Traitement médico-chirurgicaux des douleurs pelvipérinéales chroniques: Premier palier de traitement

Th Riant
Premier palier de traitement

1. Validation de la plainte, démembrement, reconnaissance d’objectifs communs
2. Thérapie manuelle
3. Regimes
4. Acupuncture
5. Neurostimulation
6. Approche psychocomportementale
7. Traitement de la cause si possible
Validation de la plainte

• Injustice, colère, catastrophisme
  • Principaux facteurs psychologiques de pérénisation des douleurs
  • Souvent légitime
    • Expertise limitée à la cause de la douleur et non à la souffrance
    • Spécialistes d’organe répondent sur l’organe
    • Hétéroévaluation toujours sous évaluation

• Croire le patient dans sa plainte
• « comme vous ne pouvez pas prouver, je ne peux prouver que je vous crois »

The role of perceived injustice in the experience of chronic pain and disability: Scale development and validation.
Objectifs communs

• Pas de traitement miracle
• Effets secondaires fréquents
• Traitements inconstamment efficaces
• Peu d’EBM

Définir les priorités du patient
Définir les critères d’évaluation du patient
Montrer les améliorations
Objectifs communs ??
Les drapeaux rouges

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>MEDECIN</th>
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<td>• Guerir?</td>
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<td>• Moins souffrir?</td>
<td>• Précéder le patient dans sa plainte</td>
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<td>• Voir ces évolutions</td>
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Premier palier de traitement

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Some physiotherapy treatments may relieve menstrual pain in women with primary dysmenorrhea: a systematic review.

Kannan P1, Claydon LS2.

Author information

Abstract

QUESTION:
In women with primary dysmenorrhea, what is the effect of physiotherapeutic interventions compared to control (either no treatment or placebo/sham) on pain and quality of life?

DESIGN:
Systematic review of randomised trials with meta-analysis.

PARTICIPANTS:
Women with primary dysmenorrhea.

INTERVENTION:
Any form of physiotherapy treatment.

OUTCOME MEASURES:
The primary outcome was menstrual pain intensity and the secondary outcome was quality of life.
RESULTS:
The search yielded 222 citations. Of these, 11 were eligible randomised trials and were included in the review. Meta-analysis revealed statistically significant reductions in pain severity on a 0-10 scale from acupuncture (weighted mean difference 2.3, 95% CI 1.6 to 2.9) and acupressure (weighted mean difference 1.4, 95% CI 0.8 to 1.9), when compared to a control group receiving no treatment. However, these are likely to be placebo effects because when the control groups in acupuncture/acupressure trials received a sham instead of no treatment, pain severity did not significantly differ between the groups. Significant reductions in pain intensity on a 0-10 scale were noted in individual trials of heat (by 1.8, 95% CI 0.9 to 2.7), transcutaneous electrical nerve stimulation (2.3, 95% CI 0.03 to 4.2), and yoga (3.2, 95% CI 2.2 to 4.2). Meta-analysis of two trials of spinal manipulation showed no significant reduction in pain. None of the included studies measured quality of life.

CONCLUSION:
Physiotherapists could consider using heat, transcutaneous electrical nerve stimulation, and yoga in the management of primary dysmenorrhea. While benefits were also identified for acupuncture and acupressure in no-treatment controlled trials, the absence of significant effects in sham-controlled trials suggests these effects are mainly attributable to placebo effects.
Premier palier de traitement

1. Validation de la plainte, démembrement, reconnaissance d’objectifs communs
2. Thérapie manuelle
3. Regimes
4. Acupuncture
5. Neurostimulation
6. Approche psychocomportementale
7. Traitement de la cause si possible
Polyamine deficient diet to relieve pain hypersensitivity.


Université Bordeaux 2, Université Bordeaux 1, UMR CNRS 5227, "Mouvement-Adaptation-Cognition", Team "Homéostasie-Allostasie-Pathologie-Réhabilitation", 146 Rue Léo Saignat, 33076 Bordeaux Cedex, France.

There is a compelling body of evidence that N-methyl-d-aspartate receptors (NMDA-R) play a critical role in the development and maintenance of pain hypersensitivity. However, long-term treatments with NMDA-R antagonists are limited by unacceptable side effects. Since polyamines modulate the functioning of NMDA-R and mainly originate from normal dietary intake and bacterial metabolism in the gut, we developed a nutritional therapy based on dietary polyamine deficiency. Here, we reported that a polyamine deficient diet (PD diet) for 7 days prevented the enhancement of tyrosine phosphorylation of the spinal NR2B subunit-containing NMDA-R associated with inflammation in rats. Based on these data, we studied the ability of PD diet to prevent long-lasting pain hypersensitivity associated with tissue injury on one hind paw by evaluating long-lasting changes in both mechanical nociceptive threshold and weight bearing. A PD diet strongly reduced long-lasting hyperalgesia induced by inflammation or incision, especially in fentanyl-treated rats. Moreover a PD diet also prevented the exaggerated hyperalgesia induced by a second inflammation performed 7 days after the first one. A PD diet also opposed
paradoxical hyperalgesia induced by non-nociceptive environmental stress in rats with pain and opioid experiences. A PD diet reversed pain hypersensitivity associated with monoarthritis or neuropathy and restored the analgesic effect of morphine. Since PD diet was devoid of any noticeable side effects, this nutritional therapy could be part of an effective and safe strategy for pre-emptive analgesia and for reducing the transition from acute to chronic pain and its outcomes in various pain syndromes.
Premier palier de traitement

1. Validation de la plainte, démembrement, reconnaissance d’objectifs communs
2. Thérapie manuelle
3. Régime
4. Acupuncture
5. Neurostimulation
6. Approche psychocomportementale
7. Traitement de la cause si possible
Acupuncture, Acupunctures

Acupuncture traditionnelle, electroacupuncture, semi permanente, acupression...
Premier palier de traitement

1. Validation de la plainte, démembrement, reconnaissance d’objectifs communs
2. Thérapie manuelle
3. Régime
4. Acupuncture
5. Neurostimulation transcutanée
6. Approche psychocomportementale
7. Traitement de la cause si possible
Stimulation électrique transcutanée

• Les dermatomes
  • Rétrotibiale
  • Dorsolombaire
  • inguinales
• Locodolenti?
• Vagale via la branche auriculaire du vague?
Transcutaneous electrical nerve stimulation as an additional treatment for women suffering from therapy-resistant provoked vestibulodynia: a feasibility study.

