The Christie NHS
NHS Foundation Trust

STANDARD OPERATING PROCEDURE (SOP) AND PATHWAY FOR THE MANAGEMENT OF PATIENTS WITH METASTATIC SPINAL CORD COMPRESSION (MSCC) WITHIN THE CHRISTIE

(Refer to the Manchester Cancer Network MSCC Pathway flowchart)

Procedure reference:	CP80	Version:	V07
Document owner:	Lena Richards, Network MSCC Coordinator / Educator	Accountable committee:	Networked Services
Date approved:	8th May 2015	Date ratified:	1st June 2015
Review date:	January 2023		
Parent policy	Manchester Cancer Network MSCC Pathway and Guidelines - www.christie.nhs.uk/MSCC		
Other associated policies	NICE MSCC Guidelines (2008)		
Target audience:	All clinical staff		

STATEMENT OF INTENT	To provide patients who have a suspicion of, or confirmed MSCC with timely and excellent care according to the network and Christie MSCC pathway and guidelines.
PURPOSE OF SOP	To ensure patients who present at the Christie or to the Christie with a suspicion of, or confirmed MSCC receive urgent clinical examination, investigations and treatment in line with the NICE guidelines (2008), the Manchester Cancer MSCC pathway and the Christie internal MSCC pathway. Early recognition of signs and symptoms, urgent diagnosis and treatment will optimise favourable outcomes, i.e. patient maintains quality of life and function and life expectancy is improved.
SCOPE	All Christie clinical staff
AUTHORISED PERSONNEL / TRAINING REQUIRED	All Christie clinical staff must be aware of the signs and symptoms of MSCC and be aware of the internal pathway and where to find this. For education and training requirements contact the MSCC service.
REFERENCES *(if applicable)*	• Manchester Cancer MSCC webpage (including Network pathway and guidelines) – www.christie.nhs.uk/MSCC • National Institute for Health and Care Excellence (2008) *Metastatic Spinal Cord Compression*: *Diagnosis and management of patients at risk of or with metastatic spinal cord compression*. Cardiff: National Collaborating Centre for Cancer, cg75. (Online). Available: http://publications.nice.org.uk/metastatic-spinal-cord-compression-cg75 (16/9/13). • National Institute for Health and Care Excellence (2012) *NICE Pathways* - http://pathways.nice.org.uk/pathways/metastatic-spinal-cordcompression

Prior to any onset of MSCC

All 'at risk' patients (Primary cancer with or without known bone metastases) should be given the Patient Information leaflet: Spinal Cord Compression 'What you need to know' by a clinician. The contents must be explained to the patient face to face. It is available within the Christie guidelines under 'Patient Information' - www.christie.nhs.uk/MSCC

Confirm diagnosis

Patient in The Christie - Out Patients (OP) or In Patients (IP) with suspicion of MSCC:

- New and persistent localised back pain (especially thoracic), chest wall pain or other unexplained atypical pain
- Unilateral or bilateral nerve root pain, tingling, burning, shooting and band-like around chest (radiates in dermatomal distribution)
- Pain on movement, coughing, sneezing, straining and lying flat
- Neurological signs may be equivocal. May report unsteadiness / heaviness in limbs, upper or lower limb weakness, reduced mobility
- Altered sensation with a sensory level
- Bladder and bowel abnormality, e.g. difficulty starting flow of urine / constipation / incontinence
- Saddle anaesthesia and sphincter disturbance (cauda equina lesion)

NB: Loss of power / mobility / sphincter problems = late signs of MSCC

- If patient is seen as an OP, place on stretcher and commence flat bed rest / log roll. Request emergency admission via CWP form. If bed available, liaise with Bed Managers (bleep 12593) for admission to Patient Admissions Transfer (PAT) suite or direct to Acute Assessment Unit (AAU), request urgent Magnetic Resonance (MR) whole spine (see section below) on same day or within 24 hours of clinical suspicion.

