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The choice of surgery and principles of rehabilitation of aseptic necrosis of caput femori in children

Abstrart: The choice of surgical intervention method depends on the stage and severity of pathologic process. Rehabilitation of children with aseptic necrosis of caput femori is a complex process and it demands many-years clinical follow-up and therapy for its salvation.

Keywords: aseptic necrosis of caput femori, surgical therapy, children.

Aseptic necrosis of caput femori (ANCF) in children is one of severe pathologies leading to invalidity. Among all pathologies of skeletal apparatus aseptic necrosis of caput femori takes 3%, among orthopedic diseases of hip joints — up to 25%. Aseptic necrosis of hip joint is a serious problem of modern clinical medicine and it is the cause of children's invalidity high rate [1; 2]. Among adults 30–40% arthrosis of hip joint are resulting from incomplete therapy of diseases such as congenital hip displacement and Pertes disease in childhood [3; 5]. The disease proceeds for a long time, 20–25% of the children have explicit deformation of caput femori, and later deforming coccyx arthrosis [4; 6].

Therapy of that pathology in children is a complex pending problem. Various methods of conservative and surgical therapy applied in the majority of clinical follow-ups prevent the achievement of desirable results. Specificity of the therapy of that pathology is that it demands a child's confinement to bed for several years, and it prevents the child's complete physical development and communication with children of the same age. And pathogenetically unproved therapy often turns out to be ineffective. Recently we could observe a clear tendency to apply surgery for that pathology. Though, inadequate surgical tactics often induces high rate of non-satisfactory outcomes. For the achievement of the best results of the therapy in each certain case it is necessary to solve a very important question "What is an indication for surgical treatment?", but the problem of answering is conditioned by the fact that it is difficult to predict an outcome at the early stage of the disease [2; 3].

In case of late diagnostics pathologic reconstruction develops in the caput, neck of the femur and hip joint. In connection to that, rehabilitation of children with aseptic necrosis of caput femori still does not lose its actual significance. The problem is mostly linked with failure of tissues, both on the side of hip joint elements and surrounding tissues. The aims of the post-operational medical rehabilitation are prophylactics of caput femori deformation and arthrosis.

Materials and methods: We checked 146 patients with aseptic necrosis of caput femori with various genesis in the age group from 2 to 14 years old. All patients got clinical therapy in the children's orthopedic SRI of traumatology and orthopedics MHC RU for the last 6 years. Among one hundred and forty seven children (173 joints) ANCF was noted in 85 children (103 joints), osteochondropathy of caput femori — Pertes disease in 61 children (70 joints) after conservative therapy and surgery of congenital hip displacement. ANCF after the treatment of congenital hip displacement: 62 girls (72.9%), 23 boys (27.1%). ANCF after therapy of congenital hip displacement: lesions of the right hip joint were observed in 21 cases (24.7%), left-side one in 49 cases (57.6%), bilateral in 15 (17.6%). Among the patients with PD there were 16 girls (26.3%) and 45 boys (73.7%). Among them right side 20 (32.7%), left side 35 (57.3%), bilateral — 6 (9.8%). Children were also classified according to the stage of disease: the first stage of the disease was noted in 15 children (10.2%), the second stage — impressive fracture in 47 children (32.2%), fragmentation stage in 58 children (39.73%), restoration stage in 20 children (13.6%), the fifth stage — in 4 children (2.7%).

For the definition of the general status of the patients and the study of the alteration in hip joint we used clinical, radiologic, Doppler, MR imaging and ultra-sound research methods. Radiologic checkings were performed on a low-dose digital roentgen apparatus Flexavision by Shimadzu (Japan), while sonographic test was performed with the help of MyLab 40 sonographic device by Esaote (Italy). Doppler checking was performed on Philips IU 22 made in Holland together with Germany, linear sensor with L 9–3 MHz frequency in B — M — 3D — 4D modes. In ultra sound checking we applied multi-frequency linear sensor with 3.5–7-12 mHz.

Results of the research. In the study of the children's general status we paid a special attention to complaints, anamnesis, age terms of the set diagnosis, previous therapy, motion volume in the joint, presence of lower limb shortening and deformation in hip joint$ we studied peculiarities of gait and Trendelenburg symptom. For the evaluation of the hip joint deformation variant we performed radiology of both hip joints in the direct projection. For the estimation of the areas of caput femori unreachable in the direct projection we performed Lawenstein radiology (with maximal abduction of both femoral bones). On a series of radiologic images we noted centralization of caput femori, stability of hip joint, antetortion angle, neck-diaphisis angle, caput femori covering degree and others.

