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AJCR (Association des Jeunes Chirurgiens du Rachis)

Newsletter #5 / Stage à New York

Un semestre à New York...

New York ville fascinante, New York ville vibrante...
Toi aussi tu as envie de faire un semestre à New York? Le Dr BITAN, chirurgien du rachis au Lenox Hill Hospital, Manhattan est de passage à Paris à la fin du mois. C'est l'occasion pour lui de nous raconter son parcours et de nous présenter son service. Il accueille des internes, futurs rachiologues, dans son service, et nous parlera des démarches à faire.
Si tu veux en faire partie, rejoins-nous au Siège de la SOFCOT - 56, rue Boissonade, Paris 14ème - le samedi 30 Avril à partir de midi. (La prochaine Réunion Parisienne du Rachis se déroulera de 10h à midi)
Un simple mail de confirmation suffit!

Rachidiennement votre,
Le bureau AJCR

Évènements à venir

- Atelier Pratique SFCR: 01 Avril 2016 - Faculté de Médecine, Nice.
  Thème abordé: Instrumentation thoraco-lombaire postérieure, percutanée et à ciel ouvert. Encadré par Stéphane Litrico et Nicolas Bronsard! Inscrivez-vous au plus vite auprès de la SFCR (www.sfcr.fr / congres@sfcr.fr)
- Réunion Parisienne du Rachis: 30 Avril 2016, 10h à 12h - Siège de la SOFCOT
- Rencontre avec le Dr BITAN: 30 Avril 2016, 12h - Siège de la SOFCOT
- Atelier pratique SFCR/AJCR: Ouverture du congrès de la SFCR à Lyon le 9 juin 2016

Sex and Spine
par Marc KHALIFÉ

En ce premier Avril, nous avons choisi un sujet un peu plus léger pour notre bibliographie mensuelle!
L'activité sexuelle de nos patients est importante pour eux, et pourtant le sujet est rarement abordé en consultation.

Le premier article a été publié dans l'European Spine Journal en 2016 et traite d'une étude menée auprès des neurochirurgiens danois. Le but était de savoir si les chirurgiens abordaient le sujet avec leurs patients, s'ils avaient conscience de leurs problèmes et s'ils leur proposaient des solutions. 89 chirurgiens d'une moyenne de 42 ans ont répondu au questionnaire: 52,3% jugent leurs connaissances très faibles; 10,2% disent n'en avoir aucune; 50% ne souhaitant pas se former d'avantage sur le sujet.
Le sujet n'est jamais abordé dans 72,4% des cas; mais l'est plus facilement avec des patients jeunes, ou ceux atteints d'un syndrome de la queue de cheval ou autre trouble neurologique.
Les raisons avancées sont: 1) l'âge du patient (41%), 2) le manque de connaissances (37,5%), 3) le manque d'initiative du patient (36%), 4) le manque de temps (26%).
35,3% des interrogés considèrent qu'il appartient au chirurgien d'aborder le sujet/ 37,5% contre.

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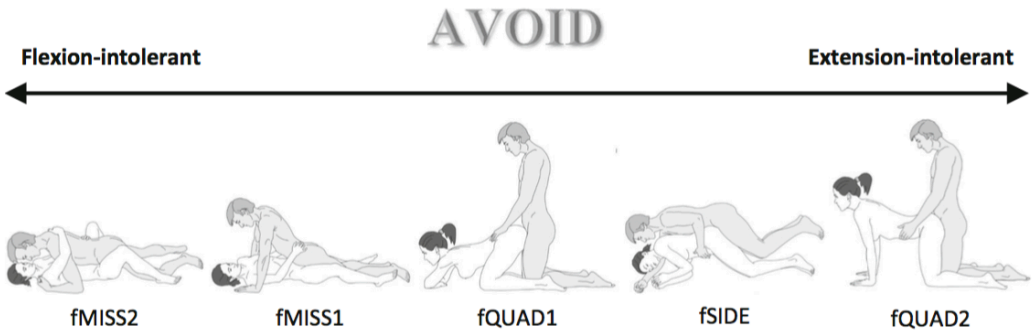
Le deuxième article a été publié dans l'European Spine Journal en 2015. C'est une étude bioméchanique sur la posture lombaire de la femme au cours du coït, étudiée via des capteurs placés sur l'épineuse de T12 et le bord droit du bassin. 10 couples ont été étudiés sur 5 positions fréquentes: En cuillère, Levrette 1 (femme en appui sur les coudes), Levrette 2 (femme en appui sur les mains), Missionnaire 1 et Missionnaire 2 (Flexion des hanches et genoux). On retrouve un travail principalement dans le plan sagittal, avec des positions plus ou moins lordosantes, permettant de tirer des recommandations selon que la patiente est plutôt intolérante à la flexion ou à l'extension.