Vallinga MS1, Spoelstra SK, Hemel IL, van de Wiel HB, Weijmar Schultz WC.

Abstract

INTRODUCTION:
The current approach to women with provoked vestibulodynia (PVD) comprises a multidimensional, multidisciplinary therapeutic protocol. As PVD is considered to be a chronic pain disorder, transcutaneous electrical nerve stimulation (TENS) can be used as an additional therapy for women with otherwise therapy-resistant PVD.

AIMS:
The aims of this study were to evaluate whether TENS has a beneficial effect on vulvar pain, sexual functioning, and sexually-related personal distress in women with therapy-resistant PVD and to assess the effect of TENS on the need for vestibulectomy.

METHODS:
A longitudinal prospective follow-up study was performed on women with therapy-
resistant PVD who received additional domiciliary TENS. Self-report questionnaires and visual analog scales (VASs) were completed at baseline (T1), post-TENS (T2), and follow-up (T3).

**MAIN OUTCOME MEASURES:**
Vulvar pain, sexual functioning, and sexually-related personal distress were the main outcome measures.

**RESULTS:**
Thirty-nine women with therapy-resistant PVD were included. Mean age was 27 ± 5.6 years (range: 19 to 41); mean duration between TENS and T3 follow-up was 10.1 ± 10.7 months (range: 2 to 32). Vulvar pain VAS scores directly post-TENS (median 3.4) and at follow-up (median 3.2) were significantly (P < 0.01) lower than at baseline (median 8.0). Post-TENS, sexual functioning scores on the Female Sexual Functioning Index questionnaire had improved significantly (P = 0.2); these scores remained stable at follow-up. Sexually-related personal distress scores had improved significantly post-TENS (P = 0.01). Only 4% of the women who received TENS needed to undergo vestibulectomy vs. 23% in our previous patient population.

**CONCLUSION:**
The addition of self-administered TENS to multidimensional treatment significantly reduced the level of vulvar pain and the need for vestibulectomy. The long-term effect was stable. These results not only support our hypothesis that TENS constitutes a feasible and beneficial addition to multidimensional treatment for therapy-resistant PVD, but also the notion that PVD can be considered as a chronic pain syndrome.


**Effectiveness of complementary pain treatment for women with deep endometriosis through Transcutaneous Electrical Nerve Stimulation (TENS): randomized controlled trial.**
Mira TA1, Giraldo PC1, Yela DA1, Benetti-Pinto CL2.

**Author information**

**Abstract**

**OBJECTIVE:**
Evaluate TENS effectiveness as a complementary treatment of chronic pelvic pain and deep dyspareunia in women with deep endometriosis.

**STUDY DESIGN:**
This randomized controlled trial was performed in a tertiary health care center, including twenty-two women with deep endometriosis undergoing hormone therapy with persistent pelvic pain and/or deep dyspareunia. This study was registered in the Brazilian Record of Clinical Trials (ReBEC), under n RBR-3rndh6. TENS application for 8 weeks followed a randomized allocation into two groups: Group 1 - acupuncture-like TENS (Frequency: 8Hz, pulse duration: 250μs) - VIF (n=11) and Group 2 - self-applied
TENS (Frequency: 85Hz, pulse duration: 75μs) (n=11). The intensity applied was "strong, but comfortable". We evaluated patients before and after treatment by the use of the Visual Analogue Scale, Deep Dyspareunia Scale and Endometriosis Quality of Life Questionnaire. We used the Wilcoxon and Mann-Whitney tests to compare before and after treatment conditions.

RESULTS:
Despite the use of hormone therapy for 1.65±2.08 years, the 22 women with deep endometriosis sustained pelvic pain complaints (VAS=5.95±2.13 and 2.45±2.42, p<.001) and/or deep dyspareunia (DDS=2.29±0.46 and 1.20±1.01, p=.001). We observed significant improvement for chronic pelvic pain, deep dyspareunia and quality of life by the use of TENS. Both application types of TENS were effective for improving the evaluated types of pain.

CONCLUSIONS:
Both resources (acupuncture-like TENS and self-applied TENS) demonstrated effectiveness as a complementary treatment of pelvic pain and deep dyspareunia, improving quality of life in women with deep endometriosis regardless of the device used for treatment.

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KEYWORDS:
Chronic pelvic pain; Dyspareunia; Endometriosis; Physical therapy; Transcutaneous Electrical Nerve Stimulation

Neuroscience. 2009 Jul 2. [Epub ahead of print]Click here to read Links

Transcutaneous electrical nerve stimulation at both high and low frequencies activates ventrolateral periaqueductal grey to decrease mechanical hyperalgesia in arthritic rats.

Desantana JM, da Silva LF, de Resende MA, Sluka KA.

Department of Physical Therapy, Federal University of Sergipe, Aracaju, Cidade Universitária Professor José Aloísio de Campos. Av. Marechal Rondon, s/n, Jardim Rosa else, São cristóvão/Surgipe, Brazil, 49.1000.

Transcutaneous electric nerve stimulation (TENS) is widely used for the treatment of pain. TENS produces an opioid-mediated antinociception that utilizes the rostroventromedial medulla (RVM). Similarly, antinociception evoked from the periaqueductal grey (PAG) is opioid-mediated and includes a relay in the RVM. Therefore, we investigated whether the ventrolateral or dorsolateral PAG mediates antinociception produced by TENS. Paw and knee joint mechanical withdrawal thresholds were assessed before and after knee joint inflammation (3% kaolin/carrageenan), and after TENS stimulation (active or sham). Cobalt chloride (CoCl(2); 5 mM) or vehicle was microinjected into the ventrolateral periaqueductal
grey (vIPAG) or dorsolateral periaqueductal grey (dIPAG) prior to treatment with TENS. Either high (100 Hz) or low (4 Hz) frequency TENS was then applied to the inflamed knee for 20 min. Active TENS significantly increased withdrawal thresholds of the paw and knee joint in the group microinjected with vehicle when compared to thresholds prior to TENS (P<0.001) or to sham TENS (P<0.001). The increases in withdrawal thresholds normally observed after TENS were prevented by microinjection of CoCl(2) into the vIPAG, but not the dIPAG prior to TENS and were significantly lower than controls treated with TENS (P<0.001). In a separate group of animals, microinjection of CoCl(2) into the vIPAG temporarily reversed the decreased mechanical withdrawal threshold suggesting a role for the vIPAG in the facilitation of joint pain. No significant difference was observed for dIPAG. We hypothesize that the effects of TENS are mediated through the vIPAG that sends projections through the RVM to the spinal cord to produce an opioid-mediated analgesia.

