

SUPPLEMENTARY DIGITAL MATERIAL 5

Supplementary Table V.—Ageing-related recommendations.

N°	Recommendation	Indicator of target population	Related information	SoR	LoE	Source (Guideline chapter, page) short title,
1	1.4.6 If an older person with a traumatic injury is on a care pathway that does not routinely involve geriatrician support, consider referral to an orthogeriatrician, a surgical liaison or a perioperative physician (as appropriate).	"older person"	<p>Traumatic injury: This includes multiple, major and severe injuries, sometimes referred to as polytrauma, and any musculoskeletal, visceral, nerve, soft tissue, spinal or limb injury that requires admission to hospital at the time of injury.</p> <p>The committee also used their experience to recommend that older people have access to orthogeriatricians, surgical support or perioperative physicians. This is important because the needs of older people with traumatic injuries are complex, and it will prevent delays further on in rehabilitation.</p>	Weak	Very low	NICE_Rehabilitation, 2022 Chapter: 1.4 Developing a rehabilitation plan and making referrals Page: 27
2	1.4.7 For adults with a fragility fracture, assess bone health and refer as necessary, for example, to a specialist bone health clinic or outpatient service. Also see the NICE guideline on osteoporosis.	"Fragility fracture"	The 2012 NICE guideline "Osteoporosis: assessing the risk of fragility fracture" is available here: https://www.nice.org.uk/guidance/cg146	Strong	Very low	NICE_Rehabilitation, 2022 Chapter: 1.4 Developing a rehabilitation plan and making referrals Page: 27
3	1.4.9 Assess all adults over 65 who have a traumatic injury for their risk of falls in line with the recommendations on multifactorial risk assessment in the NICE guideline on falls.	"adults over 65"	The 2013 NICE guideline "Falls in older people: assessing risk and prevention" is available here: https://www.nice.org.uk/guidance/cg161/chapter/1-Recommendations#multifactorial-falls-risk-assessment	Strong	Very low	NICE_Rehabilitation, 2022 Chapter: 1.4 Developing a rehabilitation plan and making referrals Page: 27
4	1.11.30 Be aware that spinal orthoses, such as cervical collars and thoracolumbar spinal orthoses, may be poorly tolerated by some people, particularly older people or those with delirium, cognitive impairment or dementia.	"older people"	Evidence showed that spinal orthoses can help improve patient rehabilitation outcomes, and they are used in current practice. However, in the committee's experience, not all trauma populations see a benefit (for example, older people) and spinal orthoses can cause adverse events if improperly fitted. Healthcare professionals should be aware that these devices may be poorly tolerated and know when to discuss problems with the surgical team. Because of these issues with the evidence, the committee made a research recommendation on spinal orthoses for older people.	Weak	Very low	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 57
5	1.11.17 Do not withhold aerobic exercise programmes from older people after a traumatic injury.	"older people"	<p>The committee discussed how for older people, fitness and strengthening programmes can help to optimise respiratory function, increase endurance when doing rehabilitation exercises, and improve mobility.</p> <p>Currently, some physiotherapists do not offer aerobic exercise programmes to older people who are frail. For these physiotherapists, there will be a change in practice and there may be a greater uptake of aerobic exercise in older people.</p>	Strong	Very low	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 60

6	1.11.49 For people with a fragility fracture, measure vitamin D levels and consider a supplement. Also see the recommendations in the NICE guideline on osteoporosis: assessing the risk of fragility fracture and the NICE guideline on vitamin D: supplement use in specific population groups.	<i>"People with a fragility fracture"</i>	<p>The 2012 NICE guideline "Osteoporosis: assessing the risk of fragility fracture" is available here: https://www.nice.org.uk/guidance/cg146</p> <p>The 2012 NICE guideline "Vitamin D: supplement use in specific population groups" is available here: https://www.nice.org.uk/guidance/ph56</p> <p>Low vitamin D status (sometimes called vitamin D deficiency) is defined by the Department of Health as a plasma concentration of 25 hydroxyvitamin D (the main circulating form of the vitamin) of below 25 nmol/litre (equal to 10 ng/ml).</p> <p>No evidence was identified for interventions aimed at increasing the uptake of vitamin D supplements among: people aged 65 or older, people who have low or no exposure to the sun, or people who have dark skin.</p> <p>Older people are also at increased risk, particularly if they are frail, because they may spend more time indoors and have limited sun exposure.</p> <p>People aged 65 years and over and people who are not exposed to much sun should also take a daily supplement containing 10 micrograms (or 400 IU) of vitamin D.</p>	Weak	Very low	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 60
