Somerset Partnership NHS
NHS Foundation Trust

MALIGNANT SPINAL CORD COMPRESSION POLICY

Version:	2
Ratified by:	Senior Managers Operational Group
Date ratified:	November 2015
Title of originator/author:	Professional Lead for Community Nursing
Title of responsible committee/group:	Clinical Governance Group
Date issued:	**November 2015**
Review date:	**October 2018**
Relevant Staff Group/s:	All Trust clinical staff

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DOCUMENT CONTROL

<table>
<tr><td>Reference Number
MM/Aug/12/SCCP</td><td>Version
2</td><td>Status
Final</td><td colspan="2">Author:
Professional Lead for Community Nursing</td></tr>
<tr><td colspan="5">Amendments: Removal of the traumatic injury section and emphasis on Malignant Spinal Cord Compression. Immediate intervention required updated</td></tr>
<tr><td colspan="5">Document objectives: This policy is primarily intended for non-medical staff in Somerset Partnership NHS Foundation Trust. It aims to raise awareness about malignant spinal cord compression. Early detection and appropriate management can improve longer term outcome, level of functioning and quality of life.</td></tr>
<tr><td colspan="5">Intended recipients: All Trust Clinical Staff</td></tr>
<tr><td colspan="5">Committee/Group Consulted: End of Life Care Best Practice Group</td></tr>
<tr><td colspan="5">Monitoring arrangements and indicators: To be overseen by the End of Life Care Best Practice Group</td></tr>
<tr><td colspan="5">Training/resource implications: There are no specific training requirements supporting this policy.</td></tr>
<tr><td colspan="2">Approving body and date</td><td colspan="2">Clinical Governance Group</td><td>Date: October 2015</td></tr>
<tr><td colspan="2">Formal Impact Assessment</td><td colspan="2">Impact Part 1</td><td>Date: September 2015</td></tr>
<tr><td colspan="2">Clinical Audit Standards</td><td colspan="2">NO</td><td>Date: N/A</td></tr>
<tr><td colspan="2">Ratification Body and date</td><td colspan="2">Senior Managers Operational Group</td><td>Date: November 2015</td></tr>
<tr><td colspan="2">Date of issue</td><td colspan="3">November 2015</td></tr>
<tr><td colspan="2">Review date</td><td colspan="3">October 2018</td></tr>
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1. INTRODUCTION

1.1 The National Institute for Health and Clinical Excellence issued guidance: 'Metastatic spinal cord compression: Diagnosis and management of adults at risk of and with metastatic spinal cord compression' in 2008.

1.2 This guidance has been developed to ensure approriate services are in place to ensure effective and efficient diagnosis, treatment, rehabilitation and onging care of those with metastic spinal cord compression.

2. PURPOSE

2.1 This policy is primarily intended for non medical staff in Somerset Partnership NHS Foundation Trust. It aims to raise awareness about malignant spinal cord compression. Early detection and appropriate management can improve longer term outcome, level of functioning and quality of life.

3. BACKGROUND

3.1 Malignant Spinal Cord Compression (MSCC) is a neurological emergency.

3.2 Functional outcome is dependent on the degree of neurological impairment at diagnosis and initial response to therapy. It is imperative signs are acted upon urgently and early.

3.3 Other factors important in prognosis are timely histology and rate of progression of the neurological symptoms. Symptoms may be present for some weeks before a neurological emergency occurs. Spinal pain precedes neurological symptoms in almost every case but diagnosis is often delayed until the onset of symptoms and signs of myelopathy. By this time damage is much more likely permanent.

3.4 Spinal Cord Compression may be the presenting symptoms of malignancy and should be considered if neurological changes are experienced.

3.5 It is important to consider MSCC in patients with a known malignancy, particularly those with known bone metastases presenting with pain and / or neurological symptoms.

4. DUTIES AND RESPONSIBILITIES

4.1 Duties in respect of the requirements of this document are as follows:

- The **Trust Board** has overall responsibility for procedural documents and delegates responsibility as appropriate
- The **Lead Director** with responsibility for this policy is the Director of Nursing and Patient Safety.
- The **Identified Lead (Author)** is the Professional Lead for Community Nursing.