Urology. 2009 May;73(5):1036-41.Click here to read Links

Electroacupuncture relieves pain in men with chronic prostatitis/chronic pelvic pain syndrome: three-arm randomized trial.

Lee SH, Lee BC.

Department of Internal Medicine, Division of Urology and Nephrology, College of Oriental Medicine, Kyung Hee University, Seoul, Republic of Korea.

OBJECTIVES: To investigate the clinical effect of electroacupuncture (EA) for chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). METHODS: We recruited 63 participants meeting the U.S. National Institutes of Health (NIH) consensus criteria for CP/CPPS. After the inclusion/exclusion criteria were applied, 39 men were randomized to 3 treatment groups: group 1, advice and exercise plus 12 sessions of EA; group 2, advice and exercise plus 12 sessions of sham EA (SEA); and group 3, advice and exercise alone (A&E) for 6 weeks. A total of 6 acupuncture points were used to stimulate the sacral nerve and release the piriformis muscle using an electrical pulse generator. Symptoms related to CP/CPPS were assessed using the NIH-Chronic Prostatitis Symptom Index (NIH-CPSI). Prostaglandin E(2) and beta-endorphin levels in postmassage urine samples were measured using an enzyme-linked immunosorbent assay. RESULTS: At 6 weeks, the NIH-CPSI total score had decreased significantly in the EA group compared with the SEA and A&E groups (P < .001). On a subscale analysis of the NIH-CPSI, the EA group showed significant decreases in pain-related symptoms compared with the SEA and A&E groups (P < .01). All 12 EA participants experienced at least a 6-point decrease in the NIH-CPSI total score compared with 2 of 12 SEA participants (16.7%) and 3 of 12 A&E participants (25.0%; P < .0001). The mean prostaglandin E(2) level in the postmassage urine samples had significantly decreased in the EA group (P = .023). In contrast, it had increased in the other 2 groups. CONCLUSIONS: In a 3-arm randomized trial
investigating the clinical effects of EA on CP/CPPS, EA therapy proved to have independent therapeutic effects, particularly for pain relief superior to SEA or A&E therapy.

Zhonghua Yi Xue Za Zhi. 2009 Apr 14;89(14):947-50. Links
[Transcutaneous electrical nerve stimulation improves oppilative symptoms and increases colonic transit in patients with slow transit constipation]
[Article in Chinese]

Shi N, Liu S, Xie XP, Hou XH.

Division of Gastroenterology, Hospital of Binzhou Medical College, Binzhou 256603, China.

OBJECTIVE: To evaluate the therapeutic value of transcutaneous electrical nerve stimulation (TENS) at acupoints in slow transit constipation (STC). METHODS: Thirty-nine patients with (STC) who met the Rome III diagnostic criteria, were randomly assigned to 2 groups: TENS treatment group including 2 males and 18 females, aged (46 +/- 14), undergoing TENS at the acupoints ST36 (Zusanli) and PC6 (Neiguan) twice a day, 30 min after breakfast and 30 min before going to bed, for 2 weeks, and control group, including 2 males and 17 females, undergoing sham TENS treatment at 2 sham acupoints. Questionnaire survey was conducted to investigate the dyschesia scores. Self-rating depression scale (SDS) and self-rating anxiety scale (SAS) were used to assess the depression and anxiety status. X-ray examination with barium strips, radiopaque marker, was used to detect the colonic transit status. RESULTS: (1) The dyschesia symptom total score after treatment in the TENS treatment group was (9.05 +/- 0.58), significantly lower than that before treatment (18.30 +/- 0.45, P < 0.01), and the oppilative symptom total score after the sham treatment of the control group was (18.00 +/- 0.46), not significantly different from that before the treatment (18.03 +/- 0.45, P > 0.05). (2) The number of vestigial barium strips of the TENS treatment group was (7.2 +/- 1.2), significantly lower than that before treatment (15.1 +/- 1.1, P < 0.01), and the change was especially obvious in the colon sector (3.3 +/- 0.8 vs 11.0 +/- 1.0, P < 0.01). However, there was no significant difference in the number of barium strips in the control group before and after the sham treatment. (3) The score of SDS and SAS of the TENS treatment group after the treatment were 34.7 +/- 0.9 and (43.7 +/- 1.5 respectively, both significantly lower than those before the treatment (37.3 +/- 0.9 and 48.1 +/- 1.8 respectively, both P < 0.05), however, there were not significant differences in the SDS and SAS scores before and after the sham treatment in the control group. CONCLUSION: TENS at the acupoints Zusanli and Neiguan is capable of improving the oppilative symptoms and ameliorating anxiety and depression state, promoting colonic transit in STC patients.
Minerva Ginecol. 2008 Dec;60(6):485-91. Links
[Use of transcutaneous electrical stimulation and biofeedback for the treatment of vulvodynia (vulvar vestibular syndrome): result of 3 years of experience]
[Article in Italian]

Dionisi B, Anglana F, Inghirami P, Lippa P, Senatori R.
Servizio di Diagnosi e Terapia delle Disfunzioni del Pavimento Pelvico e Dolore Vulvare, Casa di Cura Santa Famiglia Roma, Italia. b.dionisi@tiscali.it

AIM: The safety, tolerability and efficacy of physical therapy with biofeedback and trans electrical nerve stimulation (TENS) with intravaginal probe for the treatment of vulvar pain and vulvar discomfort in women with vulvodynia, is evaluated in the present study. Vulvodinia is a chronic syndrome of unexplained vulvar pain. Patients typically present with a history of intermittent or continuous, localized, vulvar pain, frequently accompanied by sexual dysfunction like entry dyspareunia, burning and itching localized to the vulvar vestibule. METHODS: From January 2005 and June 2007, a total 145 women diagnosed with vulvodynia presented in the ambulatory for the Diagnosis and Treatment of Vulvar Pain and Pelvic Floor Dysfunction, Clinical "Santa Famiglia", Rome. Patients were treated with weekly biofeedback (BFB) and transcutaneous electroanalgesia (TENS), in association with functional electrical stimulation (FES) and home-therapy with stretching exercise of pelvic floor. RESULTS: Hundred forty-five women completed both the biofeedback and trans electric nerve stimulation treatment for a total of 10 application, with a improvement of vulvar pain in 75.8% of cases. CONCLUSION: The pelvic floor relaxation with biofeedback and electroanalgesia is safe and effective in improvement in vulvar pain and dyspareunia in women with vulvodynia.

