Surgical management of pressure sores in neurological patients

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In neurological patients, pressure sores occur mainly after spinal cord injury, more rarely after traumatic brain injury or stroke.

We present here our multidisciplinary care for these pressure ulcers, starting with a multidisciplinary consultation involving a PMR clinician and a plastic surgeon. The surgeon determines the surgical possibilities depending on the location of the ulcer, its size and the patient’s surgical history. The PMR physician evaluates the physical risk factors for pressure ulcer and the trigger causing the present ulcer. Together, they evaluate the risk/benefit ratio of a surgical treatment. The conditions for surgical management are strict; patient understanding and cooperation are essential.

There are two main phases to the surgical treatment. Resection of the cavity, which for ischeal pressure ulcers may be very extensive, must be complete, abiding by the same rules as for cancer surgery, with a macroscopically healthy resection margin. The entire inflammatory granulation tissue is removed. Samples are taken for bacteriological and pathological analysis. Coverage and especially filling is always needed using a musculocutaneous flap, which may be regional (gluteus maximus, biceps femoris, hamstrings, tensor fascia lata, gracilis) or distant (rectus abdominal flap or total thigh flap).

We present here the results from our homogeneous series of 40 patients, treated by one operator. Management of bone infection and antibiotic treatment was decided at the multidisciplinary meeting of complex bone and joint infections (National Center referenced), with the contribution of specialists in infectious disease, bacteriology, pharmacy-pharmacology and surgery. On average, the hospital stay in the surgery ward was 6 days, ranging from 3 to 17 days. Rehabilitation in specialized centers for 4 to 6 weeks was a routine practice.

The key element for the success of this comprehensive care appears to be patient selection at the multidisciplinary consultation. The second important point is the management of bone infection, present in virtually 100% of cases and confirmed by the pathological examination.

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