7	1.11.47 Following assessment by a dietician specialising in trauma care, consider supplementation of dietary protein for people who are frail, have gastrointestinal health issues or have multiple injuries.	<i>"People who are frail"</i>	<p>This recommendation is related to the 2006 NICE guideline "Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition" available here: https://www.nice.org.uk/guidance/cg32</p> <p>1.4.2 For people who are not severely ill or injured, nor at risk of refeeding syndrome, the suggested nutritional prescription for total intake should provide all of the following:</p> <ul style="list-style-type: none"> • 0.8 to 1.5 g protein (0.13 to 0.24 g nitrogen)/kg/day <p>1.4.4 Nutrition support should be cautiously introduced in seriously ill or injured people requiring enteral tube feeding or parenteral nutrition. It should be started at no more than 50% of the estimated target energy and protein needs. It should be built up to meet full needs over the first 24 to 48 hours according to metabolic and gastrointestinal tolerance. Full requirements of fluid, electrolytes, vitamins and minerals should be provided from the outset of feeding.</p>	Weak	Very low	NICE_Rehabilitation, 2022 Chapter: 1.11 Physical rehabilitation Page: 60
8	1.15.21 For people with a spinal cord injury who are using a spinal orthosis (for example, cervical collar or thoraco-lumbar spinal orthosis), regularly assess them for complications such as pain, pressure sores,	<i>"older people"</i>		Strong	Very low	NICE_Rehabilitation, 2022 Chapter: 1.15 Rehabilitation after spinal cord injury Page: 77

	swallowing or breathing difficulties (particularly in older people or those with dementia or delirium).						
9	<p>2.1 We recommend that, in the context of bone health screening, all adult women and men with spinal cord injury (SCI), regardless of injury duration, should have measurements of serum 25-hydroxyvitamin D (25-(OH)D) done by a validated assay method; complete blood cell count; ionized calcium (or calcium adjusted for albumin), phosphate, intact parathyroid hormone, creatinine (and estimated glomerular filtration rate), bone-specific alkaline phosphatase and transaminases, hemoglobin A1C, and thyroid-stimulating hormone levels; and 24-hour urine collection for calcium and creatinine excretion.</p> <p>Clinical Consideration 2.1 These laboratory measurements should be done as soon as possible after the patient establishes ongoing care with their physician, or if there is significant loss of bone mineral density, an incident fracture, or a change in a medical condition or medication that might be expected to influence osteoporosis risk.</p> <p>Referral to an endocrinologist or appropriate subspecialist should be considered if there are unexplained serum or urine calcium levels (hyper or hypo) and/or if the workup is suggestive of hyperthyroidism or hyperparathyroidism. Referral to a nephrologist should be considered in those with chronic kidney disease stage 4 (CKD 4) (glomerular filtration rate [GFR] 15-29 mL/min) and CKD 5 (GFR 15 mL/min or less) or unexplained renal impairment.</p>	<p><i>"Senile or postmenopausal-related bone loss"</i></p>	<p>Consideration for causes of osteoporosis other than the SCI itself, such as senile or postmenopausal-related bone loss, is important, as appropriate diagnostic workups may identify secondary causes of osteoporosis, which require additional management approaches.</p> <p>In elderly postmenopausal women in the Women's Health Initiative, anemia was positively associated with incident fractures. Although this association has not been reported in individuals with SCI, anemia is a prevalent condition in this population.</p> <p>The importance of recording menopausal status in women with SCI is recognized, and information on menopausal status is collected as part of the International Spinal Cord Injury Endocrine and Metabolic Function Basic Data Set.</p>	Strong	Low	<p>Consortium_Bone health, 2022 Chapter: 2. Laboratory screening Page: 27</p>	
