INTRODUCTION
The goal of this fact sheet is to provide a reference highlighting key points of orthotic management in children. Additional information on pediatric orthotic management can be located in:

- Lower Extremity Orthotic Intervention for the Pediatric Client in Topics in Physical Therapy: Pediatrics, edited by the American Physical Therapy Association

WHAT IS AN ORTHOSIS?
An orthosis is an external device with controlling forces to improve body alignment, improve function, immobilize the injured area, prevent or improve a deformity, protect a joint or limb, limit or reduce pain, and/or provide proprioceptive feedback. Orthoses are named for the part of the body they cover. Orthoses can be custom molded and custom fitted (custom fitted from prefabricated orthoses or off the shelf). Orthoses are classified as durable medical devices (DME) and require L-codes for insurance reimbursement. A prescription signed by a physician is usually required for insurance reimbursement for custom-molded and custom-fit orthoses.

WHO DESIGNS AND PROVIDES ORTHOSIS?

- Certified orthotists have formal education in biomechanics and material sciences required in designing custom devices. They are nationally board certified, and 11 states require licensure to provide custom devices. There are approximately 3,000 certified orthotists in the US, with a limited number of orthotists specializing in pediatrics. Pediatric orthotists evaluate the child, cast the child, modify the mold, fabricate the orthosis, and custom fit the orthosis to the child.
- Physical therapists are trained in the function of orthoses and will frequently fit and measure orthoses. If the child is measured by the physical therapist, the orthoses are usually centrally fabricated and returned to the therapist for custom fitting and delivery. Following delivery of the orthosis, physical therapists provide education and functional training to the child and family. Some physical therapists fabricate and fit low-temperature orthotic devices/splints, requiring training beyond their basic education.
- Physicians, orthotists, and physical therapists often provide simple, off-the-shelf devices for acute situations. The sizing of these devices is determined by measurement and does not require custom fitting.
- Families can purchase supports and braces at pharmacies and sport stores.

WHO IS ON THE TEAM?
A team approach is always recommended for optimal outcomes. The rehabilitation team should include physicians, orthotists, physical therapists, occupational therapists, social workers, and, most importantly, the child and family. Physical therapists working with the child and family in schools and community rehabilitation settings play an integral role in developing the orthotic prescription.
Diagnosis, prognosis, short- and long-term goals, home environment, occupation, recreation, age, height, weight, and prior orthotic experience(s) should all be discussed among the rehabilitation team when determining which devices are most appropriate for the child’s current and future needs. Considerations include cost as well as adjustability of the device to meet the child’s changing needs.

**WHAT ARE THE CHARACTERISTICS OF PEDIATRIC LOWER-EXTREMITY ORTHOSES?**

**Design**
- Lower-extremity orthoses are specifically designed for the child’s functional needs, whether ambulatory or non-ambulatory, with considerations of 3-point force systems and ground reaction forces to control alignment in all 3 planes.
- Additional benefits of orthoses may include controlling or limiting joint movements, simulating an eccentric or concentric muscle function, increasing range of motion, and providing proprioceptive feedback. This is achieved by incorporating mechanical joints, springs, or flexible materials into the orthotic design.
- Transverse rotation control of the lower extremities (hips, knees, tibial torsion) requires the child to wear torsion cables or metal uprights with a hip/ waistband/belt or elastic twister straps and waistbelt.
- Lower-extremity devices should optimize leverage for control without resisting desired range of motion for activities or causing internal complications (e.g., peroneal nerve palsy).
- Orthoses may be initially fabricated to provide maximum stability and then be adjusted for less stability and more voluntary control as the child progresses.
- Designs and colors have greatly improved wearing adherence by allowing the child to personalize and have a choice in designing the orthosis.

