Paraplegia

PROGRESS IN REHABILITATION

Paraplegia

Edited by

Rudy Capildeo
and
Audrey Maxwell

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Contents

The Contributors

Gill ARNOTT,
Senior Occupational Therapist, Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry
Ida BROMLEY,
District Physiotherapist, Hampstead Health District, London
Rudy CAPILDEO,
Consultant Neurologist, Regional Centre for Neurology and Neurosurgery, Oldchurch Hospital, Romford, Essex
John CASTRO,
Consultant Urologist and Transplant Surgeon, London
Gelia KIRKBY,
Senior Social Worker, Spinal Unit, Stoke Mandeville Hospital, Bucks.
Ann MACFARLANE,
Advisory Service, Kingston and Esher District
Tim MARSHALL,
Lecturer in Social Medicine, Birmingham University
Audrey MAXWELL,
Consultant to *Therapy*, Macmillan Journals
Graham POWELL,
Senior Lecturer in Psychology, Department of Clinical Psychology, Institute of Psychiatry, London
Michael SMITH,
Community Physician, Kingston-on-Thames
William Stewart TAOR,
Consultant Orthopaedic Surgeon, Central Middlesex Hospital
Derek WILLCOCKS,
Area Resettlement Officer, London North area

Introduction

Rudy Capildeo and Audrey Maxwell

'Ah, Mr. Beatty! I have sent for you today to say that I forgot to tell you before – that all power of motion and feeling below my chest are gone; and you very well know that I can live but a short time. . . . You know I am gone.'

'My Lord, unhappily for our country, nothing can be done for you', the surgeon, Dr Scott, said. Lord Nelson died within a few hours. A bullet had penetrated his chest and lodged in his thoracic spine causing acute paraplegia.

Recent events in the Falkland Islands have reminded us about our greatest naval hero and also the consequences of war and the inevitable casualties. It was in the context of war that Ludwig Guttmann was first given the task of establishing a National Spinal Injuries Centre at Stoke Mandeville Hospital, Aylesbury, which opened on 1 February, 1944. The unit had 26 beds and 1 patient. It was anticipated that the remainder would come from the spring offensive of World War II. During the course of that war more than 700 casualties with spinal cord lesions were placed in 12 spinal units throughout the country. Later, some of these units were closed and the patients transferred to Stoke Mandeville, the number of beds increasing to 100. By 1951 the unit had 160 beds and eventually 195 beds.

The contribution to our understanding of spinal cord injuries made by Sir Ludwig Guttmann and his colleagues at the Stoke Mandeville Hospital are to be found in his book, of which the second edition was published in 1976. So what of the future?

We must review our approach today, nearly 40 years after the opening of Stoke Mandeville Spinal Injuries Unit. At a time of recession and financial restraint it is very unlikely that priority will be given to the formation of new spinal

units of the size recommended by Guttmann (1976: p. 46), namely of 50 beds, increasing eventually to 100 beds. One reason is that spinal cord injury outside wartime is not a common cause for hospital admission. In the United Kingdom the number is approximately 300 per year. Another reason is that patients should be treated, as far as possible, in their own community, because they must eventually return to that community to lead independent lives and to become accepted members of the community.

A few regional specialist units have been created with their own rehabilitation teams, but at district hospital level acute treatment and rehabilitation will be in the hands of a number of individuals rather than a rehabilitation team. This means that the 'average' doctor, nurse, physiotherapist, occupational therapist or social worker who has not worked in a spinal injury centre will have limited experience.

Progress in the future depends upon establishing new areas of expertise, training and research. In this book we have taken one type of spinal cord injury, paraplegia, and examined this subject from the point of view of the rehabilitation team. In this way we can see what has been achieved and what we can work to achieve in our patients. It is hoped that this small book will encourage a 'rehabilitation team approach' to the treatment of the paraplegic patient.

REFERENCE

Guttmann, Sir Ludwig (1976). *Spinal Cord Injuries*, 2nd edn, Blackwell, London.