interest is discussed; therapeutic goals and rehabilitation care are different than in traumatic SCI and the benefit is difficult to be assessed.

Methods.-- Retrospective study of patients admitted in PM&R hospitalization for neoplastic paraplegia during the last 10 years at Nantes.

Data collected.-- Demographics, clinical (cancer ASIA impairment scale (AIS), survey), functional (functional independence measure (FIM), bladder management) and therapeutics (surgery, radiotherapy).

Results.-- Twenty paraplegia patients were reviewed. Prostate cancer was the most frequent (35%). The patients were treated by surgery in 75% of case and by radiotherapy in 70%. At the beginning of inpatient rehabilitation, AIS grade patient status was: 6 AIS A, 2 AIS B, 7 C and 5 D. At the end of the stay, the number of ambulatory patients changed from 3 to 6, 8 patients were urinary independent and 8 showed an increase at their FIM scale. For 35% of patients, a pressure ulcer was present at admission. It was 12.5% among patients coming from neurosurgery, 35% of those coming from medicine units but 66% of those coming from oncology units or follow-up care units. The average length of stay was 4 month. For the survivors, the median survival rate was 13 months.

Discussion.-- In-hospital death rate is high, raising questions about PM&R hospitalization aims. The functional advances remain low, often restricted by pain and weakness. Bladder function evaluation is a PM&R specificity even if the number of patients becoming urinary independent remains modest.

In light of these findings, the PM&R care management criteria for metastatic paraplegia are progressively defined. They are based on well-defined goals, defined by contract; have to be achieved during a one-month stay. For our cohort, the duration of stay is too long, increased by ulcer pressure complications at admission. This fact underlines the need to create a network of competence to optimize patients’ care from acute units to PM&R unit discharge.


CO05-003–EN

Benefits of exercise for cancer patients

T. Bouillet

Oncologie médicale, CAMI CHU Avicenne, 125, boulevard de Stalingrad, Bobigny, France

No abstract provided.


CO05-004–EN

Exercise therapy after breast cancer

A. Thevenon

MPR, CHRU de Lille, rue André-Verhaeghe, 59037 Lille, France

Most patients treated for cancer have a sedentary life. In a Canadian study [1] on more than 9000 patients having been treated for cancer, only 37.1% of the breast cancer patients reached the physical activity level recommended by the American Cancer Society.

Physical activity (PA) improves quality of life of patients with breast cancer and decreases the recurrence rate. This is clearly shown for instance in the “nurses’ health study” [2], from a cohort of 121,700 women. It seems we have to offer exercise sessions to patients during and after their breast cancer treatment. Many studies showed the benefits of exercise programmes either in a structured group or at home. These programmes last two to six months and improve quality of life, fatigue and fitness. It remains difficult to build recommendations because of the great variability of the exercise programmes available.

Adherence to the programme is usually good during the study time, but once the experiment is over, physical activity practice decreases often quickly. The best studies in the literature do not give data over six months. They show a fair stability in physical capacity but a decrease of the daily physical activity amount. Adherence to exercise prescription should be a priority subject of research to achieve a sustainable improvement of the health status of these patients.

References


CO05-005–EN

Breast cancer related arm lymphoedema and supportive care in oncology

C. Boiron a, *, A. Bourassin b, *

a Unité fonctionnelle des soins oncologiques de support, institut Curie, hôpital René-Huguenin, 35, rue Dailly, 92210 Saint-Cloud, France

b Libéral, Évry, France

*Corresponding author.

Keywords: Lymphoedema; Physiotherapy; Multilayer bandaging; Elastic garment; Patient involvement

Breast cancer related arm lymphoedema (BCRL) remains a relevant complication although it occurs less frequently thanks to the sentinel lymph node biopsy.

When the BRRA is not treated, it can be responsible for severe limb swelling, skin fibrosis and high infection risk. This morbidity negatively affects quality of life.

The physical treatment is called complex decongestive physiotherapy. It is carried out in two successive phases: the first intensive treatment aims to reduce substantial lymphoedema volume and reduce the fibrous tissue. Manual lymph drainage (MLD), multilayer bandaging, specific exercise, and skin care are needed. This treatment can be implemented either in hospital or at home.

The aim of the maintenance phase is to stabilize lymphoedema volume, consisting of a combination of custom-made sleeve-and-glove compression garments worn during the day and self-bandaging technique if necessary. Frequency of MLD treatment depends on the swelling and on patient involvement. Meticulosus skin hygiene is needed to avoid erysipela.

Patient education, regular activity and weight control are major component of lymphoedema management to permit better maintenance or lead to an improvement of the BCRL.

case of overactive bladder. Phosphodiesterase type 5 inhibitors can be used in male erectile dysfunction and vaginal dilators in case of vaginal stenosis. Perineal pain can be observed. Neurological mechanism is the main mechanism and can be confirmed by means of electrophysiological testing. This neuropathic pain can be managed by various treatments (drugs, TENS, ...).


CO05-007–EN
Resource teams for pediatric palliative care and rehabilitation teams: Proximity, partnerships
C. Remy
ESPPéRA, IHOP, 1, place Joseph-Renaut, 69 373 Lyon cedex 08, France

Keywords: Pediatric oncology; Supporting care; Rehabilitation; Network competence

The 4th measure of ministerial plan 2008–2012 relative to palliative care has enabled the creation or the development of regional resources teams in charge of pediatric palliative care.

In Rhône-Alpes, ESPPéRA (pediatric palliative team for supporting care, resource and accompaniment) was created January 1st 2011 to communicate about palliative approach and train health professionals in hospitals, medico-social institutions or private practices.

