Torticollis or "wryneck" refers to lateral twisting of the neck that causes the head to tilt to one side with the chin turned to the opposite side. It is a non-specific sign with a large spectrum of aetiologies. [1]

Target patient population

Patients between 3 months and 16yrs presenting to the emergency department with acute onset torticollis. This document does not provide direction for chronic/congenital torticollis; babies with sternocleidomastoid psuedo-tumour, and does not apply to children with co-morbidities.

Target users

Clinical staff in the PED assessing and managing patients who present with acute torticollis

Assessment

History

Trauma? If yes, follow a C Spine guideline (e.g NICE guideline for spinal injury) and refer for orthopaedic opinion

Infective: Recent fever, recent diagnosis of tonsillitis/pharyngitis/ URTI symptoms. Irritability, dysphagia, drooling, odynophagia[2]

Any recent medications - has the patient received any meds associated with acute dystonic reactions? e.g. metoclopramide

CNS symptoms: Headache, strabismus, diplopia

Time course: Uncomplicated acute muscular torticollis should resolve within 7 - 10 days

Examination

Assess for midline tenderness, palpate the neck throughout and attempt active ROM (i.e. ask the patient to move their neck)
Cervical lymphadenopathy / lymphadenitis (tender fluctuant mass in area of lymphadenopathy),

Irritability, drooling in context of fever, +/- lymphadenopathy consider Grisels' syndrome (retropharyngeal abcess and associated atlantoaxial rotatory fixation)
Location of tenderness may assist with diagnosis, however deep pathology (eg: infection) may have no external signs

Neurological examination, full neuro exam should be performed looking for any focal abnormalities with specific focus on cranial nerves and upper limb exam

ENT examination: including lymph nodes, respiratory distress, stridor and/or tachypnoea

Eye examination: Nystagmus may suggest spasmus nutans (triad of nystagmus, head bobbing and torticollis)

Investigations

If symptoms suggestive of infection: FBC, CRP, Blood Cultures

Radiology: Lateral neck XR if suspicious for retropharyngeal abcess

Cervical Spine xray: In cases of trauma, or if there is cervical spine tenderness, severe pain, persistent symptoms (≥1 week), limited ROM

Ultrasound: if there is a palpable mass/collection\

CT may be appropriate in specific cases, e.g suspicion of atlanto-axial rotary displacement/ retropharyngeal abscess.
These cases should be discussed with a senior PEM clinician and/or appropriate clinical specialty who may have specific questions for CT and liaise with appropriate radiologist.

Always discuss with PEM consultant prior to ordering CT.

Management

Management depends on suspected cause:

General measure like analgesia or anti-inflammatory medications may be effective (e.g ibuprofen 10mg/kg PO, 400mg max dose)

Diazepam can be effective with some cases of spasm of the SCM (1-4yrs: 2.5mg PO, 5-16yrs: 5mg PO) [4]

Heat packs and massage may provide symptomatic relief in cases of muscular spasm causing torticollis.

Infectious causes: Initiate appropriate IV antibiotic therapy as per antibiotic guidelines and admit under medical team

Refer to ENT early if a retropharyngeal or parapharyngeal abscess is suspected

Refer to orthopaedics if any evidence of malalignment or instability on clinical or radiological assessment. Children with hyperlaxity and new torticollis (e.g Elhers-Danlos, Trisomy 21) require orthopaedic review.

Dystonic reactions: Procyclidine (<2yrs: 0.5-2mg IM/PO, 2-10yrs: 2-5mg IM/PO, >10yrs: 5-10mg IM/PO) [4]

Vision problems: eg Suspected CN palsy, new strabismus etc, refer to ophthalmology, may require admission for investigation.

Companion Documents:

Link to References

Link to Flow Chart