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EDITOR'S PAGE

Evidence based spinal cord medicine

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Dear *Spinal Cord* reader,

Evidence based medicine (EBM) is about integrating 'individual clinical expertise' and the 'best external evidence'. Individual clinical expertise has been put low on the ranking of EBM but is without doubt important, if the clinical specialized expertise is extensive. To acquire such expertise specialized multidisciplinary teams, expert centres and referral paths to these centres are needed. The best external evidence is determined by research data and clinical studies, ranked with Levels of Evidence, and translated into Grades of Recommendation. If one looks at reviews of different aspects of SC medicine it becomes clear that there is a paucity of high-level evidence to guide practice. What good clinical practice consists of, changes with longitudinal evaluations: ideas change, conditions change and expectations change. Therefore, there is constant need for critical evaluations and in-depth retrospection. In this, the second issue of Spinal Cord in 2010, several very important contributions can be found. The review paper by van Asbeck *et al*. identified 11 pressure ulcer healing assessment instruments. Clinimetric information was incomplete for all instruments, though most complete and promising were 'ruler length and width' and 'Sessing' scale. Further study of the clinimetric properties of pressure ulcer assessment instruments is necessary before the best instrument can be selected. This is a clear demonstration that more intensive work is needed before EBM can become a reality.

A step in the right direction is given by Goodwin-Wilson *et al*. They made a longitudinal audit to develop evidence based maps of rehabilitation for different lesion categories over a five-year period in a large sample of newly injured neurologically damaged patients, aged 18 or over. The paper provides examples of EB maps from one particular group, T8-T12 Frankel A. They conclude that pathways of care can be used to identify need for service change, to audit service change, to provide EB expectations for staff, patients and external parties, to look at variances affecting care, to make service transparent, to provide figures for comparison with other philosophies of care and to ensure consistency across the service.

That modern techniques can help is demonstrated in a paper by Linassi *et al*. who show that adapting the international standards for neurological classification of spinal cord injury system to a computer generated format is possible. This would promote uniformity in the collection and interpretation of impairment data, and can be utilized to educate health care personnel including residents and medical students on classifying the impairment in traumatic spinal cord injury.

Interesting clinical data related to high-tech treatments are given by Lombardi *et al*. They found in a retrospective study that sacral neuromodulation can be a useful treatment option in select incomplete SCI patients affected by chronic neurogenic bowel symptoms refractory to conservative treatment.

Gorgey *et al*. found that administration of oral baclofen did not attenuate the protective effects of spasticity on body composition and metabolic profile after SCI. The possibility that oral baclofen could exert an independent protective effect needs to be further investigated.

Costacurta *et al*. included a retrospective analysis of 106 patients, 16 years of age or younger, which represents 5.4% of the total of SCI cases. The causes of the 50.9% traumatic injuries were: gunshot, 42.6%; traffic accident, 38.9%; diving, 9.3%; and fall, 3.7%. The non-traumatic aetiologies were mainly caused by tumour (36.5%) and infection (19.2%). The average time between SCI event and arrival at the rehabilitation medical centre was 27 months. These figures call for reflection.

Many more important papers are included in this issue on clinical findings, experimental research and case reports. Enjoy reading them.

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