CO44-002-e

French participation in the clinical affairs committee (CAC) of the union of European medical specialists (UEMS) PRM section

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Keywords: Accreditation; Quality of care; Physical and rehabilitation medicine

Georges De Korvin and Alain Delarque, both delegates of the Syfmé to the UEMS PRM Section have involved themselves in Clinical Affairs Committee (CAC) activities, CAC deals with Quality of Care in PRM practice.

Georges De Korvin is the current CAC chairman. So far, six actions have been achieved: implementation of the UEMS PRM Accreditation Procedure of Programmes of Care (AP). Thirteen programmes have been accredited during the pilot phase and 10 programmes have been validated through the new patient centered procedure, started in 2010. AP has been a basis for funding negotiations in Austria, Estonia, Lithuania and France. Details on the website www.euro-prm.org;

– first Letter of Intention to Cooperate (LIT) was signed in Mulhouse, 2009. AP is one of the items of the LIT;
– ten papers have been published in Annals of PRM and International PRM journals;
– CAC participated in PRM Quality of Care sessions in SOFMER and in other National and International congresses;
– CAC has participated in PRM International Teaching Programmes i.e. European School Marseille on motor disabilities (ESM.MD), International Teaching Programme (ITP) Cofemer-Soﬁmer-IFRHI;
– an increasing number of French PRM specialists are contributing to CAC activities Yelnik, P.-A. Joseph, F. Le Moine, F. Boyer, J.-M. Coudreul, M. Chevignard.

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The territorial coordination of the After Care and Rehabilitation facilities (ACR): What place for the Physical Medicine and Rehabilitation (PMR) in France?

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Keywords: Care organisation; Full care cycle; Aftercare and rehabilitation

Introduction.– The fluid flow of the patients, the constitution of networks inside a coherent medical pathway from the Acute Care facilities (AC), towards the patient home or the Long-Term Care facilities (LTC) through the ACR is a stake in public health (global efﬁciency: beneﬁt/cost ratio depending the offer of health-care facilities, the Length of Stay, the link with ambulatory care).

Objective.– The institution of the ACR coordination for each health territory (decrees of April 17th and circular of October 3rd, 2008 concerning the ACR) aims at improving this patient flow (junction between AC and ACR but also towards the patient return to home, the ambulatory care and the LTC).

Means.– Their implementation needs firstly the inventory of the ACR facilities offer (deployment of Trajectory– software helping the medical orientation) and aims at the animation of an active partnership between AC, ACR, LTC and ambulatory care.

Modalities.– This activity needs:
– the clinical knowledge of the functional prognosis and of the elaboration of a life plan: functional recovery – evolutionary potential of the chronic diseases – evolutionary or ﬁxed sequelae;
– the knowledge in the socioeconomic domain: social and professional project;
– the knowledge of ACR, LTC and of the ambulatory sector (missions, means, limits);
– the ability to work in a multidisciplinary team and inside networks, to drive group;
– an interest to think and promote organisation in public health.

Conclusion.– The PMR competence can develop this ofﬁce, strong of its ability to take into account and manage the disability in a natural way inside a territory, a way which is structured and structuring, without exclusive.

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Possible ways and paths for patients highlighting necessary and useful links between rehabilitation and neuro-oncology

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Keywords: Neurooncology; Clinical pathways; Rehabilitation competence

Physiotherapy and rehabilitation make their way in the field of neuro-oncology. Indeed rehabilitation valuation might be of great help both in evolving tumor and long-term neurological sequelae induced by radio-chimiotherapy. We report three cases and suggest thereafter some possible progress in the managing of these patients.

Case 1.– Mr G., 55 yrs, has a right fronito-temporal anaplastic oligodendroglioma since 2008. Walking has progressively been more difﬁcult although cerebral MRI is stable. The rehabilitation doctor found out spasticity explained by a faecaloma and venous thrombosis. More technical aids and human formal care at home were settled.

Case 2.– Mrs. J., 58 yrs, has a pulmonary tumor revealed by bone and cerebral metastasis in 2008. She was treated with chimiotherapy and cerebral radiotherapy “in toto”. Three years after, she is falling, having limbs’ sensory paresthesia bothering her in basic activities of daily living, and suffers from behavioral and cognitive disorders. The rehabilitation doctor proposed functional physical therapy and an assessment in occupational therapy.

Case 3.– Ms L., 28 yrs had a pediatric brainstem medulloblastoma at the age of 2 yrs. She was treated in 1985 with surgery, radio and chimiotherapy. When