Int Braz J Urol. 2008 Nov-Dec;34(6):708-13; discussion 714. Click here to read Links
Transcutaneous electrical nerve stimulation (TENS) in the symptomatic management of chronic prostatitis/chronic pelvic pain syndrome: a placebo-control randomized trial.
Sikiru L, Shmaila H, Muhammed SA.

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OBJECTIVE: The aim of the study was to investigate the therapeutic efficacy of transcutaneous electrical nerve stimulation (TENS) in the symptomatic management of chronic prostatitis pain/chronic pelvic pain syndrome. DESIGN: A pretest, posttest randomized double blind design was used in data collection. PARTICIPANT: Twenty-four patients diagnosed with chronic prostatitis- category IIIA and IIIB of the National
Institute of Health Chronic Pain (NIH-CP) were referred for physiotherapy from the Urology department. INTERVENTION: Pre treatment pain level was assessed using the NIH-CP (pain domain) index. The TENS group received TENS treatment, 5 times per week for a period of 4 weeks (mean treatment frequency, intensity, pulse width and duration of 60 Hz, 100 microS, 25 mA and 20 minutes respectively). The Analgesic group received no TENS treatment but continued analgesics; the Control group received no TENS and Analgesic but placebo. All subjects were placed on antibiotics throughout the treatment period. OUTCOME MEASURES: Post-treatment pain level was also assessed using NIH-CP pain index. RESULT: Findings of the study revealed significant effect of TENS on chronic prostatitis pain at p < 0.05. CONCLUSION: TENS is an effective means of non-invasive symptomatic management of chronic prostatitis pain.

Cochrane Database Syst Rev. 2001;(3):CD003222.Click here to read Links

Update in:

Transcutaneous electrical nerve stimulation (TENS) for chronic pain.
Carroll D, Moore RA, McQuay HJ, Fairman F, Tramèr M, Leijon G.

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BACKGROUND: Transcutaneous electrical nerve stimulation (TENS) is used in a variety of different clinical settings to treat a range of different acute and chronic pain conditions and has become popular with both patients and health professionals. OBJECTIVES: To evaluate the effectiveness of TENS in chronic pain. SEARCH STRATEGY: The Cochrane Library, Embase, Medline, CINAHL and The Oxford Pain Database were searched. Reference lists from retrieved reports and reviews were examined. Date of the most recent search: March 1999. SELECTION CRITERIA: RCTs were eligible if they included the following treatment comparisons: active TENS versus sham TENS controls active TENS versus no treatment controls active TENS versus active TENS controls (for instance High Frequency TENS vs Low Frequency TENS) Studies of patients suffering chronic pain for three months or more which included subjective outcome measures for pain intensity, or pain relief were eligible for evaluation in this review. No restrictions were made to language or sample size. Data from abstracts, letters, or unpublished studies, and studies of TENS in angina, headache and migraine, and dysmenorrhoea were not included. DATA COLLECTION AND ANALYSIS: Data were extracted and summarised on the following items: patients and details of pain condition, study treatments, study duration, design, methods, subjective pain outcome measures, methodological quality, results for pain outcome measures and adverse effects, and the conclusions made by the authors of the original studies.
Extracted data and methodological quality of each report was confirmed by at least three of the reviewers. MAIN RESULTS: Of 107 reports identified from the searches, 88 were excluded as they did not fulfil the pre-defined entry criteria. Nineteen RCTs (from 18 reports) were evaluated. The included trials varied in terms of design, analgesic outcomes, chronic pain conditions, TENS treatments and overall methodological quality. Studies included single and multiple dose treatment comparisons of TENS. The studies were small. The reporting of the methods used and results for the analgesic outcomes were generally poor. TENS treatments and controls were often poorly defined. Few studies evaluated the long-term analgesic effectiveness of TENS and single dose evaluations of TENS are unhelpful in making clinical decisions of the long-term effectiveness of TENS in the management of chronic pain. Meta-analysis was not possible. Overall in 10 of 15 inactive control studies there was a positive analgesic outcome in favour of the active TENS treatments. For the multiple dose treatment comparison studies only three of seven were considered to be in favour of the active TENS treatments. For the active controlled studies, seven studies made direct comparisons between HFTENS and LFTENS. Five of seven studies could find no difference in terms of analgesic efficacy between HFTENS and LFTENS at any time point. REVIEWER’S CONCLUSIONS: The results of this review are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Large multi-centre randomised controlled trials of TENS in chronic pain are urgently needed.

Treatment of dysmenorrhoea with a new TENS device (OVA).
Schiøtz HA, Jettestad M, Al-Heeti D.

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hjalmar.schiotz@siv.no

Transcutaneous electrical nerve stimulation (TENS) is an established method for pain relief in dysmenorrhoea, which does not involve the use of medication. This prospective study evaluated the clinical utility of a new, very small and light, high frequency TENS device in 21 menstruating women during four menstrual cycles. The efficacy measures were pain relief evaluated on a VAS scale and reduction in use of analgesic tablets. All the participants subjectively found the device useful. There was a statistically significant drop in mean pain score from 6.73 to 5.18 points (p = 0.0009). Concurrent use of analgesic tablets was also significantly reduced (p = 0.03) and seven women stopped taking analgesics while using the device (p = 0.02). There were no adverse events. On follow-up 6 - 8 months post study, 14 of the women were still using the device regularly. This TENS device appears to be a useful treatment alternative for dysmenorrhoea.
Transcutaneous electrical acustimulation can reduce visceral perception in patients with the irritable bowel syndrome: a pilot study.

Xing J, Larive B, Mekhail N, Soffer E.

Department of Gastroenterology, Biostatistics, Cleveland Clinic Foundation, Cleveland, OH, USA.

OBJECTIVES: Acupuncture has been used as a therapy for various gastrointestinal disorders, including irritable bowel syndrome (IBS). However, there is scant information on the effect of acupuncture on gut physiology. The purpose of this study was to evaluate the effect of transcutaneous electrical acustimulation (TEAS) on rectal tone, compliance and perception in IBS patients. METHODS: Seven patients with diarrhea-predominant IBS were studied during control, sham stimulation and acupoints (ST36 and P6) stimulation periods. Rectal tone, compliance and perception to rectal balloon distension were assessed with a barostat apparatus. RESULTS: Acustimulation at ST36 and P6, but not sham stimulation, significantly increased the threshold of rectal sensation of gas, desire to defecate and pain, as compared to control period. However, rectal tone and compliance were not significantly affected during TEAS. CONCLUSIONS: TEAS, at the above acupoints, can reduce rectal sensitivity in IBS patients. The effect is not modulated by changes in rectal biomechanics.