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Le troisième article, publié dans Spine Biomechanics en 2014 est à peu près similaire pour l'étude de la posture lombaire chez l'homme. Les mêmes positions sont étudiées pour le même type de recommandation:

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Le dernier article a été publié dans le Journal of Neurosurgery:Spine en 2010 et nous parle des troubles sexuels pré- et post-exérèse d'hernie discale lombaire.
43 patients d'âge moyen 41 ans ont été inclus, et ont évalués selon: l'EVA, l'ODI, l'HADS ainsi qu'un questionnaire sur la sexualité conçu pour l'étude.
55% des hommes et 84% des femmes rapportent des troubles sexuels pré-opératoires: Diminution de la libido (47% pour les femmes, 18% pour les hommes), Dysfonction érectile et éjaculation précoce (18% des hommes). La fréquence des rapports était diminuée pour 78% des patients.
En post-opératoire: Augmentation significative de la fréquence des rapports sexuels et diminution de tous les troubles sexuels sus-cités. Le premier rapport post-opératoire était tenté à J26,5 en moyenne.

Conclusion: La vie sexuelle de nos patients est importante pour eux et est souvent altérée par la pathologie lombaire. Nous n'en parlons que très rarement avec eux, par manque d'expérience, de tempos simplement parce que nous considérons que c'est au patient lui-même d'en parler. Ils attendent de nous que nous les interrogions d'avantage sur le sujet afin de cibler leurs problèmes s'ils existent pour apporter des solutions adaptées: Conseils sur les positions plus favorables en fonction des douleurs, utilisation des hanches et des genoux au lieu du rachis lombaire, adresser à un spécialiste. Ne pas oublier que la

chirurgie peut être aussi la solution!

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Premier article:

Discussing sexual health in spinal care
N. S. Korse1 • M. P. J. Nicolai2 • S. Both3 • C. L. A. Vleggeert-Lankamp1 • H. W. Elzevier2
Eur Spine J (2016) 25:766–773 DOI 10.1007/s00586-015-3991-1

Abstract

Background The possible detrimental effects of spinal disease on sexual health are widely recognized; however, it is not known to what extent neurosurgeons discuss this topic with their patients. The aim of this study is to identify knowledge, attitude and practice patterns of neurosurgeons counseling their patients about sexual health.

Methods All members of the Dutch Association of Neu- rosurgery (neurosurgeons and residents) were sent a ques- tionnaire addressing their attitudes, knowledge and practice patterns regarding discussing sexual health.

Results Response rate was 62 % with 89 questionnaires suitable for analysis. The majority of participants (83 %) were male; mean age, 42.4 years. The mean experience in neurosurgical practice was 9 years. Respondents assumed that in 34 % of their patients, sexual health was affected due to spinal disease. The majority of respondents (64 %) stated that responsibility for discussing sexual health lies (partly) with the neurosurgeon; however, 73 % indicated to (almost) never do this. The main reasons for not discussing sexual health were patients' old age (42 %), lack of knowledge (38 %) and lack of patients' initiative to bring up the subject (36 %). Twenty-six percent indicated lack of time as a reason. There was no evidence for gender or doctor's age discordance as important barriers. Fifty per- cent of participants wished to gain more knowledge on discussing sexual health with patients.
Conclusion This study shows that despite high preva- lence of sexual dysfunction (SD) in spinal patients, coun- seling about sexual health is not often done in neurosurgical care. More training on sexual health coun- seling early in the residency program seems critical. By initiating the discussion, clinicians who deal with spinal patients have the potential to detect sexual dysfunction (SD) and to refer adequately when necessary, thereby im- proving overall quality of life of their patients.

Deuxième article:

Documenting female spine motion during coitus with a commentary on the implications for the low back pain patient
Natalie Sidorkewicz • Stuart M. McGill

Eur Spine J (2015) 24:513–520 DOI 10.1007/s00586-014-3626-y

Abstract

Purpose To describe female lumbar spine motion and posture characteristics during coitus and compare these characteristics across five common coital positions. Exac- erbation of low back pain during coital movements and positions is a prevalent issue reported by female low back pain (LBP) patients. To address this problem, the first study to examine lumbar spine biomechanics during coitus was conducted.

Methods Ten healthy males and females performed coi- tus in the following pre-selected positions and variations: QUADRUPED (fQUAD1 and fQUAD2 where the female is supporting her upper body with her elbows and hands, respectively), MISSIONARY (fMISS1 and fMISS2 where the female is minimally and more flexed at the hips and knees, respectively), and SIDELYING. An electromagnetic motion capture system was used to measure three-dimen- sional lumbar spine angles that were normalized to maxi- mum active range of motion—a transmitter and receiver were affixed to the skin overlying the lateral aspect of the pelvis and the spinous process of the twelfth thoracic vertebra, respectively. To determine if each coital position had distinct spine kinematic profiles (i.e., amplitude prob- ability distribution function and total range of lumbar spine motion), separate univariate general linear models followed by Tukey's honestly significant difference post hoc ana- lysis were used. The presentation of coital positions was randomized.

