Psychological effects of pain and physical disease on seriously war injured soldiers
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Introduction.– Soldiers sent to fight missions during foreign operations are particularly exposed to physical wounds, and to psychological wounds and in particular to war trauma. According to Freud, an organic wound can protect the person from war trauma, but what is the situation in real life? Physical pain of physical wound seems to be more protective than the injury itself.

Aim.– To study psychological effects of severe physical wounds and to study the role and impact of pain in war injured soldiers.

Methods.– We wanted to recruit about 30 war-injured soldiers with a severe physical wound. Were included soldiers who sustained loss of limb, loss of organic substance, and/or loss of functionality. They were contacted at the beginning of the rehabilitation period (1st month) for two interviews: (1) typical anamnesia questionnaire, Inventory - Scale for Traumatic Neuroses (ISTN), questionnaire on pain (Term for pain [QDSA]), Pain check-up EVA, Scale of pain impact on the everyday life [QCD23]) and (2) Rorschach test and Thematic Aperception Test (TAT). Patients were contacted again 6 months later for the same interviews.

Results.– To date, 4 patients have been assessed (three at one month, one at six months). Their most common concerns involved their physical state and their recovery. According to them, only those elements could have an impact on their psychological state. The pain had an influence on their mood, their sleep and also their relationships (pain questionnaires). Post-traumatic symptoms were noted (ISTN) and even though they are not high, they had an impact on mood, sleep, relationships, and had an interaction with pain. Since the injury, a control of the psychological movements was still acting (Rorschach), during the reviviscences and especially during the reactivation of pain.

Discussion.– Pain seems to be important for the psychological reorganization needed after a war trauma. This beginning study should permit an improvement in the psychological therapy proposed for injured soldiers from the start of their rehabilitation.


Management of shoulder pain in the hemiplegic patient: Experience of the University Hospital of Casablanca
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Introduction.– The prevalence of shoulder pain after hemiplegic stroke is 70%. A shoulder-hand syndrome, adhesive capsulitis may be the cause, favored by a glenohumeral subluxation or significant spasticity. The etiological diagnosis is mainly clinical. The treatment is mainly based on preventative taping, and prudent mobilization and electrostimulation.

Objectives.– Recall the clinical, therapeutic and prognostic elements and to evaluate our results based on data from the literature.

Methods.– Prospective study on the management of shoulder pain in 12 hemiplegic patients seen between October 2008 and March 2011.

Results.– Twelve patients, age: 51 ± 19 years post-stroke time: 3 to 28 weeks (15.5 ± 12.5); sex ratio: 8 F/4 H; hemiplegic side: 9 right/3 left, pain assessed by VAS (initial: 8 ± ; after treatment: 3 ± 1); etiologies: 10 subluxations/3 complex regional syndrome type I.

Treatment.– All patients were treated with strapping, sling immobilization when standing or sitting, analgesic medication, TENS, local infiltration of corticosteroids in cases of complex regional syndrome type I.

Discussion.– Shoulder pain is particularly high in hemiplegic particular patients, requiring particular therapeutic attention warranting research. The diagnosis of upper limb pain in the hemiplegic remains a subject of controversy. Its origin is multifactorial dominated by glenohumeral subluxation, complex regional syndrome type I, capsulitis, spasticity. We must stress the importance of the prevention avoiding decoaptation glenohumeral by proper installation of the patient and the diagnosis and initiating treatment early.

Further reading

Patients et methods.– This was a prospective study of 21 patients with cervicobrachial neuralgia, seen in PRM from 01/10/2009 to 01/03/2010. Therapy included physical treatment (physiotherapy analgesic + restraint by cervical collar), medication (analgesics, NSAIDs or other), physical therapy alone, a single restraint and an association of physical and medical treatments.

Results.– Our series included 19 women and 2 men giving a predominantly female cohort (90.48%) of any age: 7 (33.33%) aged 40–50; 10 (47.61%) received a medical treatment, 6 (28.57%) physical therapy, 3 received only physical therapy, a cervical collar only 4.76% and 4.76% and a combination of physical and medical treatment, for medical treatment 4 received Lyrica, 3 Tramadol, 3 NSAID, 1 paracetamol.

These patients were reviewed at various intervals ranging from 2 to 10 weeks: 2 weeks (n = 4), 3 weeks (n = 3), 4 weeks (n = 4), 5 weeks (n = 4), 6 weeks (n = 1), 10 weeks (n = 1) lost to follow-up (n = 4). Comparing pain by VAS, both treatments showed improvement of pain in 61.90% cases and steady state in 19.04%.

Improvement in pain depended on the type of treatment, 66.67% in the physical treatment group, 60% of patients receiving medical treatment, 100% improvement in pain with splinting alone, 33.33% and 33.33% improvement stationary state with physiotherapy alone and 100% improvement of pain, i.e. 1/1 with the combination of physical therapy medical treatment.

Discussion.– Our sample was predominantly female in full activity (40–50 years). An improvement of pain in two-thirds of all patients with combined treatments; 66.67% of good results with physical therapy and 100% with the combination treatment physical and medical treatment. It follows from our study that the combination of drugs with physical therapy provides the best result for the treatment of pain.