Esophageal visceral pain sensitivity: effects of TENS and correlation with manometric findings.

Börjesson M, Pilhall M, Eliasson T, Norssell H, Mannheimer C, Rolny P.

Multidisciplinary Pain Center, Department of Medicine, Sahlgren's University Hospital/Ostra, Gothenburg, Sweden.

Increased esophageal visceral sensitivity has been suggested to be an important factor in the development of esophageal chest pain. Transcutaneous electrical nerve stimulation (TENS) has been found effective in the treatment of visceral heart pain in severe angina pectoris, but its effect on esophageal pain perception is not known. In this study, we used the method of graded intraesophageal balloon distension to study the effects of TENS on esophageal motility and pain sensitivity. In addition, we explored the relationship between manometric findings and esophageal susceptibility to pain. TENS reduced symptoms during balloon distension significantly and decreased peristaltic velocity. Increased visceral perception was positively correlated
to the amplitude and duration of the esophageal peristalsis. This study suggests a correlation between increased peristaltic waves and visceral perception in the esophagus. TENS appears to reduce esophageal pain sensitivity and thus may be a useful treatment for noncardiac chest pain of esophageal origin.


Percutaneous tibial nerve stimulation as an off-label treatment of clitoral pain.
Elkattah R1, Trotter-Ross W, Huffaker RK.

Author information

Abstract

OBJECTIVE:

Percutaneous tibial nerve stimulation (PTNS) is used to treat refractory urinary frequency, urgency, and urgency urinary incontinence. To date, it is not approved by the US Food and Drug Administration in the treatment of chronic pain syndromes, and its use in the treatment of chronic clitoral pain has not been reported.

METHODS:

We describe 2 cases of women who presented with symptoms of urgency urinary incontinence, urinary frequency, and clitoral pain. After inadequate response to conservative treatment of their urinary symptoms, they received PTNS.

RESULTS:

By the 12th session, significant improvement in urinary symptoms and resolution of clitoral pain were noted.

CONCLUSIONS:

The findings of this report suggest that PTNS may be a therapeutic option in patients with idiopathic clitoral pain.


Randomized trial of long-term effects of percutaneous tibial nerve stimulation on chronic pelvic pain.
Istek A1, Gungor Ugurlucan F, Yasa C, Gokyildiz S, Yalcin O.

Author information

Abstract
OBJECTIVE:
To evaluate the long-term effects of percutaneous tibial nerve stimulation (PTNS) on quality of life in women with chronic pelvic pain.

MATERIALS AND METHODS:
Thirty-three women with chronic pelvic pain were randomized into PTNS (n = 16) or control (n = 17) groups. In PTNS group, weekly PTNS in 30-min sessions for 12 weeks was performed whereas the control group received no stimulation. Present pain intensity-visual analog scale (PPI-VAS), short-form McGill pain questionnaire (SF-MPQ), and SF-36 were used at baseline, 12-week, and 6-month follow-up for the evaluation of pain intensity and quality of life.

RESULTS:
Two women (12.5 %) were cured, 7 (43.8 %) were much improved, 6 (37.5 %) were the same and 1 (6.3 %) was worse after PTNS. Two women (11.8 %) were improved, 10 (58.8 %) were the same, and 5 (29.4 %) were worse in the control group. Mean PPI-VAS of PTNS group at baseline, 12 weeks, and 6 months was 8.4 ± 1.1, 3.8 ± 3.5 and 4.5 ± 3.7, respectively. There was a significant improvement in PPI-VAS scores of PTNS group whereas no change was observed in the control group. There was a slight increase in the PPI-VAS scores of the PTNS group at 6-month, but the difference was not statistically significant. There was significant improvement in all domains of SF-MPQ and SF-36 in PTNS group with continuing effects at 6 months whereas no significant change was observed in the control group.

CONCLUSION:
PTNS is a minimally invasive treatment method that leads to decrease in pain severity and improvement in quality of life in women with chronic pelvic pain with effects continuing at 6 months.
Ordonnance type

- Location pour 3 mois renouvelable une fois d’un appareil de neurostimulation transcutanée

- Mode P2 soit 80 Hz

- 30’ six fois par jour
  - Juste au seuil de sensation (pas de douleurs)

- Ne pas oublier de rendre l’appareil au bout de six mois
Do burn injuries during infancy affect pain and sensory sensitivity in later childhood?


Department of Clinical and Cognitive Neuroscience, Central Institute of Mental Health, Mannheim, Germany.

Studies in animals and humans suggest that neonatal and early infant pain or stress experiences can induce long-term alterations in somatosensory and pain processing. We studied pain and sensory sensitivity in school-aged children (9-16 years) who had suffered moderate (N=24) or severe (N=24) burn injuries in infancy (6-24 months of age) and 24 controls. Quantitative sensory testing entailing detection and pain thresholds for thermal and mechanical stimuli and perceptual sensitization to tonic heat and repetitive mechanical stimuli was performed. Two testing sites (thenar, trigeminal region), both not affected by the burn injury, were used to determine whether there are global changes in pain sensitivity. The result pattern suggests a differential impact of burn severity. Compared to controls, moderately burned children showed significantly higher mechanical detection thresholds (thenar) and significantly lower mechanical pain thresholds and significantly greater perceptual sensitization to repetitive mechanical stimuli (both testing sites). No significant alterations were observed for thermal stimuli. In contrast, severely burned children
showed, compared to controls, primarily alterations in thermal pain sensitivity (elevated pain thresholds at both testing sites, significantly greater perceptual sensitization at the thenar). In these children, mechanical pain sensitivity and detection thresholds were not consistently altered. This differential pattern of altered sensory and pain sensitivity may reflect differences in experienced stress, pain and analgesic treatment between moderately and severely burned children. Most importantly, our findings suggest that early traumatic and painful injuries, such as burns, can induce global, long-term alterations in sensory and pain processing.

JAMA. 2009 Aug 5;302(5):550-61. Click here to read Links

Sexual abuse and lifetime diagnosis of somatic disorders: a systematic review and meta-analysis.

Paras ML, Murad MH, Chen LP, Goranson EN, Sattler AL, Colbenson KM, Elamin MB, Seime RJ, Prokop LJ, Zirakzadeh A.

