CLINICAL POLICY

MANAGEMENT OF PATIENTS WITH METASTATIC SPINAL CORD COMPRESSION

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Consultation:

	Authorised by	Date Authorised	Comments
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Version History:

Date	Version	Author name and designation	Summary of main changes
June 2012	1.0	Dr. Peter Robson - Consultant Clinical Oncologist and Joint Network Lead for MSCC	First version.
July 2015	1.1	Dr. Peter Robson - Consultant Clinical Oncologist and Joint Network Lead for MSCC	Scheduled review Due to the ongoing implementation of a CCC network coordinator post, the new post holder will be involved in updating this document with Dr. Robson. Current content of policy is still relevant. Review date to be extended for a further 4 months.
February 2016	1.2	Dr. Peter Robson - Consultant Clinical Oncologist and Joint Network Lead for MSCC	Scheduled review from July 2015. Current content still valid. A new Network Co-ordinator has been appointed – full review will take place in 6 months.
July 2018	1.3	Dr. Peter Robson - Consultant Clinical Oncologist and Joint Network Lead for MSCC Kate Parker-Metastatic Spinal Cord Compression Co-ordinator	Small changes to reflect updates to network guidance issued in December 17.
October 2018	1.4	Dr. Peter Robson - Consultant Clinical Oncologist and Joint Network Lead for MSCC	One change to section 7.1, point 4 to describe how referrals are made into CCC in absence of MSCC co-ordinator (i.e. leave or out of hours)
May 2020	1.5	Kate Parker-Metastatic Spinal Cord Compression Service Lead	Minor Change to definitions; changes to section 7.1 including updated Meditech documentation and procedures during referral process; changes to section 7.4 rehabilitation; 7.5 changes to mobilisation pathway

1.0 Introduction

In November 2008 the National Institute for Health and Clinical Excellence (NICE) published guideline CG75 (*Metastatic spinal cord compression: diagnosis and management of adults at risk of and with metastatic spinal cord compression* (1)). In response to this the Merseyside and Cheshire Cancer Network (MCCN) formed the Metastatic Spinal Cord Compression (MSCC) Group that reports directly to the Non-Surgical Oncology Group (NSOG).

In September 2010 this group published guidelines on the management and treatment of this group of patients in our region (2). The latest version of these guidelines was issued in December 2017. The group has also published Primary care network guidance for this condition and a patient information sheet to be given to those patients at greatest risk of developing the condition (3).

2.0 Purpose

The aim of this policy is to define the management of patients who have been diagnosed with MSCC across Cheshire and Merseyside including those who are admitted to CCC for treatment with palliative radiotherapy.

The intended outcomes are to streamline the treatment and rehabilitation process leading to the patients being mobilized and either discharged or transferred back to the referring or local hospital in a timely fashion following completion of radiotherapy (as recommended in NICE CG75).

This policy will lead to fewer complications associated with extended bed rest (such as chest infections, pulmonary emboli and poor mobility) and allow patients to be transferred back to a local facility more readily.

3.0 Scope

This guidance is intended to apply to all patients receiving palliative radiotherapy for MSCC or Impending Metastatic Spinal Cord Compression (IMSCC) at CCC. This does not apply to patients treated with radiotherapy following a surgical decompression.

4.0 Responsibilities

This policy is the responsibility of the Network MSCC leads and will be audited by the MSCC network group.

5.0 Laws & Regulations

None applicable

6.0 Definitions

MSCC – Metastatic spinal cord compression

IMSCC – Impending metastatic spinal cord compression

Red flag symptoms – new onset progressive and/or severe back pain; radicular (band-like) back pain; new reduction in arm or leg power/tone/sensation/reflexes; new bladder or bowel incontinence, urinary retention or constipation.

7.0 Main Body of Policy

7.1 Network Guidance for management prior to admission to CCC

Following the publication of the MSCC guidelines by the Network in September 2010 the following are now in place;

1. Patients at high risk of developing MSCC (patients with breast, lung or prostate cancer or multiple myeloma) are to be given written and verbal information about the condition.
2. Patients presenting with red flag pain symptoms but no neurology will have a whole spine MRI within 1 week.