Results Female lumbar spine movement varied depend- ing on the coital position; both variations of QUADRU- PED, fQUAD1 and fQUAD2, were found to use a significantly greater range of spine motion than fMISS2 ($p = 0.017$ and $p = 0.042$, respectively). With the excep- tion of both variations of MISSIONARY, fMISS1 and fMISS2, the majority of the range of motion used was in extension. These findings are most pertinent to patients with LBP that is exacerbated by motions or postures. Based on the spine kinematic profiles of each position, the least- to-most recommended positions for a female flexion- intolerant patient are: fMISS2, fMISS1, fQUAD1, fSIDE, and fQUAD2. These recommendations would be contra- indicated for the extension-intolerant patient.

Conclusions The findings provided here may guide the clinician's specific recommendations, including alternative coital positions and/or movement patterns or suggesting a lumbar support, depending on the female LBP patient's specific motion and posture intolerances.

Troisième article:

Male Spine Motion During Coitus Implications for the Low Back Pain Patient
Natalie Sidorkewicz, MSc, and Stuart M. McGill, PhD
SPINE Volume 39, Number 20, pp 1633-1639 ©2014,

Study Design. Repeated measures design.
Objective. To describe male spine movement and posture characteristics during coitus and compare these characteristics across 5 common coital positions.
Summary of Background Data. Exacerbation of pain during coitus due to coital movements and positions is a prevalent issue reported by low back pain patients. A biomechanical analysis of spine movements and postures during coitus has never been conducted.
Methods. Ten healthy males and females engaged in coitus in the following preselected positions and variations: QUADRUPED, MISSIONARY, and SIDELYING. An optoelectronic motion capture system was used to measure 3-dimensional lumbar spine angles that were normalized to upright standing. To determine whether each coital position had distinct spine kinematic profiles, separate univariate general linear models, followed by Tukey's honestly significant difference post hoc analysis were used. The presentation of coital positions was randomized.
Results. Both variations of QUADRUPED, mQUAD1 and mQUAD2, were found to have a significantly higher cycle speed than mSIDE ($P = 0.043$ and $P = 0.034$, respectively), mMISS1 ($P = 0.003$ and $P = 0.002$, respectively), and mMISS2 ($P = 0.001$ and $P < 0.001$, respectively). Male lumbar spine movement varied depending on the coital position; however, across all positions, the majority of the range of motion used was in flexion. Based on range of motion, the least-to-most recommended positions for a male flexion-intolerant patient are mSIDE, mMISS2, mQUAD2, mMISS1, and mQUAD1.
Conclusion. Initial recommendations—which include specific coital positions to avoid, movement strategies, and role of the partner—were developed for male patients whose low back pain is exacerbated by specific motions and postures.

Quatrième article:

Assessment of sexual dysfunction before and after surgery for lumbar disc herniation
Clinical article

Naz B. Akbaş, M.D.[1], Sedat Dalbayrak, M.D.[2], Duygu G. Külcü, M.D.[3], Mesut Yılmaz, M.D.[4], Tevfik Yılmaz, M.D.[4], and Sait Naderi, M.D.[5]
Journal of Neurosurgery: Spine, Nov 2010 / Vol. 13 / No. 5 / Pages 581-585

OBJECT

Sexuality is an important aspect of human life. Sexual activity may be affected in lumbar disc herniation through different mechanisms. The aim of this study is to evaluate patients' sexual problems and sexual behavior patterns before and after surgical treatment of lumbar disc herniation.

METHODS

Forty-three patients were included in the study (mean age 41.4 years). A visual analog scale, the Oswestry Disability Index, the Hospital Anxiety and Depression Scale, and a sexuality assessment questionnaire developed for this study were administered to the patients to evaluate pain and sexual dysfunction.

RESULTS

Fifty-five percent of the men and 84% of the women reported experiencing sexual problems after the onset of low-back pain. The most common sexual problems were decreased sexual desire (18%) and premature ejaculation together with erectile dysfunction (18%) for the male patients, and decreased sexual desire (47%) for the female patients. The frequency of sexual intercourse before the operation was reduced in 78% of cases compared with the pain-free period. Postoperatively, the patients first attempted sexual intercourse a mean of 26.5 days after surgery. The frequency of intercourse was found to have increased ($p = 0.01$), while description of any type of sexual problem had decreased ($p = 0.005$) significantly.

CONCLUSIONS

Lumbar disc herniation has negative effects on sexual life, and not enough attention is given to the patients' sexual problems by the physicians. Decreased sexual desire and decreased sexual intercourse are the most commonly reported problems. Taking time during examination and giving simple recommendations may improve sexuality and life quality of the patients.