Materials and methods.— We present the extraordinary case of one, suffering from multiple disabilities following a meato-plasty and whose older sister, who has him under her charge, still has hopes, 17 years after the fact, for compensation for an apparently obvious damage. We have of course anonymized our whole presentation as per the seriousness of the presented facts.

Results.— The analysis shows: That the contribution of the rehabilitation doctor is just as important in the fair evaluation of the damage and the indispensable compensation as they are essential in recognizing the principle of compensation. That specialization of the lawyer is required to, firstly, meet the procedural requirements of expertise, on the other hand, reduce the asymmetry between the casualty and predominant insurance companies (technical staff, financial resources devoted to their defense). That cooperation between the doctor and the lawyer is required to respond appropriately to forensic hazards (questionable neutrality of the expert, exempting corporatism, orientating conclusions on biases contrary to medical ethics).

Discussion.— Is this type of case a prerogative of the French overseas departments? Is the fact that being an MPR referent of a child an obstacle to this approach?

Conclusion.— The necessary means to an accomplished rehabilitation often exceed the possibilities offered by the social protection and national solidarity. The involvement of the MPR in the indemnity issue can bring out a powerful rehabilitation leverage.

For en savoir plus

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P031-e
Evaluation and management of motor disability of congenital origin and the role of consanguinity in the region of Tlemcen

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Keywords: Motor disability; Tlemcen; Consanguinity; MIF

Introduction.— The Tlemcen region is known to be an area of high consanguinity. We were interested in the effects of consanguinity in the appraisal of debilitating congenital diseases.

Materials and methods.— A cross-sectional prospective descriptive study was conducted from January 2005 to December 2006 and included subjects with a congenital disability.

Objectives.— To describe the clinical aspects of congenital impairments, identify risk factors and the impact of consanguinity in assessing functional independence, using the scale MIF and MIF Mômes.

Results and discussion.— Sixty subjects with congenital motor disabilities, recruited during the period 2005–2006 participated in this study. The average age was 11.5 ± 10.5 years with a mean age of 14.3 years for females versus 9.3 years for boys (p = 0.05). Muscular dystrophies are the most disabling diseases, and logically oriented towards the concept of consanguinity; orphan diseases are characterized by their rarity.

Consanguinity was found in 61.7% of cases; it was present in two-thirds of neuromuscular diseases and orphan diseases. These handicaps were distributed as follows: 33 neuromuscular diseases (55% of the cohort), 12 orphan diseases (20%), and 14 birth defects (23.3%). Mean MIF was 53% (79% in patients with neuromuscular disease). Functional rehabilitation was provided present at all stages of the therapeutic programme. Consanguinity-related disability is severe, with an important psychological and economic impact.

Conclusion.— Consanguinity is a predictive risk factor for motor disability. The primary prevention is genetic counseling.

Further reading

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P032-e
Care of the 16–25 age-group in an education center for children with motor disabilities

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Keywords: 16–25 age group; Life project; Amendment Creton; SOFMER Recommendations; MDPH

The education center for children with motor disabilities (CEM) of Montrodat was provided with a special authority approval.

Since its inception in 1968, it has been allowed to welcome in-patients suffering from motor disabilities until they were 25. As a result, it prides itself on a significant experience in the care of the 16–25 age-group.

The enforcement of the laws of 2005 (about the equality of rights and life chances, participation and citizenship of disabled people), 2007 (which reformed systems of legal protection), and 2009 “hospital, patients, health-care and territories”, modified the approach and support of the 16–25 age group.

The CEM of Montrodat fitted its offers to those changes: – restructuration of transition steps within 16 and 25; – specialization of life units in homogeneous age, and life-project, groups; – late housing for youngsters coming from common facilities, after they have reached 16 years old; – welcome of young patients who had been hospitalized for years.

Further reading
Loi portant réforme de la protection juridique des majeurs no 207-308 du 5 mars 2007.
Loi Hôpital Patients Santé Territoires.
Charte européenne de l’enfant.

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P033-e
Osteoporosis and cerebral palsy: Diagnosis and treatment

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Keywords: Low bone mineral density; Cerebral palsy; Osteoporosis

Children (and adults) with cerebral palsy (CP) are now well known to present increased risk of low bone mineral density (LBMD) and fractures. Its impact on daily life is very important with regards to pain, immobilization, and may even results in juridic problems.

Osteoporosis diagnosis is suggested by spontaneous fracture(s) or is made when a very mild trauma occurred, or on systematic X-ray radiographs, or because of diffuse and chronic bone pain.
In children (adults) with CP, osteoporosis definition has been precised by ISCD (2008), i.e., the association of a significant history of fracture and a bone densitometry of less than 2 Z-score; the result has to be adjusted with regards to age, sex and height.

