

Ideally, the number of visits and plans for subsequent intervention need to be flexible. Parents facing the question of having a subsequent child will need support. Both the birth of a subsequent child and the survival of that child, especially past the age of death of the previous child, are important transitional stages for parents.

## Positional Plagiocephaly

Since the Back to Sleep campaign began in 1994 advocating non-prone sleeping for infants to prevent SIDS, an increase in the incidence of positional plagiocephaly has been observed ([Laughlin, Luerksen, Dias, et al, 2011](#)). Approximately 20% of infants have a skull that is most prevalent between 2 and 4 months old ([van Wijk, van Vlimmeren, Groothuis-Oudshoorn, et al, 2014](#)). The term **plagiocephaly** connotes an oblique or asymmetric head; *positional plagiocephaly*, *deformational plagiocephaly*, or *nonsynostotic plagiocephaly* implies an acquired condition that occurs as a result of cranial molding during infancy, usually as a result of lying in the supine position ([van Wijk, van Vlimmeren, Groothuis-Oudshoorn, et al, 2014](#)). Because infants' sutures are not closed, the skull is pliable; and when infants are placed on their backs to sleep, the posterior occiput flattens over time ([Fig. 10-4, A](#)). A typical bald spot develops, which is usually transient. As a result of prolonged pressure on one side of the skull, that side becomes misshapen; mild facial asymmetry may develop. The sternocleidomastoid muscle may tighten on the preferential side, and torticollis may also develop. Congenital or acquired torticollis may cause plagiocephaly; other causes of deformational plagiocephaly include certain craniofacial syndromes. This discussion centers only on positional plagiocephaly caused by supine sleeping position.