

Neuroplasticity in a Stroke and Stress

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Stroke is associated with paralysis leading to a poor outcomes and quality of life as well as the reduced activities-of-daily living (ADL). The novel manner of multidisciplinary care incorporates the fields of allopathy, chiropractic, psychology, neuro-rehabilitation, and also the nutrition. The Care was measured with videotaping of progress by monitoring the ADLs and work capacity levels along with the standard biomechanical orthopedic, neurological and chiropractic evaluation studies. Treatment included sacrooccipital technique (SOT) which incorporated cranial manipulative care while simultaneously performing the normal side extremity specific range of motion and then immediately following with performing the same range of motion activities on the abnormal side. Pre or post-videotaping of patient were found to be continued progress over years with showing walking 18 years later even though CT-scan illustrated the same area of the initial brain tissue damage. Generally the treatment of similar cases requires a minimum of 6 months treatment followed up with life-long wellness treatment, for the once compromised areas. Finding low risk therapeutic options to help a patient recover from brain trauma is one of the challenging endeavor. This presentation addresses the success of SOT chiropractic care and suggests that the neuroplasticity may have a biomechanical neurological connection pathway. Torticollis can developed due to a constrained intrauterine position in the last weeks of pregnancy breech lie, birth trauma or forces during delivery and late gestational age. There are three types of congenital torticollis postural, muscular and a sternocleidomastoid muscle (SCM) mass. The

postural type presents as the infant's postural preference but without muscle or passive range of motion (ROM) restrictions. The muscular type presents with SCM tightness and passive ROM limitations. The most severe form a sternocleidomastoid muscle mass from congenital muscular torticollis (CMT) presents with a fibrotic thickening of the sternocleidomastoid muscle and passive ROM limitations. Other causes of torticollis can be a dysfunction in the cranio-cervical junction, Klippel-Feil Syndrome with or without Sprengel's Deformity a dysfunction in the upper cervical spine or can be caused by a Kinematic Imbalance due to Sub-occipital Strain. The non-musculoskeletal reasons for infantile torticollis could be ocular, neurological or due to auditory problems. The pseudotumor of the sternocleidomastoid muscle is related to the severe presentations and consists of myoblasts, myofibroblasts, mesenchyme cells and fibroblasts in varied quantity and stage of differentiation or degeneration. In newborns the prevalence of this pseudotumor ranges from 0.3% to 2%. If conservative therapies are ineffective after a reasonable period of time 6 to 12 months, surgery should be considered. There is also some evidence of consequences of torticollis that is not treated such as transient motor asymmetry, motor delay, and plagiocephaly, which would be reversible if addressed early and correctly. Torticollis is a major risk factor for plagiocephaly. Chiropractic, which is part of complementary and alternative medicine (CAM) care, has been found to be safe for the children and there is an evidence-based rationale for conservative myofascial and light adjective techniques for the management of torticollis in both adults as well as in children.

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