The main risk factors of osteoporosis in CP children (adults) are prolonged immobilization secondary to motor deficit, qualitative and quantitative deficits within food intake resulting in calcium and D vitamin deficiency, endocrine disorders such as deficit in growth hormone, puberty disorders, hypogonadism, thyroid disorders. Some medications such as carbamazepin, phenytoin, proton pump inhibitors, neuroleptics, steroids, and hepargin may also concur to the occurrence of osteoporosis in these CP children (adults).

Osteoporosis treatment is based on: eviction or correction of risk factors, bisphosphonates, and exercise when possible, verticalisation and electrotherapy.

Moreover, these various therapies are more or less standardized, and more or less efficient. Presently, there are very few studies on this pathology within that population despite that osteoporosis has major impact on the daily life of these CP children.

**Further reading**


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**P034-e**

**Assessment of muscle strength and aerobic capacity during exercise in children with cerebral palsy**

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**Keywords:** Cerebral palsy; Isokinetic; Aerobic capacity

**Introduction:** The aims of this study is to evaluate muscle function and cardiorespiratory fitness during exercise in children with cerebral palsy (CP) compared to healthy children.

**Materials and methods:** This is a prospective study of children with cerebral palsy in spastic form. No child was on wheelchairs or requires technical assistance with walking. We have included a second group of children free of any brain injury to compare the different results. All patients underwent anthropometric measure with a kind impédencemètre TANITA1 model TBF 300 (weight, height, body mass index BMI, lean mass, fat mass), functional tests, including an assessment of the strength-isokinetic muscle of both lower limbs on an isokinetic device (Cybex Norm II Medimex associated with its module TEF) and a standardized exercise test (EE) using an electromagnetical cycle ergometer (Ergoline program Zan 680).

**Result:** The average age of children with cerebral palsy (CP) was 14.7 ± 5.03 years and 14.6 ± 4.67 years for child witnesses. Children with CP have a significantly lower size than in control children (p = 0.007), however they have a higher percentage of fat mass higher than healthy children (p = 0.004). Weight and BMI and lean mass were significantly similar in both groups of children. Compared with healthy children, children with CP have isokinetic muscle strength of quadriiceps and hamstring muscles lower with respectively (p < 0.01) and (p = 0.003). The metabolic equivalent (METS) was better in healthy children (p < 0.03).

**Conclusion:** In children with CP, the aerobic capacity during exercise is lower compared with healthy children in association with an impaired maximal strength isokinetic quadriiceps and hamstring muscles deficient compared to healthy children.

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**P035-e**

**Preliminary study of validation of the Arabic dialect version of “Bread Child Questionnaire” (Varni and Thompson, 1985) in assessing pain in children**

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**Keywords:** Pain; Evaluation; Arabic dialect; Child pain questionnaire

**Objectives:** Translated into Arabic dialect and validate the “Bread Child Questionnaire” (Varni and Thompson, 1985), on a Tunisian population.

**Materials and methods:** This is a descriptive study of patients hospitalized at the department of physical medicine and rehabilitation for diverse etiologies. The “Child Bread Questionnaire” is a self- or heteroquestionnaire with two major items on the location and timing of pain with six levels of response (no pain to very acute pain). The Arabic translation was performed using the method translation/translation cons.

**Result:** Being validated.

**Conclusion:** In our exercise in MPRF with children, one is often confronted with situations inducing the frequency of pain in children with disabilities and which shape the quality of care and especially the experience of the child and family but also caregivers who find themselves “pain generators” hence the need to ensure an assessment of pain with the right tools. The translation and validation of the evaluation of “child bread questionnaire” in Arabic dialect is an interesting tool helping to provide a simple tool for measuring the acute pediatric pain in the Tunisian population.

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**P036-e**

**Upper limb in children with hemiplegia: Motor evaluations, medical and physical therapies available in 2012**

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**Keywords:** Congenital hemiplegia; Unilateral cerebral palsy; Upper limb; Motor function; Evaluation; Physical therapy

Since 10 years the upper limb’s “management” of children with spastic hemiplegia has significantly improve, whether in term of evaluation, medical and rehabilitation therapies [1].

However it remains for professionals not always easy to make the right choice within the panel of available tools.

The R4P Network (Rhône Alpes Pediatric Rehabilitation Network) undertook a work at the regional level in order to offer “good practice” recommendations on this theme.

This study includes 3 steps:

- a literature review including, epidemiology, the existing evaluation alternative as well as medicinal and physical therapies;
- a discussion of the literature findings by professional expert and their current practice, in order to draw a set of recommendation;
- dissemination of the recommendations and tools developed by the research group.

The first part of this study to be outlined during this communication cession will be related to the current situation: characteristics of the concerned population, evaluations ranked as per CIF, past and new therapies, objectives outline.

**Reference**


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