**Materials**
- There are numerous types and thicknesses of materials to choose from when fabricating an orthosis. Selection of brace design and the appropriate material and design of the brace is essential for function, strength, durability, flexibility, comfort, adjustability, compliancy, hygiene, and skin integrity.
- Most orthoses are made from vacuum-molded thermoplastics. Plastic thicknesses can vary between 1/16" to ¼". Occasionally, metal/leather designs are appropriate.
- Carbon graphite/acrylic resin will increase the strength and decrease the bulk of an ankle foot orthosis (AFO); however, these materials are not as adjustable or durable to abrasion as thermoplastics.

**Straps**

Strap designs vary depending on the need:
- Chafe and loop designs optimize stability, but may be more difficult to don and have high bulk.
- Figure-eight ankle straps have good control and moderate bulk.
- Layover straps provide minimal stability and minimal bulk Straps help align and hold the limb in the orthosis and may have direct contact with the limb.

Straps should fit securely and not gap between the plastic orthosis and the child’s limb. This increases stability and decreases unnecessary pressure.

**Pads**
- Pads are often provided in areas where there are boney prominences. They are used to support and cushion these areas of concern.
- Pads may be applied in an orthosis after fabrication or after physiologic changes occur. The pads are applied to increase the 3-point force systems in order to improve alignment.
• Pads should never be applied in an area of the brace that is already providing excessive pressure to the child. Even the softest padding will increase the pressure in this area.

Trim Lines
• The length of the footplate of an orthosis may vary depending on the child’s need:
  o Full-length footplate (to end of toes) to provide resistance to keep the knee from buckling, or with utilization of a toe extensor pad for hypertonia, painful MTP joint, or if toes have a tendency to curl.
  o Trimming the footplate to stop behind the toes (sulcus) is indicated to allow a normal third rocker (MTP dorsiflexion) and often allows easier shoe donning.
  o Trimming the footplate to stop behind MT heads (rare in children) is indicated for painful MT heads.
• Full-length footplates may be designed with thin plastic or the plastic may be thinned after fabrication to allow more dorsiflexion flexibility in the third rocker.
• Trim lines should optimize leverage for control without adding bulk to make clothing or shoe wear hard to fit over the device.

What Type of Shoes Should Be Worn with an Orthosis?
• Shoes should have:
  o Good construction, leather preferred
  o Good heel counter, quality sole
  o A removable insole to increase instep depth
  o ¼”–⅜” heel height
  o Rockered toe
  o Laces or Velcro closure to instep
• The fit of the shoe can affect orthotic function. The clinician can assist the child and family in selecting the proper shoe for the prescribed orthosis.
• The heel height of the shoe can affect the child’s standing alignment while in the brace.

CAN AN ORTHOSIS BE USED FOR CONTRACTURE PREVENTION/REDUCTION?
• Dynamic assistive braces have an adjustable tension-spring assistance mechanical joint to reduce or prevent anatomical joint contractures.
• Static progressive braces hold a stretch with the force applied to the anatomical joint. Increased range may be achieved with increased manual stretch.
• Static braces have no adjustability and hold the limb in one position.
• Custom-made braces provide optimal control in all 3 planes of motion. These are indicated for long-term implications and multiple-plane control.
• Off-the-shelf braces provide adequate control in one plane of motion. There are options for purchase or rental of some braces. They are less durable than custom made and indicated for acute conditions of limited range of motion.
• Acute conditions with soft-end ranges and good skin integrity benefit from off-the-shelf styles.
• Chronic conditions or certain situations (eg, high tone/spasticity, soft-to-hard end ranges, good to poor skin integrity, a child who has periods of being agitated) should be fitted with custom braces. The cost advantage is beneficial in these situations compared to multiple serial casts.
• Other interventions for control also should be considered (eg, serial casting, anti-spasticity medications, electrical stimulation).
• Adherence of the device regimen is essential for success.
### TABLE 1: Lower-Extremity Orthosis and Indication in the Gait Cycle

