Subjects and methods

To determine whether a cut-off primary spinal angle-value exists at which the prevalence of low back pain increases.

Introduction

The starting position of the starting position from C7 to L4 through the spine and a line perpendicular to the floor) has been tested.

Case report

We report the case of a 35-year-old type 1 diabetic patient with right upper patellar tendinopathy that had persisted for more than 6 months. The patient benefited from an intratendinous infiltration of 6 mL of PRP (8.10^5 platelets/mm^3, almost no red or white blood cells) after a carefully disinfection and without local anesthesia. Typically, a standardized program of sub-maximal eccentric rehabilitation should be started 1 week after infiltration. However, the patient experienced local swelling with erythema, increased heating and pain, which appeared just underneath the patella, without biological inflammatory syndrome. In absence of septic general symptoms, no blood or wound culture were made. At 2 weeks post-infiltration, a greatly increased Doppler signal in a thicker tendon was observed by ultrasounds compared to that before infiltration, but there was no sign of infection demonstrated by either MRI or CT. However, the local inflammation did not decrease after a 3-week treatment of local cryotherapy, local and oral NSAID, and adjunct use of colchicine 1 mg. Thus, an insidious infection was suspected, even though there was no evidence of biological inflammatory syndrome or sign of infectious lesion on imagery examination. Antibiotic therapy (rifampicin 600 mg + minocycline 100 mg), was initiated for three months. Due to a lack of improvement via imaging and clinical examination, a 3-phase bone scintigraphy was performed. The results suggested the presence of a complex regional pain syndrome type 1. The patient benefited from classical physical therapy and concomitant pain killers. The evolution was favorable after 6 months of treatment.

Discussion

Even though PRP infiltration represents a new and promising treatment for tendinopathy, more studies are needed both to verify its clinical efficacy. Moreover, implementing this innovative treatment requires caution because of potential adverse events. Thus, the balance between benefits and risks must be carefully evaluated before using this treatment, especially in patients with type 1 diabetes.

Introduction

Low back pain in golfers: Research on the influence of the starting position

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Introduction

Low back pain has a high prevalence in golfers. The strain on the lower back during the golf swing has been studied extensively through biomechanical models. An increased primary spinal angle (angle between a line from C7 to L4 through the spine and a line perpendicular to the floor) has been suggested as a risk factor for LBP in golfers. However, this hypothesis has never been tested. The aim of this study is:

– to compare the mean primary spinal angle in golfers with and without low back pain;
– to determine whether a cut-off primary spinal angle-value exists at which the prevalence of low back pain increases.

Subjects and methods

Fifty-five players were evaluated based on a questionnaire on low back pain and a measurement of their primary spinal angle in the starting position.

Results

Twenty-eight and twenty-seven players were categorized as players with and without LBP respectively. The mean primary spinal angle for players with low back pain (45.47°) was significantly higher than for players without low back pain (41.62°) (p = 0.017). ROC-analysis indicated a primary spinal angle of 44° as the best cut-off value. 69% of golfers with a primary spinal angle less than 44° never had low back pain, while only 26% of players with a primary spinal angle greater than or equal to 44° never had low back pain.

Discussion

This study shows that players with low back pain had a higher mean primary spinal angle than players without low back pain, and that the prevalence of low back pain increases in players with a primary spinal angle greater than or equal to 44°, making this angle a good risk factor to examine in every golfer with low back pain.

This knowledge together with further biomechanical evaluation of other low back pain-confounders involved in the swing could possibly lead to more focused technical and muscle training, preventing or treating low back pain in golfers.

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High level sport practice has many consequences on athletes’ health. Many studies report an unusual large number of Als cases amongst footballers. Als is characterised by muscles atrophy, may involve depression and anxiety. To date, it has no cure, and does not allow recovery. The only care for it consists in limiting the use of articulations and its maintenance but there is no way to strengthen it. This diagnosis prevents physical activity and upset the athlete’s whole way of life.