- **Service Managers/Heads of Service** Responsibility for implementing the policy is devolved to Service Managers and Heads of Service.
- **All Clinical Staff** including temporary staff are individually responsible for complying with this policy.

5. EXPLANATIONS OF TERMS USED

5.1 All terms used within this document are defined within the relevant section.

6. STATEMENT OF POLICY AND GUIDANCE

Incidence and Aetiology

6.1 Approximately 4000 cases each year in England and Wales, or more than 100 cases per cancer network each year (Levack 2001, Loblaw 2003).

Signs and Symptoms (these may precede compression by several weeks)

6.2 The risk factors and signs and symptoms of Spinal Cord Compression include:-

- Past history of cancer. Generally of breast, lungs, prostate, renal, thyroid, myeloma, lymphoma
- Back pain that is getting worse or band like around the body
- Back pain made worse by coughing, sneezing or straining
- Back pain that stops the patient from sleeping
- Difficulty walking / legs giving way
- Numbness or tingling in arms or legs
- Difficulty passing urine or opening bowels
- Clumsiness or weakness of the arms or legs

Clinical Presentation

6.3 After consent is gained or practice is maintained under the guidance of the mental capacity act (refer to the Trust's Consent and Capacity to Consent to Treatment Policy) a person should be assessed via history and neurological examination by an appropriately qualified professional.

Pain

6.4 Radiating back pain is the most common symptom, often beginning mildly and worsening with time (DeMichele & Glick 2001). Although pain is cited as the first presenting symptom in 96% of those with MSCC (Quinn & DeAngelis 2000), it is important to consider that an absence of pain does not eliminate MSCC diagnosis (Posner 1995 Flounders & Ott 2003, Purdue 2004, NICE 2008).

Motor Deficits

6.5 Motor deficits may present as a deterioration in mobility including falls. Presenting features of motor deficiency may encompass muscle weakness initially presenting distally, ataxia, impaired co-ordination and paralysis.

Altered Sensation

6.6 Altered sensation manifests as numbness, paraesthesia and insensitivity to temperature and pain (DeMichele & Glick 2001). Persons should be assessed for muscle weakness and altered sensation/sensory level by an appropriate professional.

Disturbances to the Autonomic Nervous Systems

6.7 Bowel and bladder symptoms such as incontinence, urinary retention, new urinary hesitancy, constipation or faecal incontinence may occur as a result of disturbances to the autonomic nervous system, and indicate advanced MSCC (DeMichele & Glick 2001). These are considered late signs of MSCC and will suggest a worse clinical outcome. Upper motor neurone signs of clonus, upgoing plantar reflexes and hyperreflexia are associated with spinal cord damage.

Immediate Intervention Required

6.8 If a diagnosis of MSCC is suspected then non medical staff should make an immediate referral to a doctor for further assessment. The referrer should make it clear that MSCC is suspected and it is therefore imperative to assess on the same day.

Once a medical assessment has been completed, if a diagnosis of MSCC is still suspected the doctor should immediately contact the Malignant Spinal Cord Co-ordinator at either TST or YDH via switchboard or directly. Any patient transferred with suspected MSCC MUST be nursed supine and be moved via log roll. Prior to assessment slipper pans and NOT commodes should be used for toileting.

If MSCC is likely on clinical assessment patients should be given dexamethasone 16mg (oral) and PPI cover immediately, if available, and this should be handed over to the next assessor.

For Musgrove Park Hospital Patients:

- If a malignant SCC is being considered contact the Malignant Spinal Cord Co-ordinator (bleep 3609 at MPH) Mon-Fri 9-5. OOH contact the MSCC co-ordinating nurse on Beacon Ward.
- The MSCC co-ordinator at Musgrove Park Hospital will refer the patient into MAU.
- Somerset Primary Link (SPL) will be responsible for requesting a stretcher ambulance within 60 minutes. The patient MUST lie flat and will be log-rolled when admitted until MSCC has been ruled out.

