Paraplegia **24** (1986) 392–393

Letters to the Editor

Dear Sir,

The article of Dudognon *et al.*, (Paraplegia 1986, 24, 194–200), is very important as it draws the attention on the need for a *complete* neurological examination after spinal cord injury. Too often, those in charge in the emergency department have a tendency to forget that the lesion is possibly in the spinal cord at a level lower than one affecting the lower limbs. Apparently normal motor and sensory function of both legs does not exclude bladder or bowel dysfunction. Nor may the fact, that patients, with a lumbar or sacral spinal cord injury become able to urinate 'spontaneously' (= by straining) after some hours, lead to the deduction that the conus and cauda equina are without deficit.

Lesions of the lower spinal cord can be dignosed by the assessment of the perineal sensation, of the cremasteric, bulbocavernosus and anal reflexes, and of the volitional control of the anal sphincter (Comarr 1959, Bedbrook 1981). These can easily be done in no time and should not be forgotten (Dollfus and Jacob-Chia, 1974). By doing this one can avoid the patient some severe early urinary complications:

Recently we examined a young man because of gross hematuria *one week* after lumbar spinal cord trauma without apparent neurological deficit. Intravenous pyelography demonstrated bilateral hydronephrosis and an overfilled bladder. The patient had normal leg function, but a complete conus lesion had been overlooked as this patient could urinate incompletely by straining.

The instructions to all who perform a neurological examination should state:

1. The spinal cord does not end at the neurological level of the soles of the feet.
2. The more distal part can be easily evaluated by some clinical tests. These should always be done if a spinal cord injury has occurred.

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