

approach has been beneficial in terms of experience of hospitalization, including risk of bleeding, without increasing the duration of hospitalization.

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### Stress incontinence predictive factors after sacral posterior roots rhizotomy



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**Keywords:** Rhizotomy; Sacral anterior roots stimulation; Brindley; Stress incontinence; Spinal cord; Paraplegia; Urology

**Background.**– The Brindley procedure consists of the implantation of a sacral anterior-roots stimulator (SARS) combined with a sacral deafferentation (SDAF). This technique enables to restore an implant driven complete micturition in patients with supraconal lesions with an intact sacral reflex arc. SDAF abolishes neurogenic detrusor overactivity (NDO) but also reflex contraction of the striated urethral sphincter during effort and a decrease of urethral pressure. This may lead to stress incontinence [1].

**Aim.**– To estimate the prevalence of stress incontinence one year after SDAF and to examine potential predictive factors of occurrence of post-operative stress incontinence.

**Material/Patients.**– Hundred and twenty-four patients with suprasacral SCIs and implanted with a Finetech-Brindley stimulator were included. This is a retrospective and descriptive study, setting in two French centers specialized in the treatment of SCI and SRAS implantation (Rehabilitation Centre of L'Arche, Le Mans and Department of Physical and Rehabilitation Medicine, University Hospital of Nantes).

**Method.**– Seven potential predictors were examined: age at surgery, sex, level T<sub>10</sub>-L<sub>2</sub>, previous urethral surgery (sphincterotomy, cervicotomy or prostatectomy), independent transfers, maximum urethral closure pressure (MUCP) before surgery less than 30 cmH<sub>2</sub>O, bladder compliance before surgery less than 30 mL/cmH<sub>2</sub>O.

**Results.**– One year after the surgery, 9.7% of them had a stress incontinence. Before surgery, 91.1% of them had urge incontinence. Univariate analysis indicated no significant predictive factors of stress incontinence: age at surgery ( $P = 0.164$ ), sex ( $P = 0.177$ ), level T<sub>10</sub>-L<sub>2</sub> ( $P = 0.136$ ), previous urethral surgery ( $P = 0.519$ ), independent transfers ( $P = 0.172$ ), MUCP before surgery less than 30 cmH<sub>2</sub>O ( $P = 0.657$ ), bladder compliance before surgery less than 30 mL/cmH<sub>2</sub>O ( $P = 0.332$ ).

**Interpretation/Conclusion.**– Our study did not reveal predictive factors of stress incontinence after SDAF. This may be due to the few number of patients with potential predictors who underwent the procedure. The screening of patient undergoing Brindley procedure is crucial to aim an optimal post-operative result. From this study, we propose a preoperative check-up to select the population of patient that may benefit from Brindley procedure.

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### Therapeutic education in spinal cord dysfunction or multiple sclerosis patients with pressure ulcer: Raymond-Poincaré's hospital experience



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**Keywords:** Pressure ulcer; Therapeutic education; Individual or group program; Spinal cord dysfunction; Multiple sclerosis

This program is managed by an interdisciplinary team with doctors, nurses, caregivers, physical therapists, occupational therapists, psychologist, secretary, dietician, welfare worker.

Validated by ARS in 2010, this TPE [1] program focuses either on neurologic patient with pressure ulcer or in secondary prevention [2].

Raymond-Poincaré's hospital organizes a pressure ulcer consultation and also a specific day hospital. Beside our TPE team, our multidisciplinary consultation includes an infection diseases specialist and a surgeon. Patients can be hospitalized in the unit for a complex medical check-up, also we work in collaboration with other TPE programs in the hospital (wheelchair/transanal irrigation/self-catheterization).

The number of patients seen for pressure ulcer is stable since 2010 turning around 200 patients per year. Two thirds of them are in controlled wound healing and one third received specialized surgery. Within those 200 patients, 45 were affected in TPE in 2011 and 84 in 2012. There are more spinal cord injuries than multiple sclerosis. For 95% of the cases, the patient is directly concerned and in 5% it is his caregiver. Most of the sessions are individual education, some collective workshops can be proposed. The main themes of the sessions are by order of frequency: selfcare/knowledge and skills/supports-positioning/dietary competences/social support/psychological care-lived experience.

Despite the classical documents (charter of ethics, information to patients), different specific ETP tools have been created; specific ETP records, information booklet, power point, patient satisfaction questionnaire, educational playing cards... We use OVET software.

The specificity of this program is to take in charge patients having a severe neurological disability. Most of them are dependant, living far from the hospital. All these points lead us to a fitted organization of the structure with the aggregation of individual sessions.

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### Fertility preservation in spinal cord injured men



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**Keywords:** Spinal cord injury; Fertility

**Introduction.**– Spinal cord injured (SCI) men most often have an infertility because of ejaculation disorders and impaired sperm quality. Sperm cryopreservation is the best modality to ensure future fertility for these SCI patients.

**Materials and methods.**– The retrospective medical records of 32 SCI patients who came at the Reims hospital CECOS, between 1995 and 2012 were studied. In each case, we analysed the use of assisted techniques (penile vibratory stimulation, transrectal electrostimulation or surgery), type of sperm collection (antegrade, retrograde, tissue), semen parameters, the time between the injury and the sperm cryopreservation, the use of Assisted Reproductive Technology (ART) and the results.