10	<p>3.1 We recommend that clinicians adhere to the 2019 ISCD Adult Official Positions for Dual-energy X-ray absorptiometry in Patients with Spinal Cord Injury.</p>	Age ranges	<p>Definition of Sublesional Osteoporosis – the definitions applied are determined by the individual's biological sex, and their age. Males ≥ 50 years of age or postmenopausal females: Hip (total or femoral neck), distal femur, or proximal tibia T-score ≤ -2.5</p>	Strong	Moderate	<p>Consortium_Bone health, 2022 Chapter: 3. Bone density testing with dual-energy X-ray absorptiometry Page: 36</p>	
11	<p>5.2 The following are recommendations for calcium intake as a combination of food and supplements (preference for dietary intake over supplements). Group and age calcium recommendation: Men and premenopausal women age 19-50 years: 1,000 mg/day Men 50-70 years: 1,000 mg/day Women 50-70 years: 1,000-1,200 mg/day Men and women 71+ years: 1,000-1,200 mg/day</p>	Age ranges		Strong	Moderate	<p>Consortium_Bone health, 2022 Chapter: 5. Calcium and vitamin D3: diet or supplements Page: 48</p>	

	Not appropriate for individuals who are found to be hypercalcemic.					
12	1. Regular monitoring of the cardiometabolic syndrome should be carried out as part of lifelong follow-up in persons with SCI (to be carried out by the general practitioner, depending on the care situation). With increasing age, also the risk of cardiovascular disease increases. The longer the SCI, the greater the loss of lean mass. ^c	"increasing age" and "The longer the SCI"		Strong	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 16
13	2. Since tetraplegics do not show classic symptoms of a cardiac infarction, an annual ECG or long-term ECG should be performed from 10 years after the onset of paralysis or if the patient is over 60 years of age. ^c	"from 10 years after the onset of paralysis" and "patient is over 60 years of age"		Weak	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 16
14	10. Nutritional status should be obtained as part of lifelong follow-up for elevated cardiovascular risk factors. With increasing age, also the risk of cardiovascular disease increases. The longer the SCI, the greater the loss of lean mass. ^c	"increasing age" and "The longer the SCI"		Weak	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 16
15	1. As part of lifelong follow-up, symptoms of deep vein thrombosis should be asked about and clinically examined, specifically in the first year after SCI, pregnancy, hormonal contraception or in the presence of one of the following risk factors: smoking, diabetes, age > 45 years, AIS A. For further recommendations on thromboembolism prophylaxis, please refer to the AWMF S1 guideline: "Thromboembolism prophylaxis in paraplegia".	Age ranges	The AWMF S1 guideline: "Thromboembolism prophylaxis in paraplegia" is available in German here: https://register.awmf.org/de/leitlinien/detail/179-015	Strong	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.3 Cardiovascular diseases Page: 17
16	2. A symptom-based search for respiratory disturbances during sleep (recommended because of the frequency of this condition and its increasing prevalence with age) and polygraphy/polysomnography should be performed if suspected.	"Long-term course" and "its increasing prevalence with age"	SCI often leads to reduced respiratory function. The causes are (a) the reduced strength of the inspiratory and expiratory respiratory muscles (incl. auxiliary respiratory muscles) due to paralysis. (b) the altered compliance of the lung and thoracic wall, especially in the long-term course, (c) the central respiratory control, (d) the reduction of the diameter and the hyperreactivity of the airways as a result of the autonomic dysregulation and (e) the interaction between thorax and abdomen as a result of positional displacement of the diaphragm and the thoraco-abdominal pressure ratios.	Weak	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.4 Respiratory system - respiration, ventilation, respiratory infections and sleep-related breathing disorders (b440-b449) Page: 17
17	1. In the context of lifelong follow-up, if the basic status is assured (standard vaccinations, as well as for indication and booster vaccinations), the vaccination status of influenza, pneumococci, herpes zoster,	"from the age of 50"	Herpes zoster: Vaccination to prevent herpes zoster and postzoster neuralgia is recommended by the German-speaking professional societies (STIKO, BAG, National Vaccination Committee of Austria) from the age of 50 at least for high-risk patients.	Strong	Very low	German speaking society_Lifelong follow-up, 2022