Ultrasonographic signs of ANCF are exudation in the anterior part of joint lumen and neck, thickening of the cartilage of caput femori, thickening of synovial membrane, deformation, fragmentation of the caput femori ossification nuclear. The difference of thickness of joint cartilage between healthy and damaged sides exceeded 3mm in 80.5%. In 69% we detected transitory sinovitis, when the duration of pain and limitation of motions was 7–14 days. Echographically we detected exudation in the joint, but there was no above mentioned ultrasound signs.

In case of Pertes disease exudation in the joint preserved during the whole term of the disease and it was typical both for early and late stages of the disease, including fragmentation stage. ultrasound checking demonstrated the location of the caput femori lesion focus. In case of progradient progress of the disease in echogram we noted diminishing of the distance between anterior acetabular margin and metaphisis of femoral bone, deformation of caput femori with the loss of its height compared with the healthy side. In some cases there was absence or significant diminishing of the ossification nuclear. On ultrasonography after the therapy of congenital hip displacement besides the aforesaid symptoms there was immaturity of caput deformation, disorder of hip joint correlation and lateral position of the caput femori.

The main reason of aseptic necrosis of caput femori is disorder of blood supply in proximal part of femoral bone. Due

to that, for the definition of blood flow children underwent ultrasound Dopplerography of femoral arteries. In Dopplerography we detected the speed of blood flow and the resistance index of femoral arteries, and with the help of energetic Doppler mapping we estimated pathologic vessels in the area of hip joint. 112 (76.7%) children with radiologic signs of ANCF had decrease of peak speed of blood flow in the deep femoral artery and round femoral arteries.

For more complete and objective study of the structure, especially sub-cartilage area of the caput and neck of femur, form of deformation, dystrophic alterations of pelvic bones, status of growing areas in epiphisis and skewer major; for the notion of adjacent anatomy of all components of hip joint we applied MR imaging. In the comparative study of radiologic, ultrasound and MR imaging self-description in ANCF diagnostics in children we detected high self-descriptiveness of MRCT. That method provides conferment and exclusion of the pathology.

The treatment of children with aseptic necrosis of caput femori: conservative orthopedic methods in 102 children 69.8%; surgery — in 44 children 30.1%. Indication for surgery was little efficiency of conservative therapy and fast progress of the disease.

The aims of surgery were:

– centration of caput femori in acetabulum,

– normalization of joint surface correlation, improvement of blood supply processes and reparation in the damaged caput.

The following kinds of surgery were done dependently on the stage and severity of the disease:

– tunneling of the neck of femur with injection of auto transplants — 11patients;

– varising intra-capital osteotomy of femoral bone — 14;

– transplantation of anterior inferior ost of ilium on vascular muscle peduncle — 13 children;

– decompression of hip joint with application of Ilizarov's apparatus — 3 patients.

The choice of surgery depended on the degree of pathologic alterations, detected by radiologic and MRCT imaging. At the first stage of the disease tunneling of neck of femoral bone, tunneling of neck with injection of auto transplants, decompression of hip joint using Ilizarov's apparatus were applied. At the second and third stages of the disease we performed varising intra-capital osteotomy of femoral bone. The aim of surgical interventions at the initial stages (I, II) of the disease were improvement of blood circulation and reparation of the damaged caput, and at the III and IV stages — centration of caput femori in acetabulum and normalization of joint surface correlation.

After operation a plaster cast was applied for 1 month. After removal of the plaster cast additional physiotherapeutic and pharmaceutical therapy were prescribed. During postoperational period control radiologic imaging was done in 3, 6, 9, 12 months for evaluation of surgery. It was possible to apply a complete load on the operated limb of the patients with ANCF in one year. After tunneling of hip joint improvement of blood supply in round femoral arteries was noted on Dopplerography. Extra-joint reconstructive-repair interventions promoted preserving of intact elements and acceleration of dynamic reparation of the damaged bone-cartilage elements of hip joint. It had favorable effect on the further development of the joint and promoted fast restoration of its function during post-operational period. There was diminishing of epiphisary deformation, improvement of caput femori centration and congruency of joint surfaces. It was clearly seen on radiologic and CT images during postoperational period. Restoration of physiologic congruency of the joint achieved by the osteotomy rotation component and exclusion of the areal load of aseptic necrosis of caput femori, it conditions the possibility of early restoration of support function of the limb. In the control radiologic image during post-operative period and at the stages of therapy there was no notable progression of the disease. The progress of the fragmentation period was shortened and the reparative processes passed more actively.

