

Conclusion.— In spite of the frequency of PCS persisting after three months and the repercussions reported by the victims of mTBI on their professional activity, we notice that they have been maintained at their original post, without needing special adjustment. It will be good to complete the protocol by a distance interview to ensure the tenure of the job.

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P082-e

Small bowel obstruction by superior mesenteric artery syndrome: A diagnosis to know after intensive care stay

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Keywords: Small bowel obstruction; Superior mesenteric artery syndrome; Loss of weight; Nutrition

Introduction.— The superior mesenteric artery syndrome (SMAS) is a small bowel obstruction corresponding to a compression of the third portion of the duodenum (D3) between the mesenteric artery and the aorta. It was described for the first time by Rokitsky in 1861. This compression is due to the desparation of the adipose tissue between the aorta and the mesenteric artery. It is observed in the states of thinness or severe undernutrition. The clinical signs are a small bowel obstruction without hyperthermia but with fast degradation of nutritional state and water-electrolyte imbalance. The diagnosis is confirmed by imagery with duodenal dilation upstream to the obstacle with linear stop at the level of D3. The treatment is a nutritional care based on refeeding by parenteral nutrition, or by enteral way with duodenojejunostomy.

Case report.— We report the case of a patient of 29 years old, thin (68 kg for 1.90 m), hospitalised for a severe craniocerebral trauma. The evolution was marked by serious neurological and infectious complications associated with progressive and important weight loss (loss of 18 kg in 4 months, BMI = 14). In this context, the patient had presented vomiting and neurological complication with intracranial hypertension was first suspected. This clinical presentation was associated with severe extracellular deshydration. The SMAS was confirmed by abdominal scanner witch showed a gastric and duodenal distension until the space enter the mesenteric artery and the aorta, a distance between the aorta and the mesenteric artery lower than 8 mm, and an angle between this two arteries lower than 20°. The patient was treated by parenteral nutrition with a clinical state amelioration and a progressive enteral nutrition by gastrostomy.

Conclusion.— The SMAS is a rare diagnosis witch shall be thinking in front of a small bowel obstruction in thins patients in a post-resuscitation context. This complication testifies the importance of nutritional evaluation and supporting in a rehabilitation unit after intensive care stay.

Further readings

SMAS: spectrum of CT findings with multiplanar reconstructions and 3-D imaging. Abdominal imaging

Santer R, et al. Computed tomography in superior mesenteric artery syndrom. *Pediatr Radiol* 1991

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P083-e

When the PRM unit intervenes in the neurosurgery department

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Keywords: PRM unit; Traumatic brain injury; Follow-up; Neurosurgery
Recent studies in France have underlined the difficulty to assess and assist brain-injured patients at the acute stage.

After recovering a basic level of functioning (as assessed by the neurosurgeon...), the brain-injured patient is usually discharged home where the patient and family are left to manage their problems alone. Nothing new really happens until a social worker or an on-line association or a concerned professional refers the patient or family to a dedicated PRM unit. Thus insufficient assessment and information is a major cause of suffering and burden for the patients and their caregivers.

We have proposed to address this issue with a dedicated unit that works mainly in the neurosurgery department. A physical and rehabilitation practitioner and a neuropsychologist visit the neurosurgery department every week to meet, assess and assist referral of brain-injured patients.

Preliminary data from this unit show that 46 patients have been seen in 3 months, 30 patients in neurosurgery without any motor deficiency for 90% of them, and 16 stroke victims in the neurovascular unit. The most common etiology was sub-arachnoid hemorrhage (56%) and traumatic brain injury (36%). A dedicated follow-up in a specialized unit as close as possible to their home was proposed for all patients.

This kind of intervention is mandatory for these patients. To date, our work cannot be exhaustive and two types of patients still do not benefit from our intervention because they are in other departments, mainly traumatic brain injury in psychiatric wards and elderly orthopaedic patients. We are however currently developing such interventions in other departments of our hospital.