	meningococci, Covid-19 should be specifically asked about and, if necessary, recommended.					Chapter: 3.5 Immune system, vaccinations and allergies (b435) Page: 17
18	1. Colonoscopy shall be performed similar to the general population according to guidelines set by professional societies (recommended at age 50 years, with a follow-up examination every 10 years thereafter, or earlier depending on findings) ^c	Age ranges	2. If there are changes in stool consistency, shape, and frequency, assessments such as the Bristol Stool Scheme or the Neurogenic Bowel Dysfunction Score should be considered. 3. Because the colon transit time is slower in people with spinal cord injury, preparation for a colonoscopy takes several days. 4. The colonoscopy should be planned individually. For people with SCI higher than T6, flaccid SCI and those with severely limited mobility, it should be performed in a hospital setting. Intestinal preparation begins on the day of admission and lasts three to four days. After the examination, the patient should be observed for one night.	Strong	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.6 Digestive system and neurogenic bowel dysfunction Paragraph: 1 Page: 23
19	1. As part of lifelong follow-up, all individuals with SCI should have regular/annual evaluations for possible upper extremity problems (especially shoulder, elbow, wrist, and carpal tunnel syndrome). ^c 2. It is therefore advisable to carry out the checks on all patients, but to pay particular attention to elderly people and those who have been in a wheelchair for a long time. ^c	"elderly people"	4. Evaluation of the upper extremities (specifically shoulder, elbow, wrist, and carpal tunnel syndrome) should minimally include the following: - Pain history and impact on activities of daily living (VAS/NRS, WUSPI, ISCoS Data Sets) - Joint status of the upper extremities - The International Standards for Neurological Classification of Spinal Cord Injury (ISNCSCI) - Supplemental clinical examination for indication - Evaluation of assistive devices and sitting position - Evaluation of transfer and wheelchair handling ^c	Strong	Very low	German speaking society_Lifelong follow-up, 2022 Chapter: 3.10 Musculoskeletal system Page: 31
20	Clinicians should discuss with the individual with SCI, family members and caregivers that there may be an increased risk of bladder cancer in individuals with neurogenic lower urinary tract dysfunction, particularly in those with a long history of neurogenic lower urinary tract dysfunction and complicating factors, such as recurrent urinary tract infections. Clinicians should educate individuals with SCI regarding the symptoms to look out for (for example, recurrent infection, recurrent catheter blockages, or hematuria), which mean they should see a healthcare professional. ^c	"long history of neurogenic lower urinary"		Weak	Very low	Can-SCIP, 2021 Chapter: K. Bladder function Section: K.16.1
21	Educate women with SCI about the effects of perimenopausal and menopausal changes on sexual function, bone health, accelerated metabolic aging, and metabolic syndrome after SCI.	"perimenopausal and menopausal"		Strong	Very low	Can-SCIP, 2021 Chapter: R. Sexual health & relationships Section: R12.7
22	3.1 In SCI patients, higher doses might be required to improve detrusor overactivity and/or bladder compliance, which means that adverse anticholinergic events, such as dry mouth, constipation and blurred vision, might be more problematic. In addition,	"elderly patients"	Risk factors for renal damage (High evidence level): • Lower urinary tract dysfunction: decreased maximum bladder capacity, detrusor overactivity, detrusor sphincter dyssynergia, decreased bladder compliance (<10–20	Strong	Moderate	Sekido N_Urinary dysfunction, 2020 Chapter: 3. Pharmacological therapy Page: 283

	<p>especially in elderly patients, the total anticholinergic load should be taken into account to prevent cognitive impairment.</p> <p>Eventually, the panel concluded that anticholinergic drugs are recommended for patients who have the risk factors for renal damage and symptomatic urinary tract infection or urinary incontinence.</p>	<p>mL/cmH₂O), high detrusor leak point pressure (>40 cmH₂O);</p> <ul style="list-style-type: none"> • Urinary management: indwelling urethral catheterization, bladder reflex triggering (reflex voiding); and • Level and severity of the injury: tetraplegia, complete paralysis. 			
