Listening to patients with a major lower limb amputation due to peripheral vascular disease and/or diabetes: Personal experiences of the temporary prosthesis period

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Keywords: Amputation; Adjustment; Appearance; Self-consciousness

During the temporary prosthesis period in the context of major vascular lower limb amputation, we wished to listen to these patients, to understand how people had been dealing with this difficult situation. First of all, we wanted to explore the possible gap between the fact of dealing with a prosthesis and the ideas patients could have about it. After a series of questions, we finally extended the subject to what these people wanted to express.

In a first part, we develop epidemiological characteristics of this population [1] and we reflect about psychological repercussion of this surgical operation [2,3]. We present the way medical professionals in the rehabilitation department are taking care of amputated people. In a second part, we state the stories of the patients while they still were at hospital in Nantes, Rennes or Saint-Nazaire, or soon after their discharge to home. All the stories result from semi-directive interviews.

From the first interviews, we can underline five main points: the uniqueness of each personal experience, the deep desire for each one of them to keep their autonomy, the importance to find other patients to share with, the importance of the family support, and finally the evolution of the relationships between society and the person now disabled.

Amputation, considered like a last resort by the surgeon is for amputated people — on the contrary — the beginning of a new life. Throughout the process of the artificial limb operation, and even before amputation, each professional of the medical team takes an important part in supporting and backing the patient. We have to carry on for instance, in improving the offers of psychological help.

References


Assessment of the orthopaedic shoe “Pneumaflex®” among patients with foot drop

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Keywords: Orthopaedic shoe; Foot-drop; Neuropathy

Objective. – Prospective assessment of patient satisfaction with a foot orthosis consisting in a jack-assisted device, mounted on a custom-made low-upper orthopaedic shoe.

Methods. – All patients presenting with foot-drop and receiving this device were prospectively included. Their satisfaction was assessed with the QUEST questionnaire. Most of them had been previously equipped with different ankle-foot

References


Concepts of knee-ankle-foot and knee-ankle-heel orthosis used for neurological diseases

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Keywords: Lower limb orthotics; Knee-ankle-foot orthosis; Knee-ankle-heel orthosis; Lower limb neurological impairment

Aim. – To describe the basic concepts of knee-ankle-foot and knee-ankle-heel orthosis used for neurological diseases. Emphasis will be put on the knee joints whether they are presently reimbursed or not. Hip-knee-ankle-foot orthosis are out of the scope of this review.

Methods/Applications. – An overview of the technical characteristics of all available knee joints is proposed. We then consider the different neuromuscular impairments and the medico-technical responses, describing the different components, including the different knee joints. Based on the example of the “Basko” orthotic joint, we describe the evolution of the reimbursement regulations, which at present rely on very scarce objective evaluation.

Introduction.– For multiple sclerosis (MS) patients, wheelchair is bad news which, unfortunately for patients and caregivers, means treatment has failed.

Objectives.– Our objective was to develop a national inventory on prescription and use of manual wheelchairs in MS and to establish a tool for therapeutic patient education.

Method.– Patients (EDSS 5–7.5) were included from the database EDMUS of 8 MS networks. 1940 questionnaires were sent to MS patients. The semi-structured questionnaire related to different stages of acquisition of their manual wheelchair, its daily use as perceived by the patient and caregiver, and skills. Descriptive and exploratory analyses of the 538 questionnaires received were completed.

Results.– 368 patients with MS were evaluated (mean age: 53.8 years, mean duration of illness: 18.3 years). The first person to mention using a wheelchair was the patient (37%) followed by the neurologist (30.7%). The prescription was written by the general practitioner (44.6%). 72% of applications were for outdoor use with 51.6% for fatigue. 48.1% of patients had tried their manual wheelchair including 31.1% with trials outside. Only 20.6% had learned how to use it.

Discussion.– Studies on manual wheelchairs in MS are rare, while the loss of mobility is one of the characteristics of this disease. The quality of life of people with MS is influenced by their capacity to move about. The manual wheelchair mobility is one of the characteristics of this disease. The quality of life of people with MS is influenced by their capacity to move about. The manual wheelchair mobility is one of the characteristics of this disease.

Further reading


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Mobility and multiple sclerosis: Evaluation of prescription and use of the manual wheelchair in France

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Keywords: Multiple sclerosis; Mobility; Quality of life; Manual wheelchair

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Changing rules for prosthetics and orthotics prescriptions

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Keywords: Major appliances; Prescription

The French public health authorities issued a Decree on 24 March 2010 which discontinued the medical structures which offered free consultations for advice on determining and controlling the choice of orthopedic appliances. The purpose of this work is to present the current rules for the prescription of large appliances (orthot-prosthetic devices and orthopedic shoes). Initial prescriptions must be written by specialists in physical and rehabilitation medicine (PRM) or specialists in rheumatology or orthopedic surgery. It is recalled that prescriptions for certain devices were already reserved for PRM physicians: first prescription of the Harmony system, first prescription and change to energy-store foot prostheses, all requests for knee C leg or Hybrid. Other conditions are also discussed, for instance details for prescribing SIDO seat-braces with mobile backs (PRM, pediatricians, orthopedic surgeons) or therapeutic shoes for the diabetic foot (PRM physician, diabetologist...). Strict application of the 2010 Decree will allow more diabetologists or pediatricians to prescribe an initial device. Prescriptions for spinal devices by neurosurgeons also raise certain difficulties. We also discuss the impact of the new rules on expenditure control by the financing institutions and issues related to transportation management. These changes reinforce the PRM physician’s role in the fitting process.


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Effets du port d’une orthèse releveur de pied dynamique sur les paramètres biomécaniques de la marche des patients hémiparétiques

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Mots clés : Hémiplegie ; Marche ; Biomécanique ; Appareillage

Objectif.– Après un AVC, certains patients hémiplégiques présentent un équin spastique, responsable de troubles de la marche. Des orthèses releveurs de pied passifs ou dynamiques (ORPP ou ORPD) sont prescrites pour améliorer la dorsiflexion de cheville en phase oscillante. Cependant, peu d’études se sont focalisées sur les effets biomécaniques des ORPD. L’objectif de cette étude était d’évaluer l’effet d’une ORPD sur les paramètres biomécaniques de la marche des patients hémiplégiques présentant un équin spastique modéré.

Méthode.– Sept patients hémiparétiques ont effectué deux analyses de la marche avec et sans ORPD (Liberé®), à vitesse de marche préférentielle. Ce dispositif permet une mobilité articolaire de la cheville dans le plan sagittal, grâce à une bande élastique liant le pied à la jambe. Les paramètres spatiotemporels de la marche ont été améliorés avec l’ORPD du côté parétique : vitesse (+40 %), enjambée et longueur de pas (+22 %) et cadence (+17 %). Avec l’ORPD, l’attaque du pas s’est faite en légère dorsiflexion de cheville (–9 à –5 %, 0,35 ± 5 %). En phase d’appui, l’ORPD augmentait la dorsiflexion de cheville (11 ± 4 à 17 ± 4 %) et diminuait la plantarflexion (–13 ± 7 à –5 ± 6 %) et la flexion de hanche (3 ± 11 % à 1 ± 10 %) du côté parétique. En phase oscillante, l’ORPD augmentait la dorsiflexion de cheville (–2 ± 6 à 6 ± 4 %) et la flexion de genou (36 ± 13 à 40 ± 14 %), et diminuait la...