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CONTEXT: Many patients presenting for general medical care have a history of sexual abuse. The literature suggests an association between a history of sexual abuse and somatic sequelae. OBJECTIVE: To systematically assess the association between sexual abuse and a lifetime diagnosis of somatic disorders. Data Sources and Extraction A systematic literature search of electronic databases from January 1980 to December 2008. Pairs of reviewers extracted descriptive, quality, and outcome data from included studies. Odds ratios (ORs) and 95% confidence intervals (CIs) were pooled across studies by using the random-effects model. The I(2) statistic was used to assess heterogeneity. STUDY SELECTION: Eligible studies were longitudinal (case-control and cohort) and reported somatic outcomes in persons with and without history of sexual abuse. RESULTS: The search identified 23 eligible studies describing 4640 subjects. There was a significant association between a history of sexual abuse and lifetime diagnosis of functional gastrointestinal disorders (OR, 2.43; 95% CI, 1.36-4.31; I(2) = 82%; 5 studies), nonspecific chronic pain (OR, 2.20; 95% CI, 1.54-3.15; 1 study), psychogenic seizures (OR, 2.96; 95% CI, 1.12-4.69, I(2) = 0%; 3 studies), and chronic pelvic pain (OR, 2.73; 95% CI, 1.73-4.30, I(2) = 40%; 10 studies). There was no statistically significant association between sexual abuse and a lifetime diagnosis of fibromyalgia (OR, 1.61; 95% CI, 0.85-3.07, I(2) = 0%; 4 studies), obesity (OR, 1.47; 95% CI, 0.88-2.46; I(2) = 71%; 2 studies), or headache (OR, 1.49; 95% CI, 0.96-2.31; 1 study). We found no studies that assessed syncope. When analysis was restricted to studies in which sexual abuse was defined as rape, significant associations were observed between rape and a lifetime diagnosis of fibromyalgia (OR, 3.35; 95% CI, 1.51-7.46), chronic pelvic pain (OR, 3.27; 95% CI, 1.02-10.53), and functional gastrointestinal disorders (OR, 4.01; 95% CI, 1.88-8.57). CONCLUSION: Evidence suggests a history of sexual abuse is associated with lifetime diagnosis of multiple somatic disorders.
High levels of anxiety and depression have a negative effect on quality of life of women with chronic pelvic pain.

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BACKGROUND: Chronic pelvic pain (CPP) is a common and complex disease whose cause is often clinically inexplicable, with consequent difficulty in diagnosis and treatment. Patients with CPP have high levels of anxiety and depression, with a consequent impairment of their quality of life. AIMS: The objective of this study was to determine the prevalence of anxiety and depression and their impact on the quality of life of women with CPP. MATERIALS AND METHODS: A cross-sectional controlled study was conducted on 52 patients with CPP and 54 women without pain. Depression and anxiety were evaluated by the Hospital Anxiety and Depression Scale, and quality of life was evaluated by the World Health Organization Quality of life Whoqol-bref questionnaire. Data were analysed statistically by the Mann-Whitney U-test, the Fisher exact test, chi-square test and Spearman correlation test. RESULTS: The prevalence of anxiety was 73% and 37% in the CPP and control groups, respectively, and the prevalence of depression was 40% and 30% respectively. Significant differences between groups were observed in the physical, psychological and social domains. Patients with higher anxiety and depression scores present lower quality of life scores. DISCUSSION: The fact that DPC is a syndromic complex, many patients enter a chronic cycle of search for improvement of medical symptoms. The constant presence of pain may be responsible for affective changes in dynamics, family, social and sexual. Initially the person is facing the loss of a healthy body and active, to a state of dependence and limitations. In this study, patients with higher scores of anxiety and depression scores had lower quality of life and patients with lower scores of anxiety and depression had scores of quality of life. These results show that perhaps the depression and anxiety may be related to the negative impact on quality of life of these patients. CONCLUSION: In view of this association, we emphasise the importance of a specific approach to the treatment of anxiety and depression together with clinical treatment to improve the quality of life of these patients.

Cochrane Database Syst Rev. 2009 Jan 21;(1):CD006442. Click here to read Links

Psychological treatments for the management of irritable bowel syndrome. Zijdenbos IL, de Wit NJ, van der Heijden GJ, Rubin G, Quartero AO.
BACKGROUND: No consensus exists on the optimal treatment for irritable bowel syndrome (IBS). Psychological treatments are increasingly advocated but their effectiveness is unclear. OBJECTIVES: To evaluate the efficacy of psychological interventions for the treatment of irritable bowel syndrome. SEARCH STRATEGY: A computer assisted search of MEDLINE, EMBASE, PsychInfo, CINAHL, Web of Science, The Cochrane Library and Google Scholar was performed for the years 1966-2008. Local databases were searched in Europe. SELECTION CRITERIA: Randomised trials comparing single psychological interventions with either usual care or mock interventions in patients over 16 years of age. No language criterion was applied. DATA COLLECTION AND ANALYSIS: The search identified 25 studies that fulfilled the inclusion criteria. The relative risk (RR), risk difference (RD), number needed to treat (NNT) and standardized mean difference (SMD) along with 95% confidence intervals were calculated using a random effects model for each outcome. MAIN RESULTS: Psychological interventions as a group The SMD for symptom score improvement at 2 and 3 months was 0.97 (95% CI 0.29 to 1.65) and 0.62 (95% CI 0.45 to 0.79) respectively compared to usual care. Against placebo, the SMDs were 0.71 (95% CI 0.08 to 1.33) and -0.17 (95% CI -0.45 to 0.11) respectively. For improvement of abdominal pain, the SMDs at 2 and 3 months were 0.54 (95%CI 0.10 to 0.98) and 0.26 (95% CI 0.07 to 0.45) compared to usual care. The SMD from placebo at 3 months was 0.31 (95% CI -0.16 to 0.79). For improvement in quality of life, the SMD from usual care at 2 and 3 months was 0.47 (95%CI 0.11 to 0.84) and 0.31 (95%CI -0.16 to 0.77) respectively. Cognitive behavioural therapy The SMD for symptom score improvement at 2 and 3 months was 0.75 (95% CI -0.20 to 1.70) and 0.58 (95% CI 0.36 to 0.79) respectively compared to usual care. Against placebo, the SMDs were 0.68 (95% CI -0.01 to 1.36) and -0.17 (95% CI -0.45 to 0.11) respectively. For improvement of abdominal pain, the SMDs at 2 and 3 months were 0.45 (95% CI 0.00 to 0.91) and 0.22 (95% CI -0.04 to -0.49) compared to usual care. Against placebo the SMD at 3 months was 0.33 (95% CI -0.16 to 0.82). For improvement in quality of life, the SMDs at 2 and 3 months compared to usual care were 0.44 (95% CI 0.04 to 0.85) and 0.92 (95% CI 0.07 to 1.77) respectively. Interpersonal psychotherapy The RR for adequate relief of symptoms was 2.02 (95% CI 1.13 to 3.62), RD 0.30 (95% CI 0.13 to 0.46), NNT 4 for comparison with care as usual. The SMD for improvement of symptom score was 0.35 (95% CI -0.75 to 0.05) compared with usual care. Relaxation/Stress management The SMD in symptom score improvement at 2 months was 0.50 (95%CI 0.02 to 0.98) compared with usual care. The SMD in improvement of abdominal pain at 3 months was 0.02 (95%CI -0.56 to 0.61) compared with usual care. Long term results Very few long term follow-up results were available. There was no convincing evidence that treatment effects were sustained following
completion of treatment for any treatment modality. AUTHORS' CONCLUSIONS: Psychological interventions may be slightly superior to usual care or waiting list control conditions at the end of treatment although the clinical significance of this is debatable. Except for a single study, these therapies are not superior to placebo and the sustainability of their effect is questionable. The meta-analysis was significantly limited by issues of validity, heterogeneity, small sample size and outcome definition. Future research should adhere to current recommendations for IBS treatment trials and should focus on the long-term effects of treatment.