23	<p>4.3 Individuals with SCI should not be uniformly placed on high-fiber diets. Increases in fiber intake from food or a supplement should be done gradually to assess tolerance.</p> <p>Daily Fiber Quantity Recommendations: Adequate intake for daily recommended fiber is 25 g for women and 38 g for men under 50 years of age. To account for decreased food intake with aging, for men and women over 50 the daily recommended amount is 21 g for women and 30 g for men.</p>	"men and women over 50"	Strong	Low	<p>Consortium_Neurogenic bowel, 2020</p> <p>Chapter: 4. Diet, supplements, fiber, fluids, and probiotics</p> <p>Page: 27</p>
24	<p>5.1 Providers can use oral medications for bowel management; however, the evidence for their use is limited and there are no data to suggest the use of one medication over another.</p> <p>The standard dose of prucalopride is 2 mg, but in individuals older than 60 years, the dose is usually 1 mg daily.</p>	"individuals older than 60 years"	Strong	Low	<p>Consortium_Neurogenic bowel, 2020</p> <p>Chapter: 5. Oral medications</p> <p>Page: 30</p>
25	<p>6.4 The routine use of enema formulations such as sodium phosphate (Phospho-Soda), soapsuds, or milk and molasses is not recommended; however, in selected individuals, intermittent use for constipation may be helpful.</p> <p>In 2014, the FDA released a warning that physicians should be consulted prior to the use of sodium phosphate enemas for individuals who are over the age of 55</p>	"individuals who are over the age of 55"	Strong	Very low	<p>Consortium_Neurogenic bowel, 2020</p> <p>Chapter: 6. Use of suppositories, enemas, and irrigation</p> <p>Page: 34</p>
26	<p>2.20 If there is history of difficulty passing a catheter in a male, consider using a Coudé catheter or consult urology.</p> <p>A Coudé catheter is especially useful in those with a history of sphincterotomy and in older men, in particular those with a history of prostatic hypertrophy or transurethral resection of the prostate.</p>	"older men"	Strong	Very low	<p>Consortium_Autonomic dysreflexia, 2020</p> <p>Chapter: Autonomic Dysreflexia</p> <p>Page: 23</p>
27	<p>31. At present orlistat is the only licenced medication for the treatment of obesity. It is associated with increased rates of gastrointestinal events. This could include steatorrhea, fatty faecal incontinence or urgency of</p>	"older people"	Weak	Very low	<p>MASCIIP_Weight management, 2019</p> <p>Chapter: Medical and Surgical interventions</p>

bowel movements. This impact of these medications should be considered in the context of bowel management. These effects can be reduced by adhering to a low-fat diet and distributing daily fat intake over three main meals. A multivitamin and mineral supplement may be considered whilst using this medication.

If there is concern about micronutrient intake adequacy, a supplement providing the reference nutrient intake for all vitamins and minerals should be considered, particularly for vulnerable groups such as older people and young people.

