**English version**

**P013-e**

**Overweight after traumatic brain injury: Frontal syndrome or endocrine disorder?**

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Keywords: Severe traumatic brain injury; Hypopituitarism; Screening.

**Introduction.** Hypopituitarism is common after traumatic brain injury (TBI) and may decline spontaneously. The purpose of our work is to report a case of late-onset anterior pituitary dysfunction, comparing to the current literature and screening strategy.

**Case report.** A 19-year-old man, suffered from a frontal syndrome involving disinhobition, bulimic behavior with weight gain of 8 kg at 3 months post-severe TBI. The systematic endocrine assessment, at that moment, is normal. We check it 6 months later because of the persistence of weight gain, 7 kg over the pre-TBI weight, despite restrictive diet. A thyrotropic deficiency was found associated with an hypocortisolism. Overweight persisted despite adapted substitution treatment.

**Discussion.** In a study involving 48 cases, thyrotropic deficiency is found, in only one patient at 6 months after the TBI, while it was normal before [1]. However, the cortisol deficiency is often reported. A screening strategy emerges from the expert conference of 2011 about screening endocrine deficits after TBI. They advise the early morning basal cortisol measure, in TBI’s patient hospitalized at least 24 h, presenting tomographic abnormalities or clinically significant signs of hypocortisolism. The endocrine assessment should be performed at 6 months if clinical findings suggest hypopituitarism, and systematically at 12 months. After the first year, in severe TBI, no new onset hormone deficiency was defined, then, no more investigation is required [2]. In addition, unspecific clinical signs, as in our case, major weight gain, should sound a warning to the need to repeat the endocrine assessment during the first year in severe TBI. This reason must be raised especially if there are behavioral or cognitive disorders.

**References**


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**P014-e**

**Callosal disconnection syndrome after stroke in a left-handed patient**

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Keywords: Callosal disconnection syndrome; Stroke; Left-handed patient

**Introduction.** The corpus callosum is the major structure connecting both cerebral hemispheres. It is composed of four parts (rostrum, genu, body, splenium), each of which connects different brain areas. Corpus callosal lesions in stroke are very rare. Memory disorders, language and gesture disturbances may reveal CDS [1]. In the literature, these symptoms are usually lateralized. In right-handed subject, callosal disconnection including left tactile anomia, left hemialexia, right verbal anomia, left agraphia are described. Concerning gesture disturbances, there is predominantly right constructional apraxia and left motor apraxia and sometimes, intermanual conflict signs. Partial lesions of corpus callosum lead to a high clinical, and site-dependant variability.

**Case report.** We describe the case of a 65-year-old left-handed patient following a hemorrhagic stroke on genu and anterior body of corpus callosum, who presented gesture and language disturbances. These symptoms fluctuated from one spot to another and from one moment to another. Disorders were bilateral.

**Discussion.** With this case report, it is possible to assume that Ms D’s cerebral hemispheric functions organization is not only a simple reversal of the right-handers one. Even if symptoms were bilateral, there was a reversed predominance compared to a right-handed subject.

In that left-hemisphere lateralized person, largest exchanges could exist across the corpus callosum, which could alter interhemispheric cooperation balance.

**Conclusion.** Callosal disconnection syndrome may disturb unilateral symptoms in right-handers due to the specialization of each hemisphere. In left-handed subjects, symptoms can be bilateral, may be more related to a bihemispheric disorder with less lateralized functional consequences.

**References**


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**P015-e**

**Parenthood and disability: Care pathway of a mother with cerebral palsy**

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Keywords: Cerebral palsy; Parenthood; Pregnancy

**Introduction.** Becoming a parent for a person with a disability, ask questions similar but different than those so-called “valid”. It is necessary that the future parent can identify specific issues.

**Observation.** At the beginning of 2012, Ms. D, suffering from a dyskinetic cerebral palsy contact BreizhPC networks for her take care during pregnancy. Links were made automatically with the PMI, following the declaration of pregnancy. The project to accompany this single mother in the arrival of her first child was the proper identification of all possible support in order to offer a maximum assistance particularly on the early days of the arrival of the child. In the same time a specific rehabilitation is set up to manage the physical effects of pregnancy on disability and study aids and adaptations necessary for the daily management of the child by the mother.

The physiotherapist worked on movements and postures within the framework of a physical training adapted to the capabilities.

The occupational therapist worked on the adaptation of nursery equipment. The psychologist worked on the experience of Ms relative to its own histories and questioning about the consequences of the arrival of this baby in his life.

**Results.** More than a year after the onset of this story mom and her baby live in an apartment which is totally adapted. They benefit from human assistance 22 hours on 24 every day.

**Discussion.** It seemed interesting to share our experience to help health professionals who could be confronted with this situation and future parents with disabilities.

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**Superior mesenteric artery syndrome and denutrition**


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Keywords: Superior mesenteric artery syndrome; Parenthood; Pregnancy

**Introduction.** Superior mesenteric artery syndrome (SMAS) is a rare condition that occurs when the mesenteric vessels are compressed by the superior mesenteric artery. This compression can lead to a lack of blood flow to the intestines, resulting in intestinal ischemia and subsequent bowel infarction. The symptoms of SMAS include abdominal pain, nausea, vomiting, and, in severe cases, bowel necrosis and perforation. The treatment of SMAS is often surgical, involving repositioning or resection of the involved vessels.