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P084-e

Vein thrombosis of the upper limb and central neurological lesions: About three cases

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Keywords: Deep vein thrombosis; Upper limb; Pulmonary embolism; Head trauma; Spinal cord injury

Introduction.— Deep vein thrombosis (DVT) of the upper limb is rare (1–4% of all DVT) with considerable morbidity, related to the risk of pulmonary embolism. Despite a preventive anticoagulation, patients with central neurological injury are frequently exposed to such thromboembolism, due to blood stasis, hypercoagulable state, and the aggression of the vessel wall increased by the presence of peripheral venous catheterization. We report three cases of deep vein thrombosis of the upper limb, diagnosed in rehabilitation service in two head trauma and a spinal cord injury quadriplegic. Only one case was complicated by pulmonary embolism.

Discussion.— We will discuss through a literature review the pathophysiology of this entity and its main risk factors and specificity in a rehabilitation service.

Conclusion.— DVT of the upper limb are rare but dangerous and life-threatening accidents, that's why they need a special monitoring and implementation of prophylactic measures.

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P085-e

Case report: Abdominal transcutaneous exposure of the distal tip of a ventriculo-peritoneal shunt for post-traumatic hydrocephalus

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Introduction.— Hydrocephalus is a frequent complication after head trauma (0.7 to 29% [1]). Ventriculoperitoneal shunting (VPS) is a standard treatment of hydrocephalus, but has multiple complications (4 to 5%/year) [2]. We describe an exceptional case of abdominal transcuteaneous exposure of the distal tip of the shunt.

Observation.— A 53-year-old patient suffered severe head trauma after falling down stairs. After a month of coma, the patient progressed towards a state of minimal consciousness. Because of the lack of neurological improvement and the radiological aspect of hydrocephalus, a VPS was inserted. A month later, the patient presented an infectious syndrome, clinically and biologically, associated with vomiting and worsening consciousness. The abdominal scar of the VPS changed from a hardened aspect to that of a subcutaneous liquid collection. The collection was drained leading to the identification of *Corynebacterium striatum*. The abdomino-pelvic CT showed a subcutaneous thickening. The brain CT showed increased hydrocephalus. The next day, the distal tip of the VPS came out through the abdominal scar. The shunt was surgically removed. The microbiological culture of the cerebrospinal fluid and the shunt identified the same germ as in the collection. After an adapted antibiotic treatment outcome was favorable.

Discussion.— To our knowledge, no earlier case of percutaneous exposure of the distal tip of a VPS through the abdominal scar has been reported. Some cases of umbilical exposure or displacement through abdominal-pelvic organs (bladder, womb, appendix, and scrotum) or through the urethra or anus have been described. Other abdominal complications of the VPS were described (peritonitis, pseudo-cyst), the prevalence of which is increased with a history of abdominal surgery. Considering the frequency of complications, early diagnosis is crucial. An attentive examination of the abdomen both clinically and radiologically (including the surgical scar) is necessary in all patients with a ventriculoperitoneal shunt that present an infectious syndrome.

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P086-e

Returning to work after brain-damaged, prognostic factors. A retrospective cohort study of 100 subjects

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Keywords: Brain damaged; Socio-professional integration

Objectives.— Evaluation of the success rate of socio-professional reintegration of a population with brain-damaged, accompanied for socio-professional integration by a professional integration cell, research of prognostic factors of this rehabilitation, study of the difficulties of returning to work and job retention in this population. Finally comparative evaluation of this support, based on the new recommendations of the HAS approach early socio-professional insertion.

Methods.— Retrospectively studied of 100 patients hospitalized in a rehabilitation center between 2007 and 2010, having suffered from stroke, head injury or brain tumor. Data were collected from four sources: medical records of rehabilitation center (type of brain injury, initial severity (GCS) score of functional independence at the entrance and exit from the center, the presence of a shoring family), data from professional integration cell, telephone interview subjects using a questionnaire guide (social and professional status pre- and post-injury), contact with occupational physician using a questionnaire guide.

Results.— The rate of return to work is best for the patient with stroke than for victims of TBI. Family support, support in the return to work process by the socio-professional integration cell of the center and absence of behavioral sequelae appear to be predictors of success of the reintegration process.

Conclusion.— This study highlights the improving rate of social and occupational rehabilitation of brain-damaged people when accompanied by a socio-professional integration cell through a process of early insertion. Family support and absence of significant cognitive sequelae seem to be positive factors for a return to work.

Finally, it reaffirms the importance of a strategy of supporting brain-damaged in the process of vocational rehabilitation, based on new recommendations of the HAS on the process early insertion.

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