In post-operative period physiotherapy, TPT and pharmaceutical therapies were prescribed. The great attention was paid to the following of orthopedic routine, when it was possible to eliminate compression of proximal epiphisis and deformation of caput femori. Patients got abduct plaster casts and "boot" with derotator.

Massage with gymnastics, paraphine applications and electrophorrhesis swith various medicines for improvement of hip joint nutrition and osteo reparation of the proximal part of femoral bone were performed in 12–22 times per a course of therapy. Medicines such as vitamins of B group, C, PP, corpus vitreum, actovegin, Ca-D3-nikomed, rutin and pentoxifillin. Later children administered Ca and polyvitamins in ambulatory conditions.

The therapy was performed till complete restoration of the caput femori. Restoration of the shape of the caput femori and function of hip joint does not mean complete recovery. Patients should get rehabilitation therapy aiming adjustment of the joints in new and unusual conditions. Improvement of the conditions for hip joint functioning is linked with the process of adaptation and working of compensatory mechanisms. The complex of rehabilitation should involve physiotherapeutic specialists, Methodists of TPT, and others.

Thus, the choice of surgery method depends on the stage and severity of the pathologic process. Surgical interventions promote fast restoration of congruency and function, improvement of blood circulation and regeneration processes in hip joint.

Rehabilitation of the children with aseptic necrosis of caput femori is a complex process and it requires many years of clinical follow-up and therapy for its salvation.

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The role of self-assessment in evaluation of severity of premature ejaculation

Abstract: Ejaculatory control issues have been documented for more than 1,500 years. Today, PE is relevant and significant problem, and the most common male sexual disorder, affecting about 30–40% of sexually active men. The data about PE prevalence contradict each other; furthermore, there is different prevalence of PE in different regions, countries or climatic zones. Because of the variability in time required to ejaculate and in partners' desired duration of sex, exact prevalence rates of PE are difficult to determine. The etiopathogenesis of PE is poor understood as well. Development of diagnostic tools, guidelines and questionnaires for PE is an evolutionary process that continually reviews data and requires the best new researches. However, there is still no universal agreement on how to define or to diagnose PE. Development of any diagnostic tool and questionnaire for PE should be based on criteria of easily recognizable criteria of the disease. According to the analysed literature and recommendations of the ISSM, it is strongly recommended the diagnostic tools be updated and improved.

Keywords: premature ejaculation, diagnostic tools, criteria for premature ejaculation.

Introduction. Recently, knowledge of premature ejaculation (PE) has significantly advanced because of progress in understanding the physiology of ejaculation, clarifying the real prevalence of PE in population-based studies, reconceptualizing the definitions and diagnostic criterion of the disorder, assessing the psychosocial impact on patients and partners, designing validated diagnostic and outcome measures, proposing new pharmacological strategies and examining the efficacy, safety and satisfaction of these new and established therapies [1].

PE is the most common male sexual disorder, affecting 30–40% of sexually active men [2], and perhaps as many as 75% of men at some points in their lives [3]. Like erectile dysfunction (ED), PE also could impact a man's life in many aspects, such as self-esteem and relationship with the opposite sex [4]. About 10% of patients receive ineffective or unreasonable treatment. However, there is still no universal agreement on how to define or to diagnose PE.

Ejaculatory control issues have been documented for more than 1,500 years. The Kamasutra, the 4th century Indian sex handbook, declares: "Women love the man whose sexual energy lasts a long time, but they resent a man whose energy ends quickly because he stops before they reach a climax" [5].

PE occurs when a man experiences orgasm and expels semen soon after sexual activity and with minimal penile stimulation. It has also been called "early ejaculation", "rapid ejaculation", "rapid climax", "premature climax", and (historically) "ejaculation praecox". Sex researcher Alfred Kinsey did not consider rapid ejaculation a problem, but viewed it as a sign of "masculine vigor" [6]. There is no uniform cut-off defining "premature", but a consensus of experts at the International Society for Sexual Medicine (ISSM) endorsed a definition including "ejaculation which always or nearly always occurs prior to or within about one minute" [7]. The International Classification of Diseases (ICD-10) applies a cut-off of 15 seconds from the beginning of sexual intercourse [8].

Definition. In 2007, an expert committee of the International Society for Sexual Medicine (ISSM) concluded formulate a definition can only for the primary form of PE, arising at the moment of sexual debut. The ISSM defined PE as a male sexual dysfunction characterized by ejaculation that always or nearly always occurs prior to or within one minute of vaginal penetration, and the inability to delay ejaculation