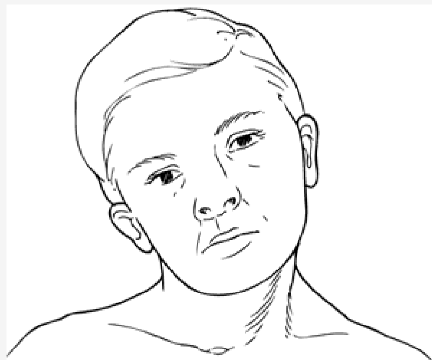
Torticollis



- Common neck posture of a patient with torticollis, note the spasm/activation of the SCM
- Caused by involuntary unilateral contraction of the SCM and Traps other muscles are splenius, scapula muscles, scalenes and platysma
- More common in females aged 30-50 years
- Causes lateral flexion and contralateral rotation
- Anterocollis more rare, rotational more common

Types of Torticollis

- **Congenital:** (caused by lesions in SCM (childbirth trauma), vertebral defomities e.g Hemivertebra, klippel feil)
- **Acquired:** post trauma (within days or 3-12 months)/adjacent inflammatory process (Osteomyelitis,lymphadenitis, pharygitis, tonsilitis, cervical abcesses, tumour, RA, Partial dislocation of C1 on C2
- **Spasmodic:** Cervical Dystonia - unknown origin
- **Acute:** Benign - affects younger and middle aged patients , sudden onset -self resolves days/weeks
- **Dermatogenic:** When the skin of the neck is injured it shortens (scars/burns)
- **Occular:** Compensational paralysis of the muscles that control inclination and rotation of the head - oblique extraoccular muscles

Presentation

- Patient remembers doing something strenous or new the day before
- On observation patient has painful fixed posture of lateral flexion and contralateral rotation of the head (can have flexion, extension, right/left tilt)
- Movement is painful and ROM is limited (lateral flexion and extension to the side of pain)
- Sleep is disturbed
- +ve Spurlings
- Palpation reveals unilateral hypertonicity/spasm of the SCM, traps and LS
- Intersectional joint restricion
- Assess shoulder, scapular girdle
- Check for patient's drugs - Dopamine blockers, Ketamine, ammphetamines, cocaine, compazine, haldol and thorazine
- In patients with Down syndrome with torticollis, consider atlanto-axial instability
- Assess for s/s of cervical adenopathy (lymph nodes), oropharynx, otoscopy, fundoscopy

DDx

- Essential Tremour
- Myasthenia Gravis
- MS
- Neuroleptic agent toxicity
- Parkinsons
- Peritonsillar Abscess
- Rehabilitation and cerebral palsy
- Retropharyngeal Abscess
- Spinal Haematoma

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DDx (cont)

- Tardive Dyskinesia
- Wilson disease

Imaging

Usually unnecessary unless:

- Trauma and "red flags"

Red Flags

- Fever (infection/inflammatory - usualy septic otolaryngological/osteoarticulr infection)
- Swollen Lymph nodes
- Significant headache
- Difficulty breathing, swallowing or speaking
- Ataxia
- Weakness, numbness or parasthesia in extremities
- Change in bladder/bowel habits
- Strabismus
- Nystagmus
- Increased ICP (Vomiting, Double vision, Confusion, headache, papiloedema)
- Reccurent vomiting

Management

- More serious causes should be ruled out
- Ice/heat
- Myofascial release of SCM, traps, LS and paraspinal muscles
- Stretching - Cx tractioning whilst resting your forearms on the patient's shoulders, forearms downward pressure, then ask patient to push against forearms with their shoulders against your resistance for 5-7 seconds while inhaling, ask patient to exhale and then stretch out and increase traction, process should be repeated 3 times
- Scapula repositioning
- SMT if tolerable
- Avoidance of sleeping on the stomach or drafty conditions
- Cervical pillows recommended
- NSAIDs and counterirritant creams, Benzodiazepines, muscle relaxants, anticholinergics, botox
- Surgery for some types

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