

**Keywords:** Rotational dislocation C0-C1; Positioning

The authors report 3 cases of tetraplegic patients due to a rotational dislocation between C0 and C1 occurring after a road accident (2 women and 1 man aged between 17 years and 27 years). All patients were resuscitated by the SAMU (mobile emergency care unit) on the premises of the accident and did not develop any cognitive impairment after this transient anoxia. Two out of the 3 patients underwent surgical cervical spinal fusion, a procedure which actually did not improve their head control.

After achieving seating positioning in a comfort-wheelchair, the need for a customized orthosis emerged for several reasons:

- absence of head control resulting in a higher risk of forward drop-head and compression of the ventilator tube in spite of a, sometimes badly tolerated, frontal strip;

- difficulties met by nurse caregivers to reproduce the optimal installation designed by the physiotherapies using the Witmaker devices, in the context of major hypotonia.

Given the poor ventilatory autonomy, orthosis molding remains challenging and demands a strict coordination between all participants. Best achieved on a depression cushion, it requires 5 professionals: a nurse, a physiotherapist, an occupational therapist, an orthotist and a PMR specialist. The neck- piece with sub-occipital support is the most critical deliverable to handle. The dorsal thoracic piece is enlarged in order to embed the armrest. Protection of ichiatic pressure points by means of silicone gel injections is warranted.

Fitting, delivery and fixation, by the occupational therapist, onto the wheelchair frame (Kyte Invacare type) with the ventilator installed at the rear. Mouth command and/or command by a caregiver; implementation of both systems.

The successful feedback as expressed by both patients and users has been immediate, thanks to the global positioning (head, trunk, limbs) and standardization of devices (neck-piece, armrest, footrest).

An increase of time spent seated was noted and has had a positive impact of the general health status and socialization (outdoor rides in bus, stroll in town. . .). Beyond the medical benefits, transfers are facilitated and a life project is more easily built up.

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### Segmental spinal myoclonus in a quadriplegic patient after traumatic spinal cord injury



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**Keywords:** Segmental spinal myoclonus; Spinal cord injury

**Introduction.**– Reported cases of spinal myoclonus after spinal cord injury are rare and the physiopathological mechanisms are still unclear [2].

**Observation.**– We report the case of a 47 years old, traumatic quadriplegic patient, C6 American Spinal Injury Association class B, presenting with rhythmic, repetitive, bilateral and synchronous, flexion-adduction movements of the lower limbs. These movements persist several hours per day, are triggered by diverse stimuli, and are aggravated in supine position. They appeared a few weeks after the trauma, and have been persisting for more than 9 months. The EMG polygraphy shows rhythmic bursts, which are bilateral, synchronous, occurring at a frequency of 0.46 Hz, including the adductor muscles and the medial hamstrings. No treatment has been established because there is no functional impairment.

**Discussion.**– Myoclonus has been defined as a muscular movement, which is sudden and brief, resulting from a muscular shake (positive myoclonus), or from the inhibition of muscular contraction (negative myoclonus) [1]. Among these, spinal myoclonus are mostly rhythmic, and topography limited to muscles innervated by one or two contiguous spinal segments. They may be unilateral or bilateral and are generally synchronous on both sides. They are most often stimulus-sensitive and may persist during sleep. Polygraphy EMG finds rhythmic, synchronous, bilateral bursts with a frequency of discharge from 0.3 Hz to 8 Hz.

They are associated with various spinal cord insults. Levetiracetam can partially reduce myoclonus [3].

**References**

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### Vertebral and spinal cord hydatidosis



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**Keywords:** Hydatidosis; Medullar; Morocco

**Introduction.**– Vertebromedullary hydatidosis is rare. It is described in the literature with case.

**Observation.**– We describe a case of 39-year-old Moroccan woman who was hospitalized for paraparesis. She has a precedent history of pleural and hepatic hydatid cyst. Symptoms start 20 days before with mechanic low back pain and intermittent claudication without fever. The neurological exams found paraparesis and hypoesthesia without superior sensitive level. Magnetic Resonance Imagery (MRI) showed cystic lesions of dorsal vertebrae (D7–D11) on pre- and laterovertebral. Lesions have progressed in medullar spine. Surgical excision with dorsal decompressive laminectomy was performed. Medical treatment was 6 months of albendazol (400 mg/day) associated with rehabilitation. Evolution was favorable and patient has found daily activity.

**Discussion.**– MRI is very helpful for the diagnosis of vertebromedullary hydatidosis [1]. Biological exams are often normal. Prognosis is good but the recurrence risk is high [2].

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### Paraparesis revealing ochronosis: a case report



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### Support for a tetraplegic patient secondary to the drug hypersensitivity syndrome DRESS syndrome



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**Keywords:** DRESS syndrome; Quadriplegia and bactrim

We report the case of 51 years old, Asian patient, no particular antecedents with a urinary infection treated with bactrim.

Two days after the beginning of the treatment, the patient was hospitalized with febrile skin rash, neurological and gastrointestinal disorders.