Proceedings of the Annual Scientific Meeting of the International Medical Society of Paraplegia, 28 to 30 July 1969, held at Stoke Mandeville Hospital, Aylesbury

Sir LUDWIG GUTTMANN, *President*—in the Chair.

I open our 1969 Annual Scientific Meeting and welcome you all most warmly —old friends and new friends—who have come here to Stoke Mandeville from all over the world to join in our Scientific Meeting. We have this year two particularly interesting main subjects which are of great interest not only to neurologists and physiologists but to anyone who is concerned with the treatment of paraplegics: (1) Classification and Nomenclature of Paraplegia; (2) Spinal Shock. Therefore, without further ado I ask Dr. Michaelis to open the discussion on the classification of paraplegia.

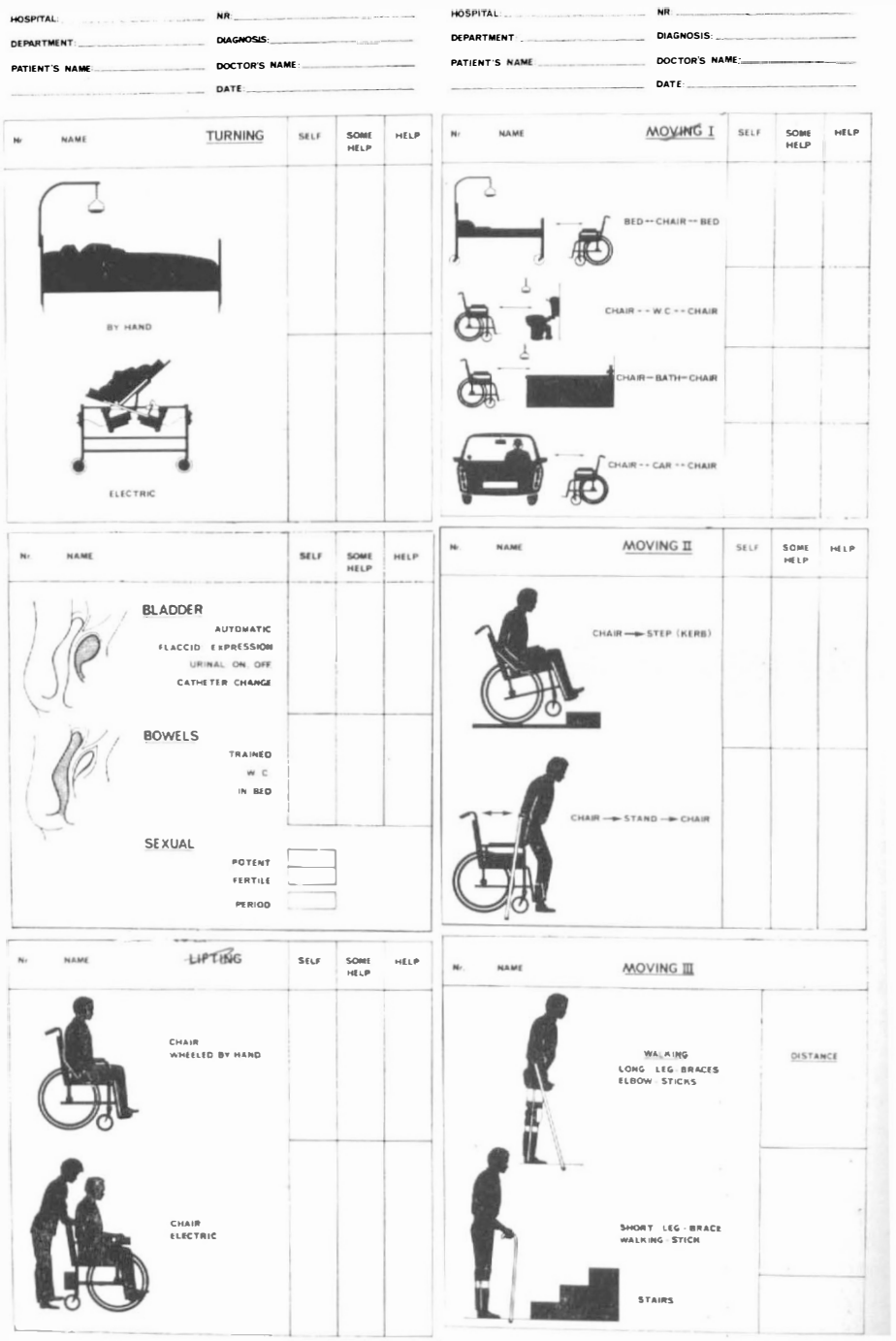
L. S. Michaelis: Opening paper.

In opening the discussion on neurological classification and nomenclature of paraplegia I propose to make only two remarks, to point 1 and point 4 of the summary of my paper, published in the May issue of *Paraplegia*, copies of which you will have found on your seats. I then will show you a few slides of a pictorial classification of disability.