<table>
<thead>
<tr>
<th>Photo of the Orthosis</th>
<th>Device &amp; Condition</th>
<th>Stance Phase (Indications)</th>
<th>Swing Phase (Indications)</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Foot Orthosis (FO)" /></td>
<td><strong>Foot Orthosis</strong>&lt;sup&gt;(FO)&lt;/sup&gt;</td>
<td>Arch alignment</td>
<td>none</td>
</tr>
<tr>
<td><img src="image" alt="University of California Biomechanics Laboratory (UCBL)" /></td>
<td><strong>University of California Biomechanics Laboratory (UCBL)</strong>&lt;br&gt;Plantar fasciitis, excessive pronation, metatarsus adductus</td>
<td>Stabilizes foot/ankle complex in sagittal and transverse planes</td>
<td>none</td>
</tr>
<tr>
<td><img src="image" alt="Supra Malleolar Orthosis (SMO)" /></td>
<td><strong>Supra Malleolar Orthosis</strong>&lt;sup&gt;(SMO)&lt;/sup&gt;</td>
<td>Stabilizes foot/ankle complex in sagittal and transverse planes</td>
<td>Resists excessive inversion/eversion (for safer initial contact)</td>
</tr>
<tr>
<td><img src="image" alt="Posterior Leaf Spring (PLS) Ankle Foot Orthosis (AFO)" /></td>
<td><strong>Posterior Leaf Spring</strong>&lt;sup&gt;(PLS) Ankle Foot Orthosis**&lt;sup&gt;(AFO)&lt;/sup&gt;</td>
<td>Flexible posterior allows simulated eccentric contraction of pre-tibial muscles to prevent foot slap. A UCBL foot plate will offer medial and lateral (M/L) foot and ankle stability</td>
<td>Swing clearance</td>
</tr>
</tbody>
</table>