  If patient is seen as an OP and there is no bed available, transfer patient to their local A&E via 999 ambulance (transfer patient flat and log roll). Call Accident & Emergency (A&E) with information regarding suspicion of MSCC and inform the local Acute Oncology team of patient's transfer.

- If patient already an IP, arrange urgent clinical assessment by the treating team and if appropriate request urgent MR scan of the whole spine to be done within 24 hours (see below).

- If patient has had a recent Computerised tomography (CT) staging scan at The Christie for suspicion of bone metastases and this shows incidental finding of cord compression or high risk of cord compression, arrange urgent admission for MR whole spine to Christie if bed available, if no bed, send to local hospital.

- If patient is at home with signs of MSCC, urgent ambulance and transfer to local A&E should take place. If treating consultant has specifically requested admission to The Christie, liaise with Bed Manager on bleep 12593 to ensure bed is available and request emergency admission via CWP form.

Management

Radiology: Referring clinician requests urgent MR scan via Christie Web Portal (CWP), see 'Patient Menu', under 'Referrals' – 'Request imaging'. The request form should state 'suspected MSCC' with a description of presenting signs and symptoms. This should be followed by a telephone call to the MR Department to make radiology aware.

Standard and agreed reporting timings: For a.m. sessions – report available by 13:00, for p.m. sessions – report available by 17:00. Where urgent information is required, reporting Radiologist can be contacted for verbal report prior to formal written report available.

Out of hours – MSCC slots are available Saturday and Sunday from 09:00 to 12:00. Patients with suspected MSCC who require urgent MR scan at the weekend should be discussed urgently in person by the referring consultant / MSCC coordinator and the on-call consultant radiologist.

If imaging confirms cord compression, during working hours, contact the MSCC coordinator or the ST on the relevant team (Medical Oncology via Baton bleep; others via switchboard). Outside of working hours, ask switchboard to contact the Clinical Oncology ST directly – it is then their responsibility to update the referring team.

MSCC Coordinator: Contact on bleep 12616 to refer or for advice / assistance.

Steroids: Start Dexamethasone 16mg OD as initial loading dose with PPI cover, subsequent days 8mg BD.

Flat bed rest / log roll: Immobilise patient (as per The Christie, Greater Manchester & Cheshire MSCC guidelines)
NB – if lying flat aggravates pain significantly, make comfortable by elevating head rest / or pillow and position at the lowest height that the patient can tolerate.

Admission to the AAU:

- Admitting team: ST or ward doctor completes a thorough assessment with a full neurological examination including PR examination.
- Nursing staff: MSCC forms to be completed every shift. Forms available on CWP under forms: 'Spinal cord compression care'. Bowel care plans to be commenced on admission for all MSCC patients.
- Physiotherapy and Occupational Therapy: Patient to be referred on admission, fax 3388 / 3968, ext 3795 or Physiotherapy bleep 12572.

Triaging and treatment

No / Impending MSCC: If MR scan shows 'no' or 'impending' MSCC (neurology intact), inform treating team to ensure continued monitoring of signs and symptoms. If symptoms persist or worsen review patient urgently. If on-going problems with symptoms, refer to the Supportive Care Team via fax (referral form on intranet), for urgent referrals, bleep 12767.

Confirmed MSCC or Impending: (ESCC 1b/c with neurology, 2 or 3) Contact the MSCC Coordinator in hours (bleep 12616), or Clinical Oncology ST on-call out of hours to triage patient and decide treatment plan. The following information is

required:

- Date and time of MR scan or results of scan if already reported
- History
- Full Neurological assessment including PR examination
- Mobility immediately prior to and on admission
- Performance status
- Prognosis if patient is a surgical candidate

Triage: the following 3 outcomes are possible:

A. Clinical status and cancer prognosis require urgent surgical opinion
B. Clinical status and cancer prognosis indicate immediate radiotherapy
C. Clinical status and cancer prognosis indicate best supportive care only

- (NB: If surgery indicated, the MSCC Coordinator service will contact the Spinal Team at Salford Royal (SRFT) via the patient pass database (https://patientpass.srft.nhs.uk), or SRFT switchboard 0161 789 7373 between the hours of 08:00 and 19:30. After 19:30, contact the neurosurgical registrar on 07623 617 892 or via switchboard.
  When a patient presents outside of MSCC Coordinator working hours, the referring team and / or on-call clinical oncology ST / consultant discuss suitability for surgery and prognosis and ensure referral via patient pass database is completed without delay.

