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LETTER TO THE EDITOR

Elective bilateral above the knee amputation in T4-complete spinal cord injury: a case report

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Dr Jaffe presents a treatment option for spasticity in a T4 paraplegic, which he believes not previously discussed in the literature, in a patient whose problem 'could not be addressed with the traditional medical treatment' and he is presenting this case to outline the working relationship between a clinician and a patient.

Firstly, such an amputation for spasticity in paraplegic patients has been described. Krause quoted by Borchard *et al*. (1919)[1] described the double amputation to prevent pressure sores developing on useless limbs to a German meeting of spinal injury consultants. The participants did not agree with this procedure and in particular, Krukenberg opposed this. This work was quoted by Silver (2003).[2]

This operation was again described in Ludwig Guttmann's textbook when he reviewed the situation in 1973.

> Not very long ago surgeons (Lindenberg, 1953; Street, 1958; Chase and White, 1959; Felix, 1959) performed amputations on patients with transverse lesions of the spinal cord as a preventive measure to the development of pressure sores, or these operations were carried out indiscriminately in paraplegics suffering from sores in the paralysed limbs which could have been healed by adequate conservative or surgical treatment or even on the grounds, that without their 'useless' legs, they will be more mobile. During the Second World War, the writer saw such mutilated victims, amongst them a tetraplegic, who had a bilateral amputation above the knees performed some time after his injury.[3]

Guttmann was strongly opposed to this procedure.

Jaffe twice postulates that no cases have been described earlier. Cases have been recorded in the German, British and North American literature and quoted in two textbooks.

Secondly, Jaffe says that on presentation, he changed the patients' medication and carried out magnetic resonance imaging.

In a case of intractable spasticity, it is vital that the patient is seen by a multidisciplinary team involving physiotherapists, doctors, occupational therapists and surgeons to eliminate the spastogenic factors and assess if the spasticity can be alleviated.

> These patients create a major therapeutic problem and all such patients should be managed in comprehensive units where careful therapy regime can be worked out and where these states can be assisted, controlled and helped materially.[4]

This view is reinforced by Robert Edgar who admirably reviews the indications for surgical treatment:

> It is also indicated if the spinal rehabilitation specialist, physical therapists, occupational therapists and patient have determined that the spasticity is a serious functional detriment and view the surgical treatment as a last resort. The neurosurgeon, if concurring, performs the procedure. In this conservative multidisciplinary approach, unnecessary surgery is eliminated.[5]

The surgical approach is graduated with deafferentation, rhizotomy and dorsal root entry zone procedure and is summarized by Edgar. If these procedures fail, then an anterior nerve root section as developed by Foerster or even an alcohol block can be performed. I have seen admirable results from the anterior nerve root section and the alcohol block, which have enabled the spastic patient to resume daily activities.

The absence of such a unified approach is contrary to the fundamental principles of treatment of paraplegic patients. Before such a drastic procedure as an amputation, it is mandatory that a psychiatrist assesses the patient.

Jaffe says

> Over the course of 8 weeks, the patient and I had long discussions regarding the benefits and alternatives to surgery. We discussed the shift in the centre of gravity, wheelchair seating and so on.

What does 'and so on' mean? Does it include the aforementioned multidisciplinary approach?

Jaffe says that his publication is meant to outline the working relationship regarding treatment options between the clinician and the patient.

This course of treatment is at variance with the accepted principles of treating a patient with spinal injury. The patient was not exposed to traditional treatment.

No one has a monopoly of knowledge, and having obtained the advice of a psychiatrist, surely it would have been prudent at the very least to have had a conference with a more experienced colleague well versed in treating patients with spinal injury.

JR Silver
Emeritus Consultant Stoke Mandeville Hospital, Wendover, Buckinghamshire, UK
E-mail: jrussellsilver@btconnect.com

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