

These revised guidelines are an outstanding achievement, and neurosurgeons should be proud of these authors who have taken the time and effort to create this work. Overall, the methodology is sound and the results are solid. I congratulate the authors for not being tempted to comment on popular but yet inadequately studied topics such as hypothermic treatment of acute spinal cord injury just because this topic appears in the newspapers.

Some of the recommendations in this volume are repeated in different chapters. For example, the first two recommendations in the paper on the management of acute traumatic central cord syndrome (ATCCS) are also found in the paper dealing with cardio-pulmonary management of spinal cord injury.

The paper on transportation of patients with acute traumatic cervical spine injuries raises some interesting policy questions for providers. In this paper, the second recommendation is that, whenever possible, patients with acute cervical spine or spinal cord injuries be transported to specialized acute spinal cord injury treatment centers. But what makes an institution a “specialized acute spinal cord injury treatment center”? Are these centers designated by a governmental agency/regulatory body, or are they self-designated? If the answer is that an acute spinal cord injury center is any institution that can provide acute critical care and surgical care, then isn't it the care itself that is important and not the designation of the institution?

What about care of the acute spinal cord injury patient that is provided within all the recommendations for critical care and surgical care published in these guidelines but provided in an institution that does not choose to call itself an “acute spinal cord injury treatment center”? Is the care inadequate because of the lack of designation or recognition? This is not a trivial issue from a medical-legal standpoint.

There is a concern shared by a number of healthcare providers that a recommendation like the second recommendation in this particular paper is the result of a conflict of interest from large medical centers that are often self-

designated specialty care centers (ie, “we can do it better so you should send all your cases to us”).

Finally, the summary Table in the introduction is incomplete. It lists many of the recommendations listed in this volume but does not list all of them. A complete and comprehensive tabulation of all the recommendations would be very helpful.

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In this newest edition of the *Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injury*, the author group has updated the 2002 guidelines in a number of ways, incorporating the newest available studies as well as scrutinizing existing studies. The review process for this edition has included additional review by the AANS/CNS Joint Guidelines Committee, and this has prompted several refinements of the recommendations that have resulted in a work that is very tightly tied to the available evidence in the literature. Features such as a summary of changes between the two sets of guidelines, and evidence tables that are easy to cross-reference with text and recommendations make this edition more accessible than ever before.

As a community neurosurgeon, it can sometimes be difficult to glean practical rules from many of the EBM practice guidelines currently available; I believe this set will be an aid not only to academicians and those with backgrounds in epidemiology and evidence-based medicine, but also to the vast majority of neurosurgeons who are extremely skilled in patient care and who look to these types of published practice guidelines for changes in current thinking about what is—and is not—supported in the neurosurgical literature. The more accessible and transparent these guidelines efforts are, the more readily they will be embraced both by our colleagues in neurosurgery and well as in other disciplines, including emergency medicine and trauma surgery; the use of the same sets of guidelines by multiple specialties will surely foster better communication

and collaboration in the care of many patients. The author group should be congratulated on another excellent effort.

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In recent years, there has been a growing national interest in enhancing the quality of patient care. One of the commonly used methods is standardization, which has been associated with increased quality of care in various health care settings. In the setting of spinal trauma, rigid standardization is frequently impractical and difficult, as there are often subtle differences between patient characteristics, injury patterns, and other clinical considerations that may result in two similarly presenting patients receiving different, yet appropriate treatment. Another method to enhance quality is to provide practitioners with factual, evidenced-based information that may validate established consensus opinion, or, in some cases, may even shift treatment paradigms. The 2012 *Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injury* is likely to improve the quality of patient care through both mechanisms.

Students of the 2002 *Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injury* will be very pleased with the current offering. The present rendition provides a balanced, evidenced-based assessment of the available literature regarding a broad swath of management strategies ranging from underappreciated topics such as the transportation of acute SCI patients, to more provocative subjects such as the use of steroids in acute spinal injury. The authors provide an easy to use table that contrasts the 2002 and 2012 recommendations for each of the

investigated topics. Although this table is handy and informative, the reader should not use this as a substitute for reading the individual chapters in detail, as the material provided allows for a better understanding of the genesis of the recommendations.

All of the topics are thoroughly investigated and presented, yet I must make special mention of the chapter entitled “Pharmacological Therapy for Acute Spinal Cord Injury.” The use of steroids in acute SCI is a very controversial subject, with practitioners falling on either side of the treatment line. To many, the literature has previously lacked clarity on this subject. One of the few criticisms of the 2002 guidelines is that the role of methylprednisolone was not clearly defined: “Treatment with methylprednisolone for either 24 or 48 hours is recommended as an option in the treatment of patients with acute spinal cord injuries...” The present day usage of methylprednisolone is fueled by both a desire to do everything humanly possible for these tragically injured patients, as well as medicolegal concerns, which can be quite significant in some communities. The 2012 guidelines clearly state that methylprednisolone is not recommended in the management of acute SCI, and that there is no Class I or II evidence to support its use. In stark contrast, there is Class I–III evidence that this treatment is associated with harmful side effects. This powerful and well-written chapter will provide an immediate and beneficial impact on patient care.

The authors should be congratulated for their excellent work. This was an arduous and challenging task that was completed in an elegant and outstanding fashion.

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