

«... La maggior parte dello sforzo riabilitativo nelle lesioni spinali è oggi diretto a minimizzare le limitazioni funzionali.

Interventi specifici diretti a massimizzare la partecipazione sociale sono limitati.

Come risultato l'impegno per la piena reintegrazione della persona nella comunità di appartenenza è spesso realizzato in modo incompleto»

[Arch Phys Med Rehabil.](#) 2007 Mar;88(3 Suppl 1):S71-5.

Spinal cord injury medicine. 4. Community reintegration after spinal cord injury.

[Scelza WM](#)¹, [Kirshblum SC](#), [Wuermsler LA](#), [Ho CH](#), [Priebe MM](#), [Chiodo AE](#).

Author information

Department of Physical Medicine and Rehabilitation, Carolinas Rehabilitation, Charlotte, NC, USA. William.Scelza@carolinashealthcare.org <William.Scelza@carolinashealthcare.org>

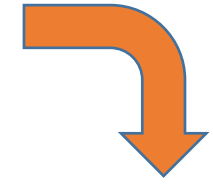
Abstract

This self-directed learning module highlights community reintegration after spinal cord injury (SCI). It is part of the study guide on spinal cord injury medicine in the Self-Directed Physiatric Education Program for practitioners and trainees in physical medicine and rehabilitation. This article specifically focuses on physical, social, psychological, and environmental barriers that affect people with SCI and on how these issues affect relations with others. Recreational and exercise options are also discussed.

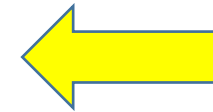
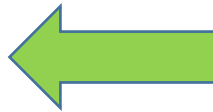
PERCORSO DI RIENTRO



CARE
CASA + RECUPERO

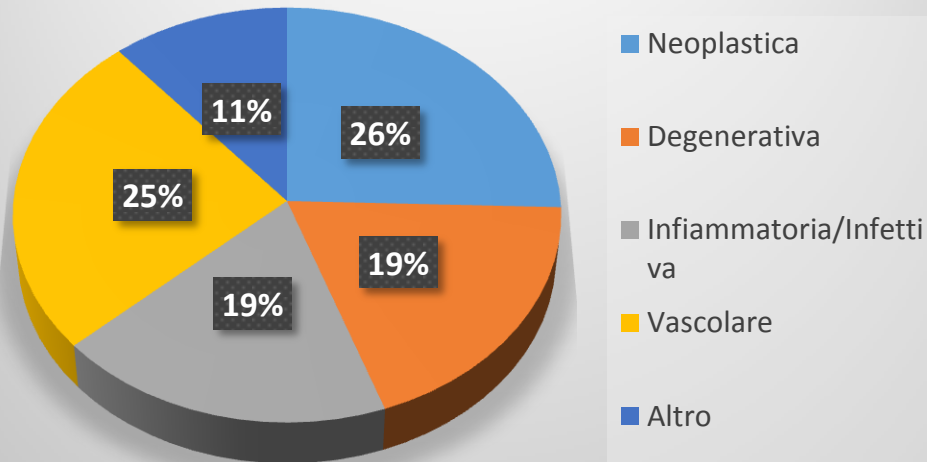


SV



Il quadro di riferimento delle lesioni midollari cambia !!!

LESIONI **NON** TRAUMATICHE



(modificato da:PW New, RA Cripps and BB Lee: Global maps of non traumatic spinal cord injury epidemiology:towards a living data repository. Spinal Cord (2014) 52,97-109)

INCREMENTO DELLA POPOLAZIONE **ANZIANA** CON LESIONE MIDOLLARE

INCREMENTO DI PARAPLEGIE (+19,2) E TETRAPLEGIE (+40,9) **INCOMPLETE**

Table 70. Trend in Neurologic Category at Discharge by Year of Injury

Neurologic Category	Year of Injury								Total
	1973-1979	1980-1984	1985-1989	1990-1994	1995-1999	2000-2004	2005-2009	2010-2013	
Tetraplegia, complete	1,155 (25.3)	1,085 (21.9)	729 (19.0)	624 (18.9)	684 (18.9)	640 (18.6)	571 (15.8)	305 (12.5)	5,793
Tetraplegia, incomplete	1,282 (28.1)	1,599 (32.3)	1,197 (31.2)	821 (24.9)	1,020 (28.2)	1,120 (32.5)	1,279 (35.5)	999 (40.9)	9,317
Tetraplegia, minimal deficit	4 (0.1)	13 (0.3)	62 (1.6)	115 (3.5)	89 (2.5)	61 (1.8)	48 (1.3)	10 (0.4)	402
Paraplegia, complete	1,265 (27.7)	1,231 (24.9)	960 (25.0)	946 (28.7)	972 (26.8)	798 (23.2)	757 (21.0)	436 (17.8)	7,365
Paraplegia, incomplete	805 (17.6)	948 (19.2)	802 (20.9)	640 (19.4)	636 (17.6)	553 (16.1)	702 (19.5)	470 (19.2)	5,556
Paraplegia, minimal deficit	0 (0.0)	19 (0.4)	50 (1.3)	95 (2.9)	54 (1.5)	51 (1.5)	37 (1.0)	8 (0.3)	314
Normal	45 (1.0)	38 (0.8)	16 (0.4)	13 (0.4)	19 (0.5)	24 (0.7)	12 (0.3)	10 (0.4)	177
Unknown	6 (0.1)	17 (0.3)	25 (0.7)	41 (1.2)	149 (4.1)	196 (5.7)	201 (5.6)	205 (8.4)	840
Total	4,562 (15.3)	4,950 (16.6)	3,841 (12.9)	3,295 (11.1)	3,623 (12.2)	3,443 (11.6)	3,607 (12.1)	2,443 (8.2)	29,764

Footnote 1: Para & Tetra minimal deficit categories were added in 1987. Some records have been updated.

[Aging Clin Exp Res.](#) 2011 Jun;23(3):202-8.

Age influences rehabilitative outcomes in patients with spinal cord injury (SCI).

[Franceschini M¹](#), [Cerrel Bazo H](#), [Lauretani F](#), [Agosti M](#), [Pagliacci MC](#).