Treatment of lymphoedema: State of the art
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Keywords: Lymphoedema; Physical therapies; Treatment
Lymphoedema is an oedema caused by a reduced transport capacity of the lymphatic system, whether or not in combination with an increase in lymph load. Lymphoedema is divided into primary (or congenital) or secondary (or acquired) lymphoedema. Patients may develop swelling of the upper or lower extremities or at the midline. The ‘International Society of Lymphology’ states that the best treatment of pitting lymphoedema is Decompressive Lymphatic Therapy (DLT) [1]. This is a two-stage treatment programme. During the first or intensive phase, the lymphoedema has to be maximally reduced. This phase consists of skin care, manual lymphatic drainage, multi-layer bandaging and exercises. The second or maintenance phase aims to conserve and optimize the result obtained in the first phase. It consists of skin care, compression by a low-stretch elastic sleeve, exercises and manual lymphatic drainage when needed. Patients with non-pitting lymphoedema receive exactly the same treatment, in exception of applying a multi-layer bandage. This patient group may also receive a surgical treatment, such as liposuction, performing a lymphovenous anastomosis or a lymph node transplantation [2]. Additional to Decompressive Lymphatic Therapy, patients with lymphoedema may receive intermittent pneumatic compression therapy and lymph tapping. During the presentation we will discuss the scientific evidence of the different modalities to treat lymphoedema and we will give an overview of the purpose and method of each modality.

References

Swallowing physiotherapy assessment as a predictor of unsuccessful extubation in relation to excess upper airway secretions
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Keywords: Extubation failure; Physiotherapy; Swallowing disorders; Gag reflex
Background.– Extubation failure may result from various causes including swallowing dysfunction. Scarce studies have focused on swallowing evaluation to predict extubation failure. We hypothesized that bedside swallowing assessment before extubation is helpful to identify patients at risk of extubation failure.

Method.– Funded by tender APHP multicenter prospective observational study. All consecutive patients hospitalized in the medical and surgical intensive care units of four university hospitals, intubated and mechanically ventilated for ≥6 days were included. Before extubation, the global swallowing pattern (GSP) was evaluated by a physiotherapist including: (1) cervical, oral, labial, and lingual motricity; (2) gag reflexes; (3) swallowing reflexes; (4) volume of pharyngeal secretions. Extubation was decided by the attending physicians blinded to GSP assessment. We investigated predictors of reintubation within the first 72 hours after patient’s extubation in relation to aspiration or excess upper airway secretions.

Results.– One hundred and sixty patients (age: 61 [48–75] [median [25–75% interquartile]], M/F ratio: 1.5, SAPSII: 54 [42–66], duration of mechanical ventilation: 11 days [8–17]) were included. Six patients died. Non-invasive ventilation was used in 39 patients (25%) after extubation. Post-extubation pneumonia was assessed in 10 patients. Twenty-three patients (14.5%) required reintubation, 16 within the first 72 hours with seven (4.4%) in relation to aspiration or excess upper airway secretions. Using a multivariate analysis, normal GSP significantly predicted absence of reintubation within the first 72 hours following extubation in relation to aspiration or excess upper airway secretions (odds ratio 0.42, 95% confidence interval [0.18; 0.99], p = 0.04). Presence of normal right (0.12, [0.03; 0.59]) or left gag reflexes (0.13, [0.03; 0.63]) was significantly associated to absence of reintubation, with a negative predictive value of 0.98. There was a trend for oral motricity assessed by asking the patient to grit teeth to predict the necessity of reintubation (0.22, [0.04; 1.23], p = 0.08).

Conclusion.– Normal GSP as well as presence of one or both gag reflexes is predictive of absence of reintubation in relation to aspiration and excess upper airway secretions. Our high rate of reintubation is probably due to the intubation delay, it will be interesting to perform a study with patient intubated 48 hours at least.

http://dx.doi.org/10.1016/j.rehab.2013.07.399

Treatment of the scapulohumeral dislocation due to rotator cuff syndrome: A comparative study between a manual relocating technique and a shoulder rehabilitation device
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Keywords: Dislocation; Shoulder; Rehabilitation
Aim.– Investigate the effect of analytical manual therapy relocating techniques realized by Sohier [1] (METHOD-1) on scapulo-humeral joint amplitudes and its comparison to an operator-independent shoulder rehabilitation device (METHOD-2).
Participants.– Twenty right-handed subjects (22 ± 5 ans), with no previous shoulder injuries within the past two years (Kapandji test). Mild pain was triggered among 18 subjects in the posterior passage way. The examination was completed by a "Japanese Orthopaedic Association Shoulder Score" (JOASS), which revealed scores ranging between 71.6 and 88.42%. 1a subjects completed 4 × 30 pomping (30s rest) with METHOD-2 while the other group completed METHOD-1.
Materiels.– One inclinometer (3B Scientific) allowing to measure the shoulder joint amplitude and a shoulder rehabilitation device. The affect was assessed by using an affect perception scale «Self Assessment Manikin» (SAM) [2]. Besides, a Borg-CR10 [3] was used to assess the pain perception.
Methods.– The participants were asked to complete a test, relocating maneuver (METHOD-1 or METHOD-2), and a retest after 6-8 days. The measured variables were the angles of abduction, elevation, medial and lateral rotation, and the scores obtained for the SAM and Borg-CR10 scales. A paired Student-T test was carried out in order to compare the test and retest results (p < .05).
Results.– The data analysis revealed a decrease in Borg-CR10 Scale (0.9) and an increase in SAM scale (1.5) in METHOD-1 participants. Comparable results were observed in METHOD-2 subjects with scale values of 1.25 and 1.7, respectively. The gains of amplitude in METHOD-1 participants [from 5.4 to 11.6] were observed in METHOD-2 subjects with scale values of 1.25 and 1.7, respectively.