The majority of primary tumors are glioblastomas (WHO grade IV). Therapeutic progress has been made in recent years. Treatment consists of surgery, radiotherapy and chemotherapy including temozolomide. Targeted therapies, mainly focused on angiogenesis, are just added to the usual arsenal. Unfortunately, in most cases, the prognosis is too quickly involved and the management of physical medicine and rehabilitation (PMR), absolutely essential, aim to help patients to maintain their autonomy (full or partial) as long as possible, and get at home, despite many deficits, at least with a relative comfort.

Anaplastic gliomas (WHO grade III) represent an heterogeneous entity being dismembered on clinical, radiological, morphological and molecular clinical aspects. The evolution is sometimes very short in few months (rapid transformation to a glioblastoma phenotype) or sometimes longer over 15 years (it looks like to a diffuse low-grade glioma). Rehabilitation should be discussed on a "case by case" basis between neurological/oncological teams and those from rehabilitation.

Diffuse low-grade gliomas (WHO grade II) mainly affect young people (midlife). The most important advances in recent years concern surgery. The slowness of the evolution allows brain plasticity. It opens the door to functional surgery most often awake. In specialized teams, operative morbidity (excluding expected and transient worsening observed in the weeks following the procedure) is less than 5% (or less than 1%). Chemotherapy (usually oral and outpatient) is available either in the case of inoperable tumors or after surgery when growth is considered as significant (if a reoperation can not be performed).

The timing of radiotherapy is discussed. Its potential neurotoxicity and the fact that its impact is the same regardless of the time of realization make that, in a majority of teams, this treatment is delayed. Rehabilitation, most often intensive, is proposed just after surgery in order to supervise and optimize recovery. The aim is clearly to allow patients to lead a normal socio-professional life. It is also for this entity that a randomized trial (rare in this area) demonstrated the interest of cognitive rehabilitation. It is not impossible that, in a near future, rehabilitation can be initiated in the preoperative period with the aim to possibly amplify the mechanisms of plasticity and thus to promote a surgical procedure whose quality is directly related to survival.

Other primary tumors, excluding meningiomas, are rare. Progression profiles appear very heterogeneous across entities and each nosology (pilocytic astrocytomas, lymphomas, medulloloblastomas, germ cell tumors, nerve sheath tumors...). If rehabilitation should be considered, the basis should be discussed by all involved actors.

Cerebral and meningeal metastases are becoming increasingly important in daily neuro-oncology. It concerns one quarter to one third of patients treated for cancer. Although the event remains pejorative specific therapeutic are in development: optimization of surgery, stereotactic radiotherapy, chemotherapy or new targeted therapies and allow, for a little more than 10% of the affected population, to obtain long survival. Again, any specific rehabilitation should be offered at the individual level and thus discussed with all the teams. Finally, neuro-oncology/PMR interfaces also cover the management of neurological complications of cancer treatments, as peripheral (toxic polyneuropathy...) and central (immunological or related to radiotherapy side effects) or genetic diseases with their features (scoliosis, cerebrovascular diseases, gliomas, cognitive deficits in neurofibromatosis, or ocular, brain or spine hemangioblastomas for the Von Hippel Lindau disease...) all specific. Transdisciplinary strategies will again, be essential.

In conclusion, the interfaces between neurooncological diseases and specialties around the PMR are numerous. To date, only a minority of patients may benefit from specialized care. The lack of facilities and staff could at least partially be offset by strengthening the dialogue between specialists and the development of joint works including collaborations such as those implemented between SOFMER, AF SOS and ANOCEF (via the “supportive care, quality of life and cognition” group). It is clearly a priority for us.

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Manual drainage versus Lymphassist® at 40 mm Hg: Comparative plethysmographic study on upper limb lymphoedema

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Keywords: Lymphedema; Manual drainage; Plethysmography; Pneumatic compression; Upper limb

Introduction.-- Compared to manual drainage (DM), sequential pneumatic compression is sometimes presented as less efficient. This is one of the major consequences of the use of inadequate pumps or programs to irreversible lymphoedema. Their substantive processing requires a retrograde program starting at the top of the oedema.

Objective.-- The response to a DM is compared to the one of a retrograde pneumatic drainage (RPD).

Subjects and methods.-- Today, the sample includes nine women (71 years old) with an (14) years and persistent upper limb lymphedema. The DPR choose was the Lymphassist®; a program of Hydroven® (FlowtronTM, England). Its algorithm was widely copied for the DM. The choice of the value of the Lymphassist® pressure is reduced to 30 or 40 mmHg. The pressure of 40 mmHg was chosen for this study. The wave moves without pressure gradient. Each treatment lasts 16 min and is followed by a rest time of 15 min. The order of execution is drawn at random. The relative reduction of the oedema was objectified by mercury (JSITM, SU4) gauge plethysmograph; the gauge placed at 20 cm above the elbow, where the passage has been the most common.

Results.-- DM produced a gradual reduction of oedema. It reached 11.9 ml/100ml/ded after the 16 minutes of massage. After the same amount of time, the RPD response was: 0 ml/100ml/ded.

Discussion.-- DM assured an unsurprisingly decongestion and comparable to our previous studies. In contrast, the Lymphassist® showed complete inefficiency at least into the phase of substantive treatment of a former persistent lymphoedema of the upper limb.

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Allofunctional status in Belgian women one year after completion of therapy for breast cancer

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Keywords: International Classification of Functioning; Disability and health (ICF) status; Breast cancer; Rehabilitation

Purpose.-- The world health organization advises the use of the international classification of functioning disability and health as a basis for common language and concepts for the health professionals. The objective of this study was to evaluate the disability and health status after treatment for breast cancer (i.e. body function and structure, activity, participation).

Patients and methods.-- Patients receiving radiotherapy after breast cancer were followed for one year. Functioning status were assessed before (T0), at the end of the radiotherapy (T1), and after three (T3), six (T6) and twelve months (T12). Body structure and function were assessed by means of: the pain threshold test,