---

**Notes:**
- **Foot Orthosis (FO):** Used to align the arch in the foot.
- **University of California Biomechanics Laboratory (UCBL):** Orthosis designed to address plantar fasciitis, excessive pronation, and metatarsus adductus.
- **Supra Malleolar Orthosis (SMO):** Used in severe pronation or supination to stabilize the foot/ankle complex.
- **Posterior Leaf Spring (PLS) Ankle Foot Orthosis (AFO):** Designed for drop foot, peroneal palsy, with minimal to no medial or lateral instability, to prevent foot slap and provide stability.
<table>
<thead>
<tr>
<th>Photo of the Orthosis</th>
<th>Device &amp; Condition</th>
<th>Stance Phase (Indications)</th>
<th>Swing Phase (Indications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Articulating Ankle Foot Orthosis (AAFO) with dorsiflexion (DF)</td>
<td>Assists joints with DF. Mild drop foot with medial and lateral instability</td>
<td>Simulated eccentric contraction of pretibial muscle to prevent foot slap. Provides good transverse and medial lateral stability of the foot and ankle complex. Allows DF and advancement of the contralateral limb.</td>
<td>Simulated concentric contraction of pre-tibial muscles. Provides transverse and medial and lateral stability of the foot and ankle complex.</td>
</tr>
<tr>
<td>Articulating Ankle Foot Orthosis (AAFO) with plantar flexion (PF) stop</td>
<td>Toe walking, mild to moderate genu recurvatum, moderate to severe M/L instabilities of foot/ ankle</td>
<td>Encourages knee flexion moment at initial contact through midstance. Provides transverse and M/L stability of the foot and ankle complex. Allows DF and advancement of the contralateral limb.</td>
<td>Swing phase clearance. Provides transverse and medial/lateral stability of the foot and ankle complex.</td>
</tr>
<tr>
<td>Solid Ankle Foot Orthosis (SAFO)</td>
<td>Severe hypertonia, severe rheumatoid arthritis of foot and ankle</td>
<td>Encourages knee flexion moment in initial contact to midstance. Resists excessive knee flexion and ankle DF. Provides M/L stability of the foot and ankle complex.</td>
<td>Swing phase clearance. Provides transverse and M/L stability of the foot and ankle complex.</td>
</tr>
<tr>
<td>Photo of the Orthosis</td>
<td>Device &amp; Condition</td>
<td>Stance Phase (Indications)</td>
<td>Swing Phase (Indications)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><img src="image" alt="Floor Reaction Ankle Foot Orthosis (FRAFO)" /></td>
<td>Floor Reaction Ankle Foot Orthosis (FRAFO) with the foot in neutral slight plantar flexion Weak quadriceps muscles with no M/L knee instability</td>
<td>Encourages knee extension moment to prevent knee forward buckling. Provides M/L stability of the foot and ankle complex.</td>
<td>Swing phase clearance More difficult going up hils. Provides transverse and M/L stability of the foot and ankle complex.</td>
</tr>
<tr>
<td><img src="image" alt="Floor Reaction Ankle Foot Orthosis (FRAFO) for crouch gait" /></td>
<td>Floor Reaction Ankle Foot Orthosis (FRAFO) for crouch gait Lower-level paraplegia associated with hip and knee flexion contractures</td>
<td>Decreases the crouch gait and keeps torso vertical and center of mass in middle of the foot. Provides transverse and M/L stability of the foot and ankle complex.</td>
<td>Swing phase clearance</td>
</tr>
<tr>
<td><img src="image" alt="Knee Ankle Foot Orthosis (KAFO)" /></td>
<td>Knee Ankle Foot Orthosis (KAFO) Low thoracic/ high lumbar level paraplegia, severe knee hyperextension, M/L instability at the knee, Blounts disease</td>
<td>AFO section provides M/L stability of the ankle, swing phase control, ground reaction forces on the knee. Knee joint &amp; thigh extension provide M/L knee support. Locked knee joints option provides maximal sagittal plane support but unlock for sitting.</td>
<td>Swing phase clearance M/L stability for the knee in preparation for initial contact</td>
</tr>
<tr>
<td>Photo of the Orthosis</td>
<td>Device &amp; Condition</td>
<td>Stance Phase (Indications)</td>
<td>Swing Phase (Indications)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><a href="https://www.camphealthcare.com">Image of Hip Knee Ankle Foot Orthosis (HKAFO)</a></td>
<td><strong>Hip Knee Ankle Foot Orthosis</strong> (HKAFO) Paraplegia</td>
<td>Maximum support for lower extremities in all 3 planes and lower torso</td>
<td>Swing phase clearance Prevents scissoring</td>
</tr>
<tr>
<td><a href="https://www.camphealthcare.com">Image of Reciprocating Gait Orthosis (RGO)</a></td>
<td><strong>Reciprocating Gait Orthosis</strong> (RGO) Hip Knee Ankle Orthosis Mid-thoracic to high-lumbar paraplegia</td>
<td>Maximum support for lower extremities and lower torso</td>
<td>Swing phase clearance Assists in advancement of the lower limbs</td>
</tr>
<tr>
<td><a href="https://www.camphealthcare.com">Image of Legg-Calf-Perthes</a></td>
<td><strong>Legg-Calf-Perthes</strong></td>
<td>Encourages proper blood flow to the femoral neck and head</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


WEBSITES

- Surestep–Dynamic Stabilizing System. Available at: www.surestep.net
- Ultraflex. Available at: www.ultraflexsystems.com
- Cascade DAFO. Available at: www.cascadedafo.com

©2009 by the APTA Academy of Pediatric Physical Therapy, www.pediatricapta.org

Developed by expert contributor the APTA Practice Group. Special thanks to Karl Barner, LPO & Colleen Coulter-O’Berry, PT, DPT, MS, Board-Certified Pediatric Clinical Specialist of Children’s Healthcare of Atlanta for their contributions to the previous version of this fact sheet. Supported by the Fact Sheet Committee of APTA Pediatrics.

The APTA Academy of Pediatric Physical Therapy provides access to these member-produced fact sheets and resources for informational purposes only. They are not intended to represent the position of APTA Pediatrics or of the American Physical Therapy Association.