Discussion and conclusion

Lipomodelling and lipofilling have become widely applied in reconstruction following breast cancer surgery, or cosmetic augmentation. To our knowledge, this is the first time this technique has been used in the prevention of pressure ulcers in patients with SCI, and our early results are very encouraging.

Keywords

Spinal cord injury; Pressure sore; Lipofilling; Prevention; Seating clinic

Disclosure of interest

The authors have not supplied their declaration of conflict of interest.

http://dx.doi.org/10.1016/j.rehab.2015.07.053

C006-004-e

Therapeutic strategy for taking care of perineal pressure ulcers in spinal cord injury (SCI) patients

M. Thomas-Pohl (Dr)a, C. Hugeron (Dr)a, E. Chartier-Kastler (Prof)b, P. Denys (Prof)b, C. Rech (Dr)c, H. Chaussard (Dr)c, D. Ben Smail (Prof)c

a Service de MPR, Widal 1, hôpital Raymond-Poincaré, Garches, France
b Service d’urologie, hôpital de la Pitié-Salpêtrière, 75013 Paris
c Service de neuro-uropäologie, hôpital Raymond-Poincaré, Garches

E-mail address: thomas_marie@hotmail.com (M. Thomas-ohl)

Objective

The perineal pressure ulcer is, from the outset, a serious bedsore as it exposes the patient to the risk of fistula in addition to the regular complications associated with bedsores. Treatments reported in the literature couple recovery by musculocutaneous flap combined either with urethroplasty or urinary diversion [1], without decision-making criteria. The objective of this study is to analyze the management of perineal pressure ulcers in SCI patients and suggest a suitable therapeutic strategy.

Materials and methods

Retrospective, observational study of a group of SCI patients picked up at the Garches hospital and in the urology department at the Pitie-Salpêtrière, between 2002 and 2014.

Results

The study includes 20 patients, of which 15 show urethrococutaneous fistula. Following a musculocutaneous flap combined or not with an urethroplasty, but without joint urological care, no patient recovered. None of the two urethral reconstructions have helped to heal the bedsores or enabled the reuse of urethra for self-catheterization. After cystoprostatectomy and Bricker, only 2 out of 15 patients relapsed, given a follow-up period between 1 and 6 years.

Discussion

Like any pressure ulcer, the treatment of perineal pressure ulcer requires a careful evaluation of the circumstances of occurrence and risk factors (history of ischiectomy, proximal hip removal, prolonged indwelling catheter), and a ureteronephric (bladder balance and voiding mode), skin, nutrition, neuro-orthopedic, seat, and socio-psychological assessment. In the presence of urethrococutaneous fistula, a urinary diversion seems absolutely necessary: usually a non-continent bypass with cystoprostatectomy and Bricker which remains surgically heavy and may negatively affects self-image exceptionally, a continent diversion may be considered with closure of the bladder neck. The urethroplasty by experienced urologists associated with bedsores surgery could have been discussed but was not be performed for technical reasons (surgeries on 2 different hospitals). In the absence of fistula, but the presence of chronic perineal maceration with bad management of bladder, trans-ileal cutaneou ureterostomy with cystoprostatectomy ensures the complete drying of the perineum.

Keywords

Spinal cord injury; Perineal pressure ulcer; Urethrococutaneous fistula; Urethroplasty; Urinary diversion

Disclosure of interest

The authors have not supplied their declaration of conflict of interest.

Reference


http://dx.doi.org/10.1016/j.rehab.2015.07.054

C006-005-e

The medical and surgical care chain in neuro-injured patients: The experience of the Nantes University Hospital from 2004 to 2014

C. Lefèvrea,*, F. Bellier Waast (Dr)b, P. Kiény (Dr)c, F. Lejeune (Dr)d, M. Lefort (Dr)e, B. Perrouin-Verbe (Prof)f

a CHU de Nantes, service de MPR neurologique, Nantes, France
b CHU de Nantes, service de chirurgie plastique

E-mail address: chloe.nenard@live.fr (C. Lefèvre)

Introduction

The management of pressure sores in neuro-injured patients at the Nantes University Hospital was organized for 30 years in a medical-surgical care chain. The last ten years of this activity are traced in this retrospective study.

Patients and methods

All records of patients who had a surgical flap to cover pressure sore between 1 January 2004 and 31 December 2014 were analysed to synthesize results.

Results

One hundred and thirteen men and 49 women (n = 162) were operated of 250 flaps. This was mainly spinal cord injured patients (78%). Patients were divided into two groups: pressure ulcer(s) single or multiple (several lesions operated at the same time or later). There were 67% of ischial lesions, 20% of sacral lesions and 12% trochanteric lesions. The most used flap was that of glutaeus maximus (82%) for the ischial and sacral lesions, then comes the tensor fascia lata (12%) for trochanteric lesions. Feature of our series (unlike others [1]), the hamstring’s flap is only used as a last resort (6%) in multirecidivist patients. The complication rate delaying delivery to the chair in theoretical time of six weeks is 35%, to be analysed according to age, general health, the size and number of initial lesions. However, the rate of recurrence after healing of the flap is only 10%.

Discussion

A medical and surgical management, long and sometimes complex [2], but our long-term results are satisfactory regarding to the low recurrence rate.

Keywords

Pressure ulcer; Pressure sore; Decubitus ulcer; Surgical flap; Spinal cord injury

Disclosure of interest

The authors have not supplied their declaration of conflict of interest.

References


http://dx.doi.org/10.1016/j.rehab.2015.07.055