A randomized clinical trial for women with vulvodynia: Cognitive-behavioral therapy vs. supportive psychotherapy. Masheb RM, Kerns RD, Lozano C, Minkin MJ, Richman S.

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Many treatments used for women with vulvodynia are based solely upon expert opinion. This randomized trial aimed to test the relative efficacy of cognitive-behavioral therapy (CBT) and supportive psychotherapy (SPT) in women with vulvodynia. Of the 50 participants, 42 (84%) completed 10-week treatments and 47 (94%) completed one-year follow-up assessments. Mixed effects modeling was used to make use of all available data. Participants had statistically significant decreases in pain severity (p's<0.001) with 42% of the overall sample achieving clinical improvement. CBT, relative to SPT, resulted in significantly greater improvement in pain severity during physician examination (p=0.014), and greater improvement in sexual function (p=0.034), from pre- to post-treatment. Treatment effects were well maintained at one-year follow-up in both groups. Participants in the CBT condition reported significantly greater treatment improvement, satisfaction and credibility than participants in the SPT condition (p's<0.05). Findings from the present study suggest that psychosocial treatments for vulvodynia are effective. CBT, a directed treatment approach that involves learning and practice of specific pain-relevant coping and self-management skills, yielded better outcomes and greater patient satisfaction than a less directive approach.


OBJECTIVES: Chronic pelvic pain is a common source of disability among women in the western world. Here we report that 3 months of Mensendieck somatocognitive intervention in chronic pelvic pain patients was followed by continued improvements of outcomes at 1-year follow-up in a randomized, controlled study design. METHODS: Forty women with chronic pelvic pain unexplained by pelvic pathology were randomly assigned to 2 groups: (1) standard gynecologic treatment and (2) gynecologic treatment plus somatocognitive therapy aimed at reducing physical pain by changing posture, movement, and respiration patterns. A standardized Mensendieck test (SMT) of motor function (assessing posture, movement, gait, sitting posture, and respiration), a self-rating questionnaire assessing psychologic distress and general well-being (GHQ-30) and a visual analog score of pain (VAS) were obtained before, after 90 days of treatment and 1 year after inclusion. RESULTS: Patients treated by standard gynecologic treatment/supervision did not improve significantly at 1-year follow-up in any of the test modalities. By contrast, those who in addition received somatocognitive therapy had improved scores for all motor functions and pain, as well as GHQ-30 scores for coping, and anxiety-insomnia-distress. CONCLUSION: Mensendieck somatocognitive therapy combined with standard gynecologic care improves psychologic distress, pain experience, and motor functions of women with chronic pelvic pain better than gynecologic treatment alone. The effect lasted and even further improvement occurred 9 months after treatment.
Hypnose :
Un état de conscience modifié qui peut être incité par une autre personne et au cours duquel une variété de phénomènes peut apparaître spontanément ou en réponse aux stimulus verbaux ou autres. Ces phénomènes lui incluent des changements dans la conscience et la mémoire (le souvenir), la sensibilité accrue à la suggestion et la production par le patient de réponses et des idées peu familières dans son état d'esprit habituel. De nouveaux phénomènes comme l'anesthésie, la paralysie et la rigidité de muscles et des changements de vasomoteur peuvent être produits et enlevés dans l'état hypnotique.


Eternel serpent de mer
La technique proposée par Whorvell est clairement basée sur la suggestion, focalisée sur la plainte et le problème beaucoup plus que des techniques comme l’hynmose seche ou la recherche des étiologies.

The gut focused hypnotherapy
Transe puis suggestions repetitives d’amélioration fonctionnelle propre au patient , Utilisation de métaphores contrôle du transit (du flot) en fonction des besoins

Deux séances d’apprentissage puis dix séances focalisé sur l’intestin
Malgré les évidents problèmes méthodologiques, le caractère hypnothérapeute
dépendant
Tres bonne efficacité y compris sur le long terme avec dans leur équipe une amélioration soutenue pendant 2 à 5 ans chez 83% des patients initialement repondeurs

Mode d’action
Effet placebo
Amélioration des fonctions cognitives, des échelles d’anxiété et de dépression
Amélioration persistante de l’hypersensibilité rectale à la distention par ballon

Indication
Colopathie sévère
Eventuellement par du personnel non médical formé
Randomized trial of a hypnosis intervention for treatment of hot flashes among breast cancer survivors.

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PURPOSE: Hot flashes are a significant problem for many breast cancer survivors. Hot flashes can cause discomfort, disrupted sleep, anxiety, and decreased quality of life. A well-tolerated and effective mind-body treatment for hot flashes would be of great value. On the basis of previous case studies, this study was developed to evaluate the effect of a hypnosis intervention for hot flashes. PATIENTS AND METHODS: Sixty female breast cancer survivors with hot flashes were randomly assigned to receive hypnosis intervention (five weekly sessions) or no treatment. Eligible patients had to have a history of primary breast cancer without evidence of detectable disease and 14 or more weekly hot flashes for at least 1 month. The major outcome measure was a bivariate construct that represented hot flash frequency and hot flash score, which was analyzed by a classic sums and differences comparison. Secondary outcome measures were self-reports of interference of hot flashes on daily activities. RESULTS: Fifty-one randomly assigned women completed the study. By the end of the treatment period, hot flash scores (frequency x average severity) decreased 68% from baseline to end point in the hypnosis arm (P < .001). Significant improvements in self-
reported anxiety, depression, interference of hot flashes on daily activities, and sleep were observed for patients who received the hypnosis intervention (P < .005) in comparison to the no treatment control group. CONCLUSION: Hypnosis appears to reduce perceived hot flashes in breast cancer survivors and may have additional benefits such as reduced anxiety and depression, and improved sleep.