Point 1, the definition of the level of a lesion of the spinal cord, recommends the adoption, as generally as possible, of the method A, that is giving the number of the most distal uninvolved segment of the cord, followed by the number(s) of the damaged vertebrae. If we cannot agree on using this method in all centres, including those at present using method B (calling the lesion by the number of the most proximal involved segment), then I would like to suggest that we as a society at least should recommend the use of a method to all new centres to be opened in the future.

Point 4, the right time for making a definite prognosis, has, in my experience, a considerable bearing on the morale of our patients. If, when giving a definite verdict within a day or two after the accident, we are proved wrong by events—and I believe we all know of cases who did either better or worse than we at first expected—we are risking losing his trust in our knowledge or truthfulness. I would therefore recommend that neither the patient nor the relatives are given more than cautious replies as to the prognosis of recovery of neurological function and that these replies are given by the doctor in charge, not by less-experienced members of the medical or paramedical staff. Three weeks in paraplegia and six weeks in tetraplegia are the periods required to be certain that a complete lesion will not recover to any extent of practical importance. In incomplete lesions several months may be required before the final degree of recovery can be foreseen.

A few words only to introduce a pictorial classification of residual ability or disability which I have devised in order to make it possible for non-specialised doctors, insurance officials, lawyers and judges, to get a really clear impression of the consequences of spinal cord injury in the individual case (Figs. 1-3). Functions


HOSPITAL:
NR:
DEPARTMENT:
DIAGNOSIS:
PATIENT'S NAME:
DOCTOR'S NAME:
DATE:
HOSPITAL:
NR:
DEPARTMENT:
DIAGNOSIS:
PATIENT'S NAME:
DOCTOR'S NAME:
DATE:
Nr NAME TURNING SELF SOME HELP HELP
BY HAND
ELECTRIC
Nr NAME MOVING I SELF SOME HELP HELP
BED ↔ CHAIR ↔ BED
CHAIR ↔ W.C. ↔ CHAIR
CHAIR ↔ BATH ↔ CHAIR
CHAIR ↔ CAR ↔ CHAIR
Nr NAME SELF SOME HELP HELP
BLADDER
AUTOMATIC
FLACCID EXPRESSION
URINAL ON. OFF
CATHETER CHANGE
BOWELS
TRAINED
W.C.
IN BED
SEXUAL
POTENT
FERTILE
PERIOD
Nr NAME MOVING II SELF SOME HELP HELP
CHAIR → STEP (KERB)
CHAIR → STAND → CHAIR
Nr NAME LIFTING SELF SOME HELP HELP
CHAIR WHEELED BY HAND
CHAIR ELECTRIC
Nr NAME MOVING III
WALKING
LONG LEG BRACES
ELBOW STICKS
DISTANCE
SHORT LEG BRACE
WALKING STICK
STAIRS

FIGS. 1 AND 2

are illustrated on the left side; on the right, where applicable, three degrees of independence or dependence on help are tabulated. The patient needs either no help, some help or is entirely dependent on help. By marking the sheets which

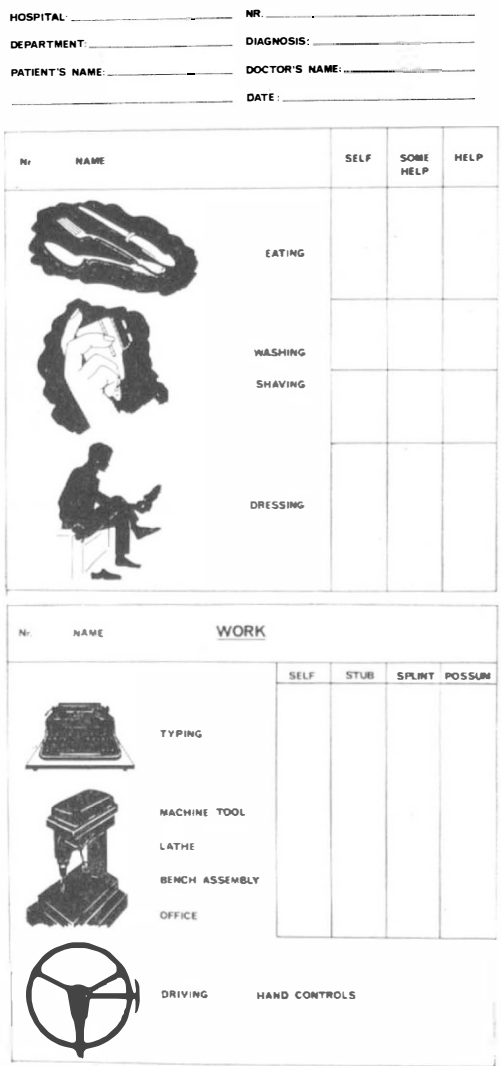


FIG. 3

should accompany all discharge notes or final insurance reports, a clear picture should be obtained by all concerned. For international use, only a few words of text would have to be translated. The illustrations are self-explanatory.

As you will hear, Dr. Cheshire is giving us a classification of cervical injuries which he devised for use among ourselves. The two methods are complementary.