This communication tries, in the absence of data from empirical studies based on a sample allowing to statistically apprehend this trouble’s prevalence, to consider the case of a particular ex-professional female soccer player at the international level. She was born in 1954 and diagnosed with spinal onset in 2011, age of 57.

We studied and will present her emotional state following the announcement of the diagnosis, as well as the effect of ending sport practice. To evaluate emotions we used Rosenberg Self Esteem Scale and The Profile of Mood Scale in french version Self esteem is weak and emotional profil looks like iceberg profil, expected psychological profil of an elite athlete. 

The data suggests that medical and psychological care enhances psychological well being. Finding new goals can help diminish depression.

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P072-e

**Instrumental assessment of tears of the anterior cruciate ligament**

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The purpose of this study is to realize a review of the bibliography on the instrumental assessment (IA) of tears of the anterior cruciate ligament (ACL). 

Manual assessment « Gold Standard » is usually realized by the Lachman test and the Pivot-Shift (PS). However, a number of tears of the LCA (25% for S Besch) [2] are not diagnosed by these tests. For this reason, instrumental measurement are developed. This review listed three types of IA: instrumental Lachman, instrumental Pivot-Shift and studies of rotations. For instrumental Lachman, three devices are used in medical practice: KT-1000, Rolimeter and GNRB with globally same results compare to manual Lachman [1]. We point Lachman, three devices are used in medical practice: KT-1000, Rolimeter and Lachman, instrumental Pivot-Shift and studies of rotations. For instrumental Lachman, three devices are used in medical practice: KT-1000, Rolimeter and GNRB with globally same results compare to manual Lachman [1]. We point Lachman, three devices are used in medical practice: KT-1000, Rolimeter and GNRB with globally same results compare to manual Lachman [1]. We point Lachman, three devices are used in medical practice: KT-1000, Rolimeter and GNRB with globally same results compare to manual Lachman [1]. We point Lachman, three devices are used in medical practice: KT-1000, Rolimeter and GNRB with globally same results compare to manual Lachman [1].

In practice, “Gold Standard” for assessment of LCA tears remains the manual Lachman and the manual Pivot-Shift. In problematic cases, help of instrumental Lachman allows to improve diagnostic efficiency. Rolimeter is interesting because its low size and its moderate cost. The GNRB is probably the most interesting device because it avoids the problem of "operator dependency" and also improve the assessment of ACL partial tears.

**References**  

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**P073-e**

**A case of low back pain due to lumbosacral transitional vertebra in a professional triathlete**

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**Keywords:** Lumbosacral transitional vertebra; LSTV; Triathlete; Bertolli

**Introduction.**— A lumbosacral transitional vertebra (LSTV) is a common congenital anomaly, first described by Bertolli in 1917. It is characterized by an anomalous enlargement of the transverse process of the most caudal lumbar vertebra, which can articulate or fuse with the sacrum or ilium. Castellvi radiographically classified seven types. The exact role of a transitional vertebra in low back pain is unclear. Literature suggests that having a transitional vertebra does not necessitate symptoms and that the appearance of symptoms implies the presence of specific pathology.

**Observation.**— We describe the case of a 32-year-old male professional triathlete who presented with deteriorating right-sided lumbo-sacral pain not responding to conservative therapy since more than a year. A LSTV and arthritis of the pseudojoint between L5 and the adjacent sacral ala were visualized by skeletal scintigraphy and MRI. Fluoroscopically guided corticosteroid injection into the pseudarticulation eliminated the discomfort completely.

**Discussion.**— A similar case has never been described but we suggest that due to the high intensity of sports associated with professional triathlon and change in the biomechanical characteristics that comes with an LSTV, the professional triathlete is more susceptible to develop symptoms. On the other hand a triathlete could be protected by the diversity of sports associated with triathlon. Literature also indicates that not every type of LSTV has the same prevalence and severity of developing symptoms.

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