Hypnosis reduces distress and duration of an invasive medical procedure for children.
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OBJECTIVE: Voiding cystourethrography (VCUG) is a commonly performed radiologic procedure in children that can be both painful and frightening. Given the distress that some children experience during the VCUG and the need for children to be alert and cooperative during the procedure, finding a psychological intervention that helps children to manage anxiety, distress, and pain is clearly desirable. This study was designed to examine whether relaxation and analgesia facilitated with hypnosis could reduce distress and procedure time for children who undergo this procedure.

METHODS: Forty-four children who were scheduled for an upcoming VCUG were randomized to receive hypnosis (n = 21) or routine care (n = 23) while undergoing the procedure. The sample consisted of 29 (66%) girls and 15 (34%) boys with a mean age of 7.6 years (SD: 2.5; range: 4-15 years). Ethnic/racial backgrounds were 72.7% white, 18.2% Asian, 4.5% Latino, 2.3% black, and 2.3% Filipino. The mean number of previous VCUGs was 2.95 (SD: 2.51; mode: 2; range: 1-15). Potential participants were identified through computerized hospital records of upcoming VCUGs. Parents were contacted by telephone and invited to participate if their child was eligible. To be eligible for the study, the child must have undergone at least 1 previous VCUG, been at least 4 years of age at that time, and experienced distress during that procedure, and both the child and the participating parent had to be English speaking. Each eligible child and parent met with the research assistant (RA) before the day of the scheduled procedure for an initial assessment. Children were queried regarding the degree of crying, fear, and pain that they had experienced during their most recent VCUG. Parents completed a series of parallel questions. Immediately after this assessment, those who were randomized to the hypnosis condition were given a 1-hour training session in self-hypnotic visual imagery by a trained therapist. Parents and children were instructed to practice using the imaginative self-hypnosis procedure several times a day in preparation for the upcoming procedure. The therapist was also present during the procedure to conduct similar exercises with the child. The majority (83%) of those who were randomized to the routine care control
group chose to participate in a hospital-provided recreation therapy program (offered as part of routine care). The program includes demonstration of the procedure with dolls, relaxation and breath work training, and assistance during the procedure. On the day of the VCUG, the RA met the family at the clinic before the procedure, and both the child and the parent rated the child's present level of fearfulness. During the procedure, the RA recorded observational ratings of the child's emotional tone and behavior and timed the overall procedure and its phases. Immediately after the VCUG, the child was asked how much crying, fear, and pain he or she had experienced during the procedure; the parent rated the child's experience on the same dimensions and also how traumatic the procedure had been (both generally and compared with their previous one), and the medical staff rated the degree of procedural difficulty. Outcomes included child reports of distress during the procedure, parent reports of how traumatic the present VCUG was compared with the previous one, observer ratings of distress during the procedure, medical staff reports of the difficulty of the procedure overall, and total procedural time. RESULTS: Results indicate significant benefits for the hypnosis group compared with the routine care group in the following 4 areas: (1) parents of children in the hypnosis group compared with those in the routine care group reported that the procedure was significantly less traumatic for their children compared with their previous VCUG procedure; (2) observational ratings of typical distress levels during the procedure were significantly lower for children in the hypnosis condition compared with those in the routine care condition; (3) medical staff reported a significant difference between groups in the overall difficulty of conducting the procedure, with less difficulty reported for the hypnosis group; and (4) total procedural time was significantly shorter—by almost 14 minutes—for the hypnosis group compared with the routine care group. Moderate to large effect sizes were obtained on each of these 4 outcomes. CONCLUSIONS: Hypnotic relaxation may provide a systematic method for improving the overall medical care of children with urinary tract abnormalities and may be beneficial for children who undergo other invasive medical procedures. Because the VCUG is an essential part of the evaluation of urinary tract infections and vesicoureteral reflux in children, lower distress during the procedure may improve patient and family compliance with initial as well as follow-up evaluations. These findings augment the accumulating literature demonstrating the benefits of using hypnosis to reduce distress in the pediatric setting. The present findings are noteworthy in that this study was a controlled, randomized trial conducted in a naturalistic medical setting. In this context, we achieved a convergence of subjective and objective outcomes with moderate to large effect sizes, including those that may have an impact on patient care and procedure cost, that were consistently supportive of the beneficial effects of hypnosis—a noninvasive intervention with minimal risk. The findings, therefore, have immediate implications for pediatric care. Limitations of this study include the lack of participant and staff blindness to the child's condition assignment, which could have introduced bias into reports. However, the objective
procedural time differences between groups were consistent with the other, more subjective outcome findings. The sample was also small and primarily white in ethnic/racial makeup, which may have restricted our ability to detect some differences and may limit the generalizability of findings to more representative samples. In addition, the sample comprised children who had already undergone at least 1 VCUG during which they had had difficulty. Consequently, additional research is needed to determine whether hypnosis would be helpful to those who are undergoing their first VCUG. Additional limitations, clinical observations, and directions for future research are also discussed.
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Faut-il le dire au patient ?
Faut-il le rechercher explicitement systématiquement?

**POUR**
- Assurer la sécurité du patient
- Proposer une aide adaptée
- Temps gagné

**CONTRE**
- Pas de modification de traitement à court terme
- Le passé EST passé
- Risque de ressurgence
- Devancer la plainte du patient
- Imposer la confidence
- Temps nécessaire

Montrer que l’on peut entendre,
*C’est le patient qui choisit le lieu et la personne*

*Y. Dolan : « Le viol, c’est ce que j’ai vécu, pas ce que je suis »*
Premier palier de traitement

1. Validation de la plainte, démembrement, reconnaissance d’objectifs communs
2. Thérapie manuelle
3. Régime
4. Acupuncture
5. Neurostimulation
6. Approche psychocomportementale
7. Traitement de la cause si possible
Traiter la cause

- Quand c’est possible +++
- En évaluant le bénéfice risque
- Avec une bonne alliance avec le patient