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 Rokitansky 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 thinsness 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 duodenojenostomy.

Case report.– We report the case of a patient of 29 years old, thin (68 kg for 1.90 m), hospitalised for a severe cranioencebral 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 due to intracranial hypertension was first suspected. This clinical presentation was associated with severe extracranial deshydratation. 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 which will 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

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 aggregation of the vessel wall increased by the presence of peripheral venous catherization. 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.

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

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Keywords: 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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When the PRM unit intervenes in the neurosurgery department

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P085-e
Case report: Abdominal transcutaneous exposure of the distal tip of a ventriculo-peritoneal shunt for post-traumatic hydrocephalus