28	6.7 Postanal repair results in satisfactory outcome in the long term in patients with neurogenic sphincter weakness. However, this is a single center experience, which needs further confirmation.	<i>"the elderly"</i>	Postanal repair is inexpensive in comparison with graciloplasty and sacral nerve stimulation, and has low morbidity. Additionally, this procedure is useful in the elderly or those with significant co-morbidities. Although long-term continence has been found to deteriorate, the procedure can result in a satisfactory outcome in the long-term in a proportion of patients.	Weak	Very low	International Consultation on Incontinence, 2018 Chapter: Surgical treatment Page: 52
29	35. It is recommended that Physical and Rehabilitation Medicine (PRM) physicians continue long-term follow-up of persons with SCI, also when ageing, aiming to meet the individualised needs of the person using diverse treatment strategies along the lifespan of these persons with a life-long disability (see also Evidence-Based Position Paper (EBPP) ⁶ for ageing persons with disabilities).	"patients with SCIs ageing" and "especially in the second and third decades post SCI"	Patients undergo annual re-evaluations for the first 3-5 years until they establish a consistent record of healthy routines and participation in the community. ²⁰⁻²³ as patients with SCIs ageing, especially in the second and third decades post SCI, their medical and functional conditions may change dramatically and may require the resumption of annual evaluations. The Evidence based position paper on physical and rehabilitation Medicine (prM) professional practice for ageing people with disabilities is available here: 10.23736/S1973-9087.17.04864-X	Strong	Very low	UEMS_PRM, 2018 Chapter: D. Recommendations on PRM management and process Page: 804
30	3.2.3 Special care should be taken of patients at risk for autonomic dysreflexia (mainly patients with SCI above T6), being aware of the clinical signs of the onset of the crisis (eg, head sweating, headache) and its management (stop the filling, tilting the table, nifedipine). Moreover, blood pressure assessment during the urodynamic study is advisable.	<i>"elderly"</i>	In 2013, Huang et al underlined how aging decreases autonomic dysreflexia symptoms and the magnitude of diastolic blood pressure elevation, possibly through the mechanism of decreased baroreceptor sensitivity.	Strong	No classification possible ^a	International Continence Society_Uroynamics, 2018 Chapter: Uroynamics in SCI Paragraph: 3.3.2 Page: 586
	Considering the high incidence of silent episodes of autonomic dysreflexia during the urodynamic, they recommended that monitoring of cardiovascular parameters during these procedures be routinely performed.					
	The authors strongly recommended blood pressure monitoring during urodynamic especially for elderly SCI patients.					

31	<p>1. Evidence-based guidelines for treating hypertension in the general population should be used to treat individuals with SCI. For most adults, a threshold for initiating pharmacological treatment and treatment target of 140/90 mm Hg is reasonable, although different targets may be considered in certain individuals and sub-populations.</p>	<p>"adults age 60 or higher"</p>	<p>The Panel recommends initiating pharmacological treatment to lower blood pressure at systolic blood pressure of 140 mm Hg or higher or diastolic blood pressure of 90 mm Hg or higher in most adults with SCI. While the Panel recognizes differences in treatment goals and targets for certain sub-populations between various guidelines, it does not endorse a specific guideline over the others given the current lack of high-quality evidence to make that determination. For individual patients, clinicians should use a combination of factors to set BP goals, including scientific evidence, clinical judgment, and patient tolerance. In some patients, including those with albuminuria, chronic kidney disease, or additional cardiovascular risk factors, clinicians could consider a lower BP target (for example 130/80 mm Hg) if lower targets can be achieved without undue treatment burden, while recognizing that the benefit of pursuing these targets levels using antihypertensive drugs is currently not established through RCTs.</p>	<p>Strong Low</p>	<p>Consortium_Cardiometabolic risk, 2018 Chapter: Pharmacotherapy for Hypertension Page: 28</p>
32	<p>2. Consider SCI-related factors when selecting an antihypertensive agent, such as the effect of thiazide diuretics on bladder management.</p>	<p>"older patients"</p>	<p>Studies to systematically test antihypertensive agents in people with SCI are lacking. In the absence of such evidence, it is reasonable to apply guidelines for choosing antihypertensive agents in the general population to people with SCI. However, SCI-related factors may affect the choice of an antihypertensive agent in some circumstances.</p>	<p>Strong Very low</p>	<p>Consortium_Cardiometabolic risk, 2018 Chapter: Pharmacotherapy for Hypertension Page: 28</p>
