Clinical examination showed the following symptoms: 40 °C temperature, lymphadenopathy, skin rash of the whole integument with intervals of healthy skin, purpura of the soft palate and uvula and a pyramidal syndrome.
The biological exams showed hypereosinophilia at 2000 elements/mm^3, a mononucleosis syndrome and hepatic insufficiency.
Evolution: worsening with complete tetraplegia installation, respiratory disorders and heart failure requiring intubation in intensive care unit, despite the effective dose corticosteroid therapy and discontinuation of the treatment.
After a battery of biological examinations and radiological diagnosis of DRESS was addressed due to bactrim.
The patient was admitted in the of Physical Medicine and Rehabilitation Department.
After four months of hospitalization, we have noted a gradual recovery of muscle strength and sensitivity. In functional terms the patient walks with two English canes persistent. The skin rashes persisted requiring change in treatment by a dermatologist.
Conclusion.– It is very important to acknowledge the DRESS syndrome because of its potential severity, its similarity to other diseases and the appropriate therapeutic sanction: stopping the causing drug.
This pathology associates both mucocutaneous and systemic signs. It manifests itself by severe cutaneous reaction associated with hyperthermia and multi-visceral involvement (lymphadenopathy, hepatitis, nephritis, interstitial pneumonia. . .) as well as hematological abnormalities (high eosinophilia. . .). Each symptom is variable from one individual to another in its appearance and in its expression, but severe visceral involvement remains the leading cause of mortality.
In our case, the neurological disorder is predominant. It worsens the functional prognosis of our patient.
DRESS syndrome secondary to bactrim remains very rare.

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P098-e

Clinical results of Brindley neurostimulator: Preliminary results

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Keywords: Brindley; Sacral anterior roots stimulation; Spinal cord injury
Background.– The Brindley procedure consists of the implantation of a sacral anterior-roots stimulator (SARS) combined with a sacral deafferentation (SDAF) [1].
Aim.– This study evaluate long term efficacy and complications of a sacral anterior-roots stimulator to enable complete micturition.
Material.– Twenty-nine patients with supra-sacral spinal cord injury (SCI), implanted of a Finetech-Brindley stimulator for more than 6 months were included.
Method.– This is a retrospective and descriptive study, setting in one French center, Nantes University Hospital, specialized in the treatment of SCI's patients, and the Finetech-Brindley bladder controller implantation. The main outcome measure is the ability to urinate on demand with a residual volume of less than 50 mL. Each patient was asked to fill a questionnaire about their use of the Finetech-Brindley stimulator and their satisfaction.
Results.– Since surgery, 27 patients have achieved an implant driven complete micturition without additional method to empty their bladder. Two patients have never been able to have complete micturition, one because of a low implant driven detrusor contraction and one because of a lack of sacral deafferentation. Today, five patients who used to enable complete electrical micturition, now use intermittent catheterization. Among them two patients changed their micturition mode because of a change of their neurological status without link with the neurostimulator, one because of the removal of the device due to an infection and two because of cable failures which will be surgically repaired. Six patients underwent a second surgery for an incomplete deafferentation, three for an implantable device failure. The Brindley stimulator is used to help defecation in 60%. Three men use the Brindley stimulator for sexual intercourse without other medication. Patients who underwent surgery are "satisfied".
Conclusion.– Our results are similar to other publications. The use of SARS to empty the bladder combined with SDAF as a treatment of neurogenic bladder dysfunction in complete SCI's patients remains an efficacy and useful technique.
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P099-e

Verrucous carcinoma and recurrent sacral pressure ulcer in a patient spina bifida: About a case and review of the literature

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Keywords: Verrucous squamous; Cell carcinoma; Meningomyelocele; Spina bifida; Bedsore; Marjolin's ulcer
Introduction.– Verrucous carcinoma is a rare variant of highly differentiated squamous cell carcinoma, mostly observed in the mouth and pharynx. Verrucous carcinoma of the skin occurs extremely rarely and usually mimics chronic infection, in a context of a chronic wound, corresponding to Marjolin's ulcer. In patient with meningomyelocele, only 8 cases of sacral squamous cell carcinoma have been reported in the literature. No cases of verrucous carcinoma had been described.
Observation.– The case reported here was unusual in that the verrucous carcinoma arose in a chronic sacral pressure ulcer with a purulent appearance, in this man operated for meningomyelocele at the age of one year. The extension of this carcinoma was exceptional to say the least, reaching the sacrum, L4–L5 and the pelvis, despite four iterative extended surgeries. One explanation comes from the fact that verrucous carcinomas are particularly well differentiated and merge the anatomopathological analysis with simple epidermoid cysts. The patient finally passed away of a major deterioration of his general condition.
Discussion.– The eight cases described in the literature are all squamous cell carcinomas in patients with spina bifida also an important extension, and most led to death. Marjolin ulcer is often developed on sacred bedsore in spinal cord injured [2], but it is possible that dysraphism per se may therefore constitute a supplementary risk factor [3] for the development of carcinoma in the dysraphic zone, by the fact of an invagination of epithelial elements in intradermal. The association between spina bifida and the development of Marjolin's ulcers must be taken into account in the management of these patients, who require very close follow-up. Any wound or fistula occurring over the dysraphic zone must not be ignored whenever it becomes chronic, recurrent, or presents signs of transformation [1].
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P100-e

Paraplegia after meningoencephalitis complicated by an arachnoisis in a patient with a Currarino syndrome. About a case

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