

in neurogenic bladder of MS. This result is similar with the data obtained in idiopathic non-neurogenic OAB.

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SEA-MS-F: Sexual Expectation Assessment in Multiple Sclerosis (MS): a new questionnaire to assess sexual expectations in female MS patients

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Keywords: Multiple sclerosis; Sex; Expectation; Orgasm

Sexual disorders are frequent in MS (40 to 90%) and interfere with quality of life. Many studies concerning male patients have been published, but only few studies are available in women. Moreover, sexual expectations of MS patients are not really known and no study was specifically designed to evaluate these expectations. The aim of the study was to create and validate such a specific questionnaire.

Material and method – Following a full literature analysis and neuro-urologists survey, we have constructed a first version (V1) of SEA-MS-F. This version was validated using the Delphi method. The Delphi method is a structured communication technique, originally developed as a systematic, interactive forecasting method which relies on a panel of experts. Questions were accurate and graded on a visual scale (0 to 10). The experts' answers were anonymously obtained by means electronic mails via Internet.

Results – Three rounds were necessary to obtain a full consensus. Final version of this 8-question questionnaires is online (www.SEEMS.jimdo.com). These questions concern sexual desire, arousal, pleasure, orgasm, body image, partner and couple's relationship.

Comments – SEA-MS-F is the first questionnaire specifically designed to assess sexual expectations in MS patients. Psychometric validation of this questionnaire is ongoing.

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Functional surgery in neuro-urology and indications

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Urinary functional surgery in neurological patients must meet two major objectives:

- Secure the upper urinary tract by maintaining low bladder pressure;
- Ensure patient comfort by finding a voiding way adapted to the patients disability.

What means?

–The *maintenance of low bladder pressure*:

Surgery is indicated after failure of medical treatment (antimuscarinic) and after failure or intolerance of detrusor injections of botulinum toxin;

Enterocystoplasty preferably associated with a supra-trigonal cystectomy is the method of choice for a large bladder capacity and compliant reservoir;

The bladder reflectivity can be abolished by posterior *rhizotomy* S2 to S4, which implies the lack of prior sensitivity and sacral reflex erections.

– *Ensure continence*:

The maintenance of low bladder pressure during bladder filling phase is essential to ensure continence; When urinary incontinence is due to an impairment in urethral resistance, several methods can be used; For women: suburethral tape, fascial slings around bladder neck, colpopexy, adjustable peri-urethral balloons, artificial urinary sphincter; For men: adjustable peri-urethral balloon, peri-cervical fascial sling, peri-cervical - peri-prostatic or bulbar artificial urinary sphincter;

Brindley Neurostimulator ensuring electrostimulated micturition and associated with sacral rhizotomy afferents to suppress reflex activity; Continent Cystostomy Monti or Mitrofanoff type to enable intermittent self-catheterisation when the patient cannot achieve through the urethra; The lowering of urethral resistance may allow a bladder that has kept a good reflex activity, to ensure complete drainage with low bladder pressure. This is the goal achieved by endoscopic sphincterotomy, whether surgical or prosthetic; When any previous solutions is possible, the urinary catheter permanently cannot be a solution in the mid and long term, because of the frequency and severity of complications related to indwelling catheters; An ileal external urinary diversion may be an acceptable solution when the physical or cognitive abilities do not allow for alternatives.

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Detrusor innervation: Which sacral roots? Findings of intraoperative electrophysiological studies during Sacral Anterior Roots Stimulation surgery

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Objective – To describe which sacral roots are preferentially involved in the detrusor contraction.

Materials and methods – Retrospective study of 27 patient cases with supraconal spinal cord injury who underwent implantation of a sacral anterior roots stimulator associated with posterior sacral rhizotomy between 1998 and 2011. Analysis of electrophysiological data and urodynamic data during intraoperative stimulation.

Results – S3 roots are involved mainly in the detrusor contraction (70%). The S3 right root contributes more frequently (43.3%) and more efficiently in the detrusor contraction (average: 96 cm H₂O [34–140] versus 81 cm H₂O [32–120] for left S3. A detrusor contraction was induced in 30% stimulation of the root S4. Therefore, when S4 root is predominant, the right root induces stronger contraction amplitude than the left one (right S4 average 83 cm H₂O [40–120], vs left S4: average 62.2 [40–95]). S2 roots do not, in visceral parameters, contribute to increase the bladder pressure response beyond 30 cm H₂O. S3 and S4 are still trapped together and connected to the channel involved in the Brindley voiding program.

Discussion – The intraoperative exploration during Brindley surgery confirms the limited data of the literature: the prevalence of the S3 right in the genesis of the detrusor contraction. Fujimura et al., in his article on radical resection of sacral neoplasm, has shown that the preservation of S3 roots is predictive of a recovery of a detrusor contractility in 69% of the cases and of a normal vesico-sphincteric status.

Our electrophysiological study confirms these data.

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Antibiotic prophylaxis, urodynamic evaluation and clean intermittent catheterization

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Keywords: Urodynamic evaluation; Clean intermittent catheterization; Antibiotic prophylaxis; Urinary tract infection