	<p>(...)Hyponatremia, hypokalemia, or decline in renal function sometimes occur during the first nine months of thiazide use, and older patients may be especially vulnerable to renal electrolyte disturbances, gout, hyperglycemia, and hypotension.</p>		<p>The 2014 Joint National Committee Guidelines for the Management of Hypertension in Adults recommend initial antihypertensive treatment with a thiazidetype diuretic, calcium channel blocker, angiotensin-converting enzyme inhibitor, or angiotensin receptor blocker in the non-black population, and either a thiazide-type diuretic or calcium channel blocker in the black population.</p>		
33	<p>7.0 We recommend that anticoagulant thromboprophylaxis continue at least eight weeks after injury in SCI patients with limited mobility.</p>	<p>"older age"</p>	<p>Age: Most studies have found a strong relationship between increasing age and risk of Venous Thromboembolism (Maung, 2011; Giorgi-Pierfranceschi, 2013; Chung, 2014). However, an age effect was not observed in large study of more than 12,000 SCI patients from California (Godat, 2015).</p>	<p>Strong Low</p>	<p>Consortium_Venous thromboembolism, 2016 Chapter: Duration of Thromboprophylaxis Page: 16</p>
	<p>The specific duration should be individualised for each patient, taking into consideration the level and completeness of the neurological injury, concomitant injuries and medical conditions, bleeding risk, functional status, and feasibility. Factors suggesting longer duration of thromboprophylaxis include motor complete injuries, lower-extremity fractures, older age, previous venous thromboembolism, cancer, and obesity.</p>				
34	<p>1. Conduct an assessment of pressure ulcer risk factors in individuals with SCI at every appropriate opportunity. Assess the following risk factors for the development of pressure ulcers: - Demographic (age)</p>	<p>"As individuals with SCI age"</p>	<p>Demographic risk factor age: As individuals with SCI age, particularly after age 40, the number and severity of pressure ulcers that develop increase (Vidal and Sarrias (1991)). Muscle mass, collagen, and normal elastin decreases with age, increasing the risk for</p>	<p>Strong High to low</p>	<p>Consortium_Pressure ulcers, 2014 Chapter: Risk and Risk assessment Page: 11</p>

	<ul style="list-style-type: none"> - SCI-related, such as incontinence - Comorbid medical - Nutritional - Psychological, cognitive, contextual, and social - Support surface for bed, wheelchair, and all durable medical equipment (DME) surface such as shower/commode chair or bathroom equipment related. <p>Use both a validated risk-assessment tool and clinical judgment to assess risk.</p>		<p>developing pressure ulcers (Bergstrom <i>et al.</i>, 1996). Rochon <i>et al.</i> (1993) found that SCI individuals 60 years or older were at higher risk than younger individuals with SCI but observed that comorbidities may be more important than age in predicting this pressure ulcer development. Salzberg <i>et al.</i> (1998) and Mawson <i>et al.</i> (1988) did not find associations between age and pressure ulcer development in persons with SCI in either the community or immediately post injury in their studies. Chen (2005) found pressure ulcers were more common in persons with SCI who were older than 50 as compared to those who were younger.</p>			
35	<p>4.2: 24-hour approach to pressure ulcer risk management</p> <p>Perform a comprehensive assessment of posture and positioning to evaluate pressure ulcer risk. Consider all surfaces in both recumbent and sitting positions that a person uses to participate in daily activities over the entire 24-hour period.</p> <p>(...) Long-term spinal cord injury phase: The risk of pressure ulcers may increase over time due to changes in function, strength, and mobility that typically occur with increasing duration of spinal cord injury and with aging. Physical changes increase pressure ulcer risk and may require more intensive pressure ulcer management practices.</p>	"aging"	<p>The 24-hour approach to pressure ulcer risk management includes a comprehensive assessment of posture and positioning to evaluate pressure ulcer risk and considers all surfaces in both recumbent and sitting positions that a person uses to participate in daily activities over the entire 24-hour period. More information is available on chapter "Assessment principles for the 24-hour approach"</p>	Not described	Very low	<p>Canadian_Pressure ulcers, 2013</p> <p>Chapter: 24-hour approach to pressure ulcer risk management</p> <p>Page: 70</p>