- On arrival the patient will be medically assessed and a whole spine MRI will be undertaken. Clexane will be omitted if the patient could be considered for surgery if MSCC confirmed

For Yeovil District Hospital Patients:

- The Malignant Spinal Cord Co-ordinator (for suspected malignant SCC) is on 07799 703 266. Out of hours it is the Medicine Registrar via the switchboard (01935 475122)

Investigations

6.9 A **whole spine** MRI (Magnetic Resonance Imaging) is the investigation of choice.

6.10 NICE Guidance (CG75 2008) states that an MRI scan should be available within 24 hours in the case of spinal pain suggestive of spinal metastases and neurological symptoms or signs suggestive of SCC, and occasionally sooner if there is a pressing clinical need for emergency surgery.

6.11 Additional screening tests will be required if the patient does not have a diagnosis of cancer and there is no other clearly established cause for the SCC. This might include usual blood tests and additional X-Rays and / or scans.

Treatment

6.12 In order to maximise recovery and minimise functional deficits, treatments should be commenced as soon as possible once a diagnosis has been established. Bucholtz (1999) suggests that the main aims of treatment are pain management, maintenance or improvement in neurological status, and spinal stabilisation. Treatments may include the following and are indicated by the type and location of the tumour, its rapidity of onset and the overall prognosis (Flounders & Ott 2003, Purdue 2004, NICE 2008)

Steroid Therapy

6.13 The aim of steroids is to reduce oedema within the spinal cord. (Quinn & DeAngelis 2000).

Analgesia

6.14 An accurate assessment should be carried out to determine the type and severity of pain and its effects on the patient. Assessment should include the quality, intensity, duration and location of back pain and any radicular or referred pain, as well as noting the type and dose of any analgesics used, their effectiveness and any related side-effects.

Additional specific treatments

6.15 These depend on the underlying cause but may include surgical resection / decompression. Radiotherapy and chemotherapy may be indicated.

Secondary Complications

6.16 The following secondary complications can arise as a consequence of reduced mobility and sensation (Flounders & Ott 2003, Purdue 2004, NICE 2008)

- Venous Thromboembolism
- Pressure ulcers
- Bladder and bowel management problems
- Circulatory problems including oedema
- Respiratory problems including chest infections
- Traumatic injury due to loss of sensation

7. TRAINING REQUIREMENTS

7.1 There are no specific training requirements necessary to support this policy. All non medical staff working in relevant clinical areas should read and familiarise themselves with this policy.

8. EQUALITY IMPACT ASSESSMENT

8.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

9. MONITORING COMPLIANCE AND EFFECTIVENESS

9.1 Overall monitoring will be by the End of Life Best Practice Group.

9.2 Incidents will be reported to the End of Life Best Practice Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This group will be responsible for ensuring improvements, where necessary, are implemented.

9.3 The End of Life Best practice group will provide a report to the Clinical Governance Group every six months.

10. COUNTER FRAUD

10.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the

inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

11. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

11.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

11.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 18:	Notification of other incidents

11.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

12. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

12.1 References

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DeMichele, A, Glick, J, Cancer – related emergencies. In R. Lenhard, R.Osteen, T. Gansler (Eds), Clinical Oncology (pp. 733 – 764). Atlanta, GA: American Cancer Society (2001)

Flounders, JA, Ott B, Oncology Emergency Modules: Spinal Cord Compression (2003)

Levack, P et al, A prospective audit of the diagnosis, management and outcome of malignant cord compression (CRAG 97/08). Edinburgh: CRAG (2001)

Loblaw DA, Laperriere NJ, Mackillop WJ, A population-based study of malignant spinal cord compression in Ontario. Clinical Oncology 15 (4): 211-17 (2003)

National Institute of Clinical Excellence Clinical Guideline CG75. Metastatic Spinal Cord Compression (2008)

Posner J, Neurologic complications of cancer, Philadelphia: Davis (1995)

Purdue C, Diagnosis and treatment of malignant spinal cord compression, 2004

Quinn J, DeAngelis L, Neurologic emergencies in the cancer patient, Seminars in Oncology, 27, 311-321 (2000)

National Guidelines

National Institute of Clinical Excellence Clinical Guideline CG75. Metastatic Spinal Cord Compression (2008)

12.2 **Cross reference to other Somerset Partnership Trust policies and associated documents**

Bowel Care for Adults

Pressure Ulceration

Venous Thromboembolism

Consent and Capacity to Consent to Treatment

Record Keeping and Record Management Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.