Evaluation of quality of life in complete locked-in syndrome patients

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Keywords: Locked-in syndrome; Stroke; ALS; Quality of life

Goal.– There are few studies where quality of life (QOL) and contributively factors are assessed in patients LIS with complete physical and functional disability and dependence to caregivers.

We compared quality of life (QOL) of locked-in LIS (LIS patients) with QOL of healthy controls.

Methods.– We included nine LIS patients (eight vascular aetiology, one post-traumatic), 11 healthy controls. The following scales were administered to patients: McGILL, Short-Form SF-36, Beck depression inventory-II (BDI-II) and the Tokyo Alexithymia Scale.

Results.– Mean McGill and SF36 were not significantly different between LIS group and healthy controls; there were no significant differences between the two groups for others scales either except for BDI-II, depressive symptoms were significantly more frequent in LIS patients.

Discussion.– Our results agree with several previous studies. Several factors may have an impact on QOL of LIS patients such as family support and patient-computer communication devices, these may have contributed to improve QOL of LIS patients in this study.

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Repercussion on professional activity of post-concussion syndrome secondary to a mild traumatic brain injury

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Keywords: Mild traumatic brain injury; Post-concussion syndrome; Professional repercussions

Goal.– Look for the existence of repercussions on professional activity of a post-concussion syndrome consequential to a mild traumatic brain injury.

Population and method.–

– descriptive prospective study, in process;
– inclusion specifications: victims of a mild traumatic brain injury (mTBI) according to the definition of “France Traumatisme Crâniens”; admitted to Emergency; aged 18–62; exercising a professional activity;
– search of a post-concussion syndrome (PCS) on the phone after one and three months: Rivermead Post-Concussion Symptoms Questionnaire;
– consultation in case of unfavorable evolution between the two questionnaires: Neurobehavioral Rating Scale-revised (NRS-r), followed by a possible multidisciplinary rehabilitative care in a Functional Reeducation Center;
– search for professional repercussions of the mTBI after six months: unstandardized closed phone questionnaire.

Preliminary results after 15 months.–

– 53 patients included; 34 studied here (the other 19 not being yet at six months after their TBI);
– 53% (18/34) presented a PCS one month after their TBI, persisting after three months for 44% (15/34);
– 24% (8/34) underwent the NRS-r and 9% (3/34) went in reeducation, which saw an unfavorable evolution;
– 74% (25/34) went on sick leave from 1 to 90 days, (22 days on average).

Professional repercussions of the TBI after six months: repercussions are present for 35% (12/34) of cases; among those twelve people, all speak of a persistent tiredness, nine indicate memory troubles, seven attention troubles and a slowness of movement; all the patients of this set (34/34) resumed their former job after six months; only one of them changed his post within his firm for his own convenience and not because of incapacity pronounced by the occupational doctor.
Conclusion.– In spite of the frequency of PCSs 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 desperation 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 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 craniocebral trauma. The evolution was 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. The SMAS was confirmed by abdominal scanner which 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 these 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 thin 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

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P085-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.

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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
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