  If awaiting surgical opinion or transfer to SRFT patient should remain of flat bed rest / log roll and on 8 mg Dexamethasone + PPI unless spinal team advise otherwise. In some instances patient may be transferred to SRFT for assessment for suitability for surgery and if not suitable, will return to the Christie on the same day. Patient's bed at the Christie must in these cases, be kept for 24 hours.

- If surgery not indicated and patient triaged to have radiotherapy, on-call Clinical Oncology team and MSCC service will arrange urgent treatment within 24 hours of confirmation of MSCC.

- If patient is not suitable for any treatment and is for best supportive care, ensure referral to Supportive Care team has been made.

Spinal stability and re-mobilisation

Re-mobilisation: Once MR scan has been reported, and if 'confirmed' or 'impending' cord compression, decision regarding spinal stability should take place at the earliest opportunity and is a joint decision by the Clinical Oncology ST, Physiotherapist and with advice from Radiology. Refer to the Stability guidelines on the Christie MSCC webpage – within the Guidelines - see http://www.christie.nhs.uk.

NB – This decision must be documented in the patient notes and on CWP.

Spinal team should not routinely be contacted for advice regarding stability; however, if a referral for surgery has already been made, the spinal team are happy to comment.

If MR scan is reported on a Friday, ensure graded sitting commences ASAP to avoid

unnecessary flat bed rest over the weekend. This can be done by a trained member of staff, e.g. doctor or physiotherapist. The mobility physiotherapy service is available Sat/Sun 08:00 to 12:00 (contact physio on-call via switch).

Bracing with Cervical collars / Thoraco-lumbar supports

- If cervical collars are required for patients with suspicion of, or confirmed MSCC (patients with severe pain on movement and/or deteriorating neurology where pain is due to spinal instability) refer to the Physiotherapy Department from 8 am – 5 pm (Mon-Fri). Out of hours, contact the on-call physiotherapist via switchboard (overnight, 17:30 to 08:00).
  The physiotherapy department have a stock of collars available 24/7, however, braces (CTLSO/CTO/TLSO/LSO) must be ordered from the manufacturers. These require patients to be measured and are ordered on a bespoke basis. Whilst waiting, patients must remain on flat bed rest / log rolled until the brace can be obtained and fitted.

- For removal and re-positioning including care of collar/brace the physiotherapist will handover to nurse responsible for patient so that nursing team can continue with safe collar care. In emergencies, the on-call physiotherapist may be contacted between 17:30 and 08:00 for any queries regarding re-positioning / care of collar / brace.

- Mandatory MSCC training including management of collars to be attended by all registered nursing and radiotherapy staff, and other staff members who require this training. Book a place via ESR.

- All patients who are prescribed with a brace require routine follow up by clinical team to review the need for continued use of the brace. Brace prescription should include rationale for brace (spinal stability / pain control), duration of use (24 hours/day / for mobilising only).

VERSION CONTROL SHEET *Insert version number and any minor amendments in this section*

Version	Date	Author	Status	Comment
V01	17/6/15	Lena Richards	Created	
V02	29/2/16	Lena Richards	Updated	Medical Assessment Unit changed to Oncology Assessment Unit
V03	15/8/16	Lena Richards	Updated	Contact details updated
V04	12/01/17	Lena Richards	Updated	Communication of radiology findings
VO5	03/01/18	Lena Richards	Updated	Contact details updated
VO6		Lena Richards	Updated	Symptoms, contact details
VO7	22/09/20	Lena Richards Kristina Coe	Updated	Reviewed as date expired