3. Patients with neurological signs or symptoms are to be admitted to their local hospital, put on bed rest, given Dexamethasone 16mg and a PPI (proton pump inhibitor) and have a full spine MRI within 24 hours.
4. Confirmed cases of MSCC/IMSCC are referred directly to Clatterbridge MSCC Coordinator via the Network referral pathway. During leave or out of hours this information will be collected via Triage (CCC Hotline) and passed to the on-call team.
5. The Consultant clinical oncologist on-call (CCOW/COD) assesses which patients require a surgical opinion (based on symptoms, extent of disease and patient fitness) using Tokuhashi and SINS tools to aid decision making. Ideally and if applicable, the patients' usual CCC consultant would also be involved.
6. A case discussion is held between the Consultant spinal surgeon and the Consultant oncologist (and if required a Consultant radiologist) resulting in a decision on the most appropriate management plan.
7. Patients are transferred to the appropriate hospital for treatment.
8. Prior to transfer, patients with pain due to instability who are unsuitable for surgical intervention should be considered for a suitable brace
9. A patient information leaflet should be provided
10. At all stages from the initial referral onwards, any discussions and management plan should be clearly documented in Meditech using the documents MSCC Note, MSCC Assessment and MSCC Management Following R/T.

7.2 Management following acceptance for treatment at CCC

After acceptance by our hospital, the patient should be rapidly transferred to CCC to enable treatment to commence within 24 hours of the confirmed diagnosis of MSCC.

Patients will be clinically reviewed on arrival and have the decision to treat confirmed. Their radiotherapy will be planned urgently by the Consultant on-call.

Provision is available for planning and treatment at the weekends and on Bank Holidays. Radiotherapy dose and fractionation will depend on the tumour type, the stage of presentation and the neurological status of the patient;

1. A single 8Gy fraction is appropriate for pain relief in patients who have had no neurological function for >48 hours (these patients should ideally be transferred back to the referring hospital on the same day).
2. Palliative treatment 8Gy single or 20Gy/5# at depth is standard for most cases of MSCC.
3. 30Gy/10# at depth is sometimes used in patients with a better prognosis.
4. Radical treatments may be considered in certain circumstances (e.g. plasmacytoma).

On admission to the ward at CCC patients should;

1. Be maintained in a flat position (or at an angle if medically unable to lie flat).
2. Receive planning and treatment with palliative radiotherapy.
3. Commence or continue on Dexamethasone 16mg daily with a proton pump inhibitor.
4. Commence low molecular weight heparin (unless contraindicated).
5. Full medical admission with neurological assessment and documentation of function, continence and pain.
6. The outcome of any surgical discussion should be documented in the medical notes.
7. Full nursing, nutritional and venous thrombo-embolism assessment with anti-embolism stockings (documentation of level of function, continence and pain).
8. Referral to palliative care team if appropriate.
9. Referral to physiotherapy and occupational therapy for all MSCC and IMSCC patients on admission.
10. Prompt decision and documentation of resuscitation status for all patients

11. MDT Discharge planning should commence on admission with an aim to discharge home or transfer back to the appropriate location on completion of treatment.
12. Further investigation should be considered if appropriate for staging or diagnosis of an unknown primary (for example CT scan or blood tests) – biopsy may be more appropriate to do after referral back to the local hospital.
13. Further treatment may be added if appropriate (for example hormones or zoledronic acid).

In certain circumstances (for example a fit patient with no neurological deficit), the Consultant may decide that bed rest and high dose steroids are not required. This should be documented clearly in the notes.

7.4 Rehabilitation and discharge

After commencement of fractionated radiotherapy, patients continue on bed rest and 16mg Dexamethasone until completion of the 2nd fraction of treatment. For patients receiving a single fraction of radiotherapy, the same guidance applies from 24 hours after completing their single fraction. The patient should receive bed exercises (active or passive depending on functional state) from the physiotherapist who has assessed them.

Further management depends upon the neurological status of the patient as per the following categories;

1. **No neurological deficit**
    a. Bed exercises
    b. Allow to sit up and gradually mobilize using the mobilization pathway (page 10) over a 24 hour period.
    c. Reduce steroids by half every 2 days (aim to discharge home on 2mg daily for the next week).

d. Stop LMWH and anti-embolism stockings once mobile.

