

# cord injury

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Pressure ulcers Many are preventable. Patients should be turned regularly on an appropriate mattress to minimise the risk of skin breakdown. Pain and spasticity Neurogenic pain is common. Once reflex activity returns following cord injury , spasticity may occur and can be problematic. Intrathecal infusion of baclofen may be required in resistant cases. Autonomic dysreflexia This is a paroxysmal syndrome of hypertension, hyperhidrosis (above the level of injury), bradycardia, flushing and headache in response to noxious visceral and other stimuli. It is most commonly triggered by bladder distension or rectal loading from faecal impaction. Neurological deterioration Post-traumatic syringomyelia may occur in around 28% of patients with spinal cord injury up to 30 years following injury . Approximately 30% of cases are symptomatic. Clinically , patients present with segmental pain at or above the level of injury , sensory loss, progressive asymmetrical weakness or increased spasticity . This warrants early MRI assessment. Expanding cavities require neurosurgical intervention. Thromboembolic events Deep vein thrombosis occurs in 30% of patients with spinal cord injury . Fatal pulmonary embolus is reported in 1-2% of cases. Thromboprophylaxis with compression stockings and low-molecular-weight heparin is indicated, provided there are no contraindications. contractures Disuse osteoporosis is an inevitable consequence of spinal cord injury and fragility fractures may occur. Heterotopic ossification may affect the hips, knees, shoulders and elbows. It occurs in 25% of patients with spinal cord injury . Surgery is appropriate in selected cases. Soft-tissue contractures around joints may occur as a result of spasticity but can be avoided by appropriate physical therapy , positioning and splinting. - cord injury

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