Pediatric palliative cares were initially developed by pediatric oncologists for children suffering from cancer; however, most children suffering from a pathology “limiting or threatening life” present more broadly a disability at some point in time in their care. At that point in time, a PMR team (physical medicine and rehabilitation) or medico-social team (such as accompaniment services, SESSAD, IME, CEM, ... ) provides care for them.

These caregivers are mainly trained for re-education and rehabilitation approach, which is similar to a palliative approach, as it relies on a care project which takes into consideration the patient deficiencies and incapacities, and is integrated to a life project without a cure outlook.

Yet, SSR or medico-social teams face difficulties when life is threatened at short or mid term: difficulties in identifying a palliative situation, in adapting the care project, in applying different techniques (such as palliative chemotherapy) or in handling the end of life symptoms. More generally, these teams may not feel comfortable or even legitimate at this moment of the child’s life.

I will first identify the different clinical situations that can lead a disabled child to begin palliative care, and I will then develop the specificities and complementarities between cultures and practices of rehabilitation teams and SPP resource teams. I will also consider how these teams could cross train each other.


Posters

Version française

P053–FR
Paraplegie après injection intrathécale de Méthotrexate
T. Nguyen, A. Palacio, F. Beuret-Blanquart
CRMPR les Herbiers, MPR, rééducation neurologique, 111, rue Herbeuse, 76230 Bois-Guillaume, France

Mots clés : Chimiothérapie intrathécale ; Méthotrexate ; Cytarabine ; Paraplegie

Introduction.– Nous rapportons un cas de lymphome du manteau compliqué d’une paraplegie après injection intrathécale de Méthotrexate. Observation.– Une femme de 53 ans, caucasienne, se présente en novembre 2009 pour polyadénopathies cervicales. Une biopsie ganglionnaire est réalisée, diagnostiquant un lymphome à cellules du manteau. Une chimiothérapie selon le protocole LYM A (traitement d’entretien par Rituximab) est entreprise en décembre 2009. Le 20 janvier 2010, la 2e cure est réalisée. Le lendemain, une injection intrathécale comprenant Méthotrexate, Aracynite et Hydrocortisone est effectuée. Huit jours plus tard, la patiente développe une paraplegie de niveau moteur et sensitif Th9, flasque, avec rétention urinaire. L’electromyogramme (EMG) a mis en évidence une atteinte pluriradiculaire. L’imagerie par résonance magnétique (IRM) élimine une compression médullaire, et retrouve un oedème du cône terminal et de la moelle dorsale basse sans prise de contraste anormale. Un bilan étiologique exhaustif infectieux et auto-immun s’avère négatif ; la ponction lombaire est normale. Le diagnostic de myélite secondaire à l’injection intrathécale de Méthotrexate est retenu. Aucune amélioration n’est constatée après bolus de corticoïdes. Treize mois après, l’IRM de contrôle montre une atrophie de la moelle avant le cône terminal. Depuis, la patiente a récupéré partiellement mais garde une paraparésie avec des troubles sensitifs encore importants ; elle marche sur courtes distances avec 2 cannes.

Discussion.– La neurotoxicité après injection intrathécale de Méthotrexate est une complication rare ; peu de cas ont été décrits dans la littérature [1,2]. Elle peut prendre plusieurs formes : syndrome méningé, épilepsie, encéphalopathie, paraplegie voire tétraplegie. Le mécanisme pathologique est encore inconnu ; plusieurs facteurs ont été incriminés : diluant, conservateur, faute de liquide céphalo-rachidien, carence locale en folates... L’évolution est variable : récupération partielle ou complète. Contrairement à ce qui est décrit dans la littérature, notre patiente a développé sa paraplegie dès la 1re injection.

Références


Version anglaise

P053–EN
Paraplegia after intrathecal injection of Methotrexate
T. Nguyen, A. Palacio, F. Beuret-Blanquart
CRMPR les Herbiers, MPR, rééducation neurologique, 111, rue Herbeuse, 76230 Bois-Guillaume, France

Keywords: Intrathecal chemotherapy; Methotrexate; Cytarabine; Paraplegia

Introduction.– We report a case of mantle cell lymphoma complicated with paraplegia after intrathecal injection of Methotrexate.

Case report.– A 53-year-old Caucasian woman consulted in November 2009 for cervical polyadenopathies. A node biopsy is performed, diagnosing mantle cell lymphoma. Chemotherapy according to the protocol LYM A (Rituximab maintenance regimen) was begun in December 2009. On January 20 2010, the second cure was delivered. The next day, a lumbar puncture including Methotrexate, AraCytine and Hydrocortisone was made. Eight days later, the patient develops flask paraplegia of motor and sensory level Th9 with urinary retention. The electromyography (EMG) brought to light a pluriradicular impingement. The magnetic resonance imaging (MRI) eliminated cord compression, and found an oedema of the terminal cone and the low dorsal narrow without abnormal contrast uptake. The infectious and autoimmune etiologic assessment was negative; the lumbar puncture was normal. The diagnosis of secondary myelitis due to the intrathecal injection of Methotrexate was retained. No improvement was noticed after bolus of corticoids. Thirteen months later, a follow-up MRI revealed medullary atrophy before the terminal cone. Since, the patient recovered partially but paraparesis persisted with important sensory disorders; she can walk short distances with 2 crutches.

Discussion.– Neurotoxicity of intrathecal injections of Methotrexate is a rare complication; not enough cases have been well documented in the literature [1,2]. It can take several forms: meningeal irritation, epilepsy, encephalopathy, paraplegia even quadriplegia. The pathological mechanism is still unknown; several factors were incriminated: diluant, preservatives, leakage of cerebrospinal fluid, local folate deficiency... The evolution is variable: partial or complete recovery. Contrary to what is described in the literature, our patient developed the paraplegia after the first injection.