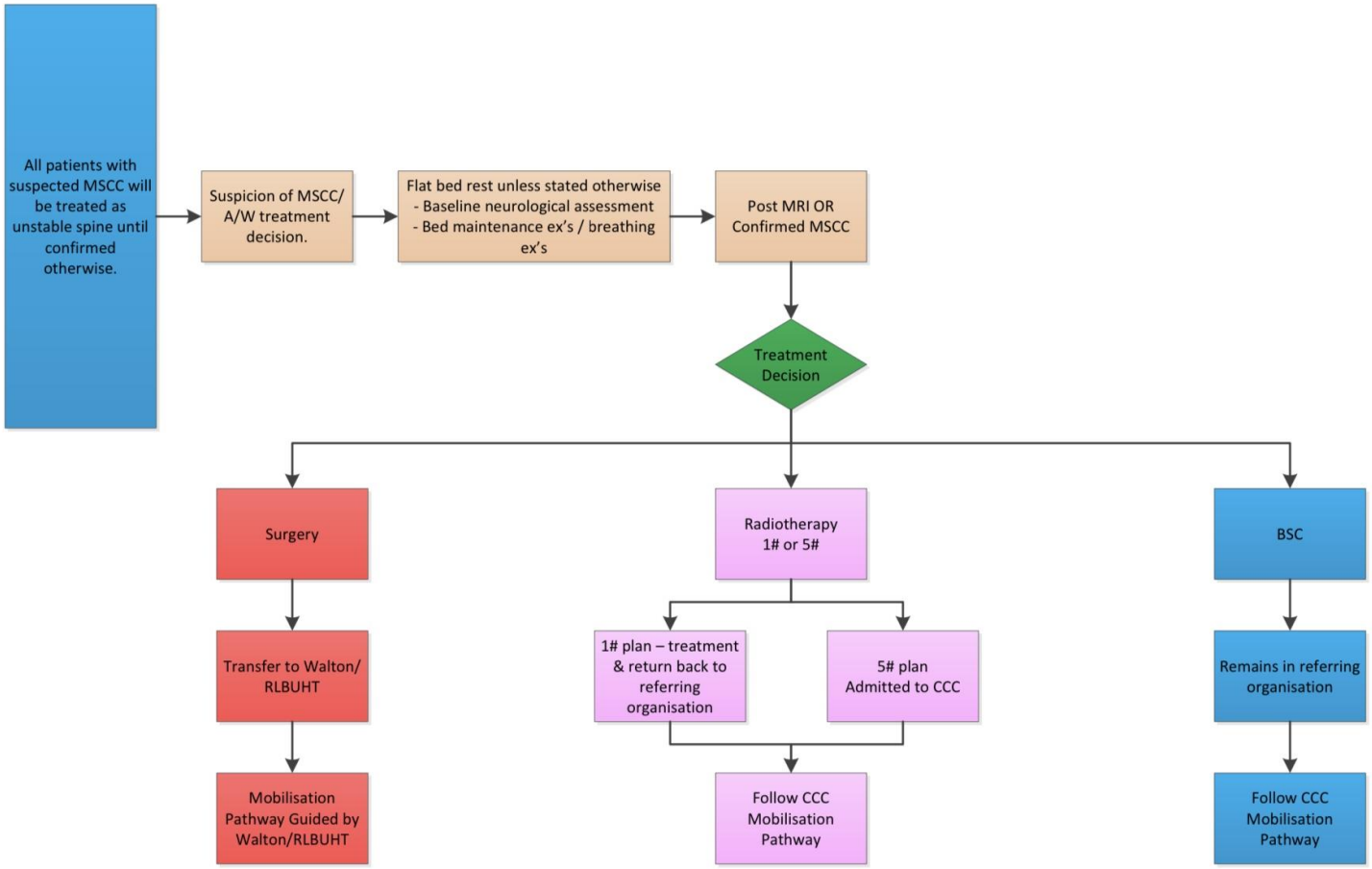
2. **Intermediate patients (neither category 1 nor 3)**
    a. Continue bed exercises provided by the physiotherapist that has assessed patient.
    b. Reduce steroids by half every 2 days (aim to discharge home on 2mg daily for the next week).
    c. Stop LMWH and anti-embolism stockings once mobile.

3. **Complete neurological loss** (no power or sensation)
    a. Allow to sit up gradually to 45 degrees if comfortable.
    b. Continue bed exercises provided by the physiotherapist who has assessed.
    c. Reduce steroids rapidly over next 3 days.