36	<p>4.5: Reassessment</p> <p>Reassess pressure management using a 24-hour approach every 2 years, or more often if a pressure ulcer develops or there is a significant change in health status — including weight changes or functional ability — or if there are changes in living situation or a deterioration in the support surface/equipment.</p> <p>(...) Reassessment can achieve the following: Identify the impact of physical changes due to aging and increasing duration of spinal cord injury, including postural changes, muscle wasting, and spasticity.</p>	"aging"	<p>Changes due to long-term or permanent alterations in health status may also necessitate more frequent reassessment of positioning, support surfaces, and pressure management approaches. Upgrading equipment, increasing support services, or modifying functional movements, such as transfers, may be required to prevent pressure ulcer development over a person's lifespan.</p>	Not described	Very low	<p>Canadian_Pressure ulcers, 2013</p> <p>Chapter: Reassessment</p> <p>Page: 77</p>
37	<p>6.17: Education about the need for regular reassessment</p> <p>Educate the individual with spinal cord injury to monitor the condition of seating equipment and support surfaces regularly to ensure the equipment remains effective for pressure management.</p>	"aging changes"	<p>People with SCI need to understand that regular reassessment becomes even more important over time. Many physical changes, including long-term postural changes, aging changes, and new comorbidities, can affect pressure ulcer risk.</p>	Not described	Very low	<p>Canadian_Pressure ulcers, 2013</p> <p>Chapter: Reassessment of seating systems</p> <p>Page: 127</p>
38	<p>6.10: Cushion maintenance</p> <p>Teach the individual with spinal cord injury and the caregiver to:</p> <ul style="list-style-type: none"> - Care for and maintain the wheelchair cushion - Monitor the cushion for signs of wear at an appropriate frequency 	"aging changes"		Not described	Very low	<p>Canadian_Pressure ulcers, 2013</p> <p>Chapter: Wheelchair cushions</p> <p>Page: 120</p>

	<ul style="list-style-type: none"> - Set up the cushion properly, including orientation and monitoring for bottoming out - Replace the cushion if it is deteriorating - Avoid placing additional layers on top of the cushion unless deemed essential <p>Aging changes affecting the skin can increase susceptibility to pressure ulcer development, and routine reassessment can ensure that cushion choice remains appropriate.</p>					
39	<p>6.18: Schedule for periodic reassessment</p> <p>Establish a mechanism for regular reassessment of performance of sitting support surfaces specific to pressure ulcer prevention and treatment. Schedule reassessment at least every 2 years, or sooner if any of the following occur:</p> <ul style="list-style-type: none"> - Health status changes, including weight or medical changes - Changes in functional status - Equipment wear or disrepair - Pressure ulcer development - Changes in living situation 	"aging"	<p>Postural management, positioning, and pressure-redistributing movements are central to pressure ulcer prevention. Initial good habits can deteriorate over time; periodic re-education is beneficial. Similarly, changes in equipment, support surfaces, and pressure management strategies may be necessary to accommodate changes in physical status associated with aging and increasing duration of spinal cord injury.</p>	Not described	Very low	<p>Canadian_Pressure ulcers, 2013</p> <p>Chapter: Reassessment of seating systems</p> <p>Page: 127</p>
40	<p>1.10.7 Discuss with the person, and their family members and carers, that there may be an increased risk of bladder cancer in people with neurogenic lower urinary tract dysfunction, in particular those with a long history of neurogenic lower urinary tract dysfunction and complicating factors, such as recurrent urinary tract infections. Tell them the symptoms to look out for (especially haematuria) that mean they should see a healthcare professional.</p>	"long history of neurogenic lower urinary"		Strong	Very low	<p>NICE_Urinary incontinence, 2012</p> <p>Chapter: 1.10</p> <p>Page: 39</p>
<p>*The guideline states that recommendations are graded according to the European Association of Urology (EAU) classification system, modified from the Oxford Centre for Evidence-Based Medicine Levels of Evidence and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach. However, the link provided in the guideline is no longer available. The current version (March 2022) of the Guidelines Office Development Handbook from the European Association of Urology is not consistent with the gradings given in the guideline. The strength of the recommendation in this guideline was inferred from the wording of the recommendation (e.g., we recommend = strong, we suggest = weak).</p>						