

It is reported that there was no prostatic hypertrophy in this 55-year-old patient.

EB Ultimately, a new cystomanometry was performed in May 2024, apparently revealing detrusor oedema at 200 ml (oedema not seen).

This, of course, suggests the possibility of a neurovesicocentrale secondary to the spinal lesion.

In October 2024, he agreed to self-condrainage, which he performed 3 times a day (only...) and... only... for 2 months.

At present, therefore, he has stopped all self-drainage; he is discreetly nycturic with nocturnal rising and little pollakiuric with an intermictional delay of 3 hours.

There does not appear to be any alteration in the perception of the need to urinate or the urethral passage of urine.

There may be some urgency, but he describes a safety time of more than 20 minutes and little or no leakage on urgency.

He is rather frankly dysuric, with a diminished stream and fractured micturition, but he does not usually become infected, and there is no leakage on exertion in the hypothesis of "regorgement".

Alongside these vesico-sphincter disorders, there are significant anorectal disorders, with true constipation (one bowel movement every 3 days) associated with a degree of dyschezia (but without the need for digital evacuation).

He has regular episodes of fecal hypocontinence with defecatory emergencies, and therefore active anal incontinence with a safety time of less than 5 minutes.

This is compounded by his rather anxious psychological state, with occasional panic attacks concerning the imminence of the need to defecate, which makes his daily life, and particularly his professional life, extremely complex.

On the genito-sexual side, however, no dyserection, dysejaculation or dysorgasmia were reported.

On neurological examination, I won't go back over the spasticity of the lower limbs. Bilateral pyramidal syndrome with Babinski sign.

There is no major orthopedic deformity.

In my opinion, neurological rehabilitation treatment specialized in spasticity of the spinal cord injured patient is highly indispensable.

I'll give him the contact details of my colleague Professor François GENET at the RAYMOND-PIONCARE hospital in GARCHES, who deals specifically with these problems and will undoubtedly be able to help him.

As far as the neuroperineal examination is concerned, there is clearly no hypoesthesia in the sacral territories, and in any case the reflexes of the medullary cord (anal reflex to coughing, anal reflex to pain, etc.) are not affected.

hu1bo-anal, reflexebulbo-cavernous) are well preserved, testifying to the integrity, at least in part, of the terminal cone and thus to the possibility of an "automatic" bladder... the risks of which are well known.

Control of the external sphincter is totally abolished, and tone is not greatly increased.

In the final analysis, he poses the problem of the neuroperineal sequelae of a spinal lesion, with urinary disorders characterized possibly by incomplete retention, certainly by dysuria, some leakage in emergencies with complications (ureterohydronephrosis); associated with significant anorectal disorders (dyschezia, constipation, fecal incontinence in emergencies), without genito-sexual disorders; all in a context of significant spasticity of the lower limbs.

Clearly, multimodal management is absolutely essential.

I won't go back over the spasticity of the limbs, which Professor GENET will be dealing with in copy of this letter.

Conceiving the neuroparal sphère, it is essential to take into account anorectal disorders in the treatment and management of neurological bladder, if only as part of a bladder-rectum "Cross Talk".

Regarding his anorectal disorders, of course he can try modifiers du trafic (MOVICOL, SPAGULAX) as well as volumetric exonerating suppositories (**EDUCTYL**).

But above all, we will very probably very quickly end up with trans-anal colonic irrigations (PERISTEEN), which could be very beneficial for him, including psychologically.

It is quite possible that there is a real recto-anal dyssynergy in the context of perineal spasticity, and here again, of course, we could discuss toxin injections in the pubo-rectum, or even toxin injections in the rectum to avoid fécalœ impdriosities, but, of course, colonic irrigations would be the solution.

The work-up could be completed by a transit time for radio-opaque markers, defecography and anorectal manometry.

From a vesice-sphincter point of view, it is absolutely inais@nsable to have a renal **échography**, a new renal biology and above all urodynamic explorations in standard and sensitizing condiãons (slow filling, fast filling, ice water test, ...) in order to better understand the physiopathological mechanisms of this neurovessia and propose an adapted treatment.

If we assume that the patient has a central neurovessel with dëtusor hyperactivity, we must stabilize this filling phase to avoid hyperpressure, which can be deleterious to the upper apparatus, using anticholinergics or beta-3 adrenergic agonists, or intra-detrusor injections of botulinum toxin, before imagining anything more complicated.

Of course, the emptying phase must be treated (after urodynamic video or retrograde urethrocystography with per-mictional films to check for reflux).

This emptying should at best be ensured to avoid per-mictional hyperpressures by self-catheterization, for which therapeutic education should be completely reviewed (choice of catheter, position, etc.).

I hope that Mr GAITO has understood all this, and that he will think carefully about the necessity of self-catheterization.

I remain at his disposal to organize all these urodynamic tests during a brief day hospitalization.

 Yours faithfully, Madame, et Chère Confrère, à l'assurance de mes sentiments les meilleurs."

P.S.: Of course, renal function will need to be checked, firstly by a biologie de contrôle and perhaps even by a scintigraphy, but we'll see all this during the day hospitalization.

Appointment made

- 05/16/2025 at 08:45 : (PSL HDJ NEURO UROLOGIE - BOTTARD 2EME)

Courier validated electronically by Professor AMARENCO GERARD /e 17Æ3/2025

Professor G. AMARENCO
PUPH

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