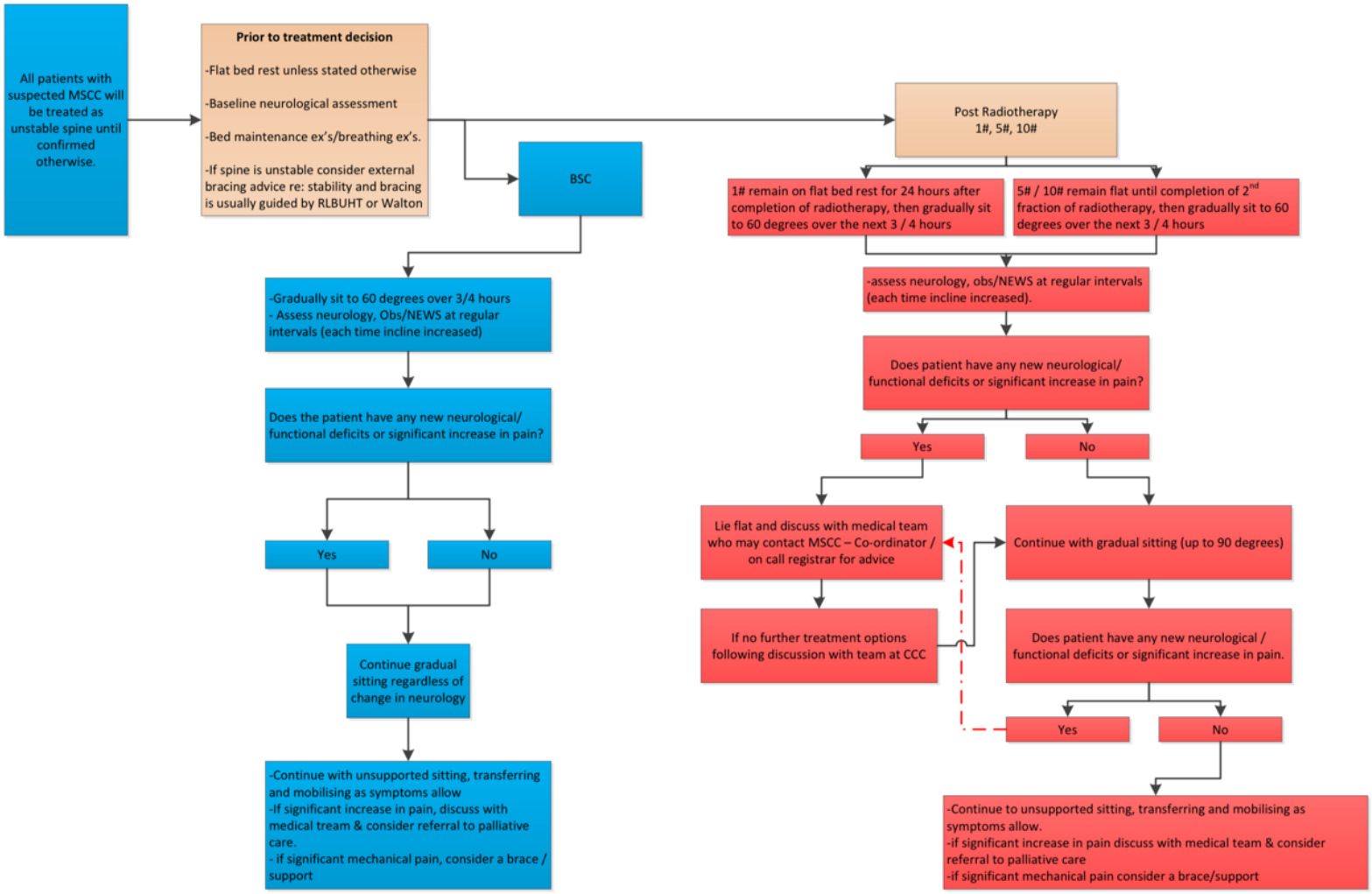
Any patients who experience increased pain or neurological deterioration on mobilisation should be returned to lying flat and be reviewed by the medical team. Patients who experience instability pain should be assessed and fitted with an appropriate brace by the appliance department. These patients should then be mobilised to the point where they remain comfortable. Use of braces may be discussed with the spinal surgical teams at Walton or RLUH.

7.5 Mobilisation pathway for patients with MSCC

Mobilisation Pathway for Patients with MSCC



CCC Mobilisation Pathway Post Radiotherapy



8.0 Audit

Management of patients with MSCC is audited by the Cheshire and Merseyside MSCC group. Audits of the process from diagnosis to management are performed on a yearly basis. Audit of treatments and outcomes of patients at all treatment centres are presented at the biannual MSCC collaborative case review meeting.

The MSCC group is also subject to Peer review as part of the Acute Oncology measures (4).

9.0 References

9.1 Internet

1. NICE guidance
   https://www.nice.org.uk/guidance/cg75
   https://www.nice.org.uk/guidance/qs56
2. MSCC Pathway Guidelines for Cheshire and Merseyside December 2017
3. MCCN MSCC Primary Care Network Guidance
   https://www.nwcscnsenate.nhs.uk/files/8314/1232/8169/MSCC_Primary_Care_Network_Guideline_Version_1.1.pdf

9.2 Publications

National Cancer Peer Review Programme. Evidence Guide for: Trusts Acute Oncology.