Name of Policy: Policy for the diagnosis and management of Metastatic Spinal Cord Compression (MSCC)

Effective From: 02/10/2017

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This policy supersedes all previous issues
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<th>Release</th>
<th>Author/Reviewer</th>
<th>Ratified by/Authorised by</th>
<th>Date</th>
<th>Changes (Please identify page no.)</th>
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<td>Alison East Macmillan Acute Oncology Clinical Nurse Specialist</td>
<td>SafeCare Council Gateshead Acute Oncology Steering Group Cancer Unit Group</td>
<td>09/10/2013</td>
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<td>Lynsey Robson Macmillan Acute Oncology Nurse Consultant</td>
<td>SafeCare Council</td>
<td>09/09/2017</td>
<td>Page 3,4,5,7,8,9,10,15,16.</td>
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</tbody>
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References to relevant QST (2016) standards are bracketed in the contents list of this policy.

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1 **Introduction**

Patients with metastatic spinal cord compression (MSCC) sometimes suffer delays in diagnosis that can lead to avoidable disability that adversely affects their quality of life. For all those affected by MSCC (including family and carers) it is important to recognise the impact of this diagnosis and the wide ranging needs and support required throughout this period of care.

National recommendations endorse a systematic approach should be taken to dealing with the cancer related emergency MSCC. This policy takes into account recommendations from the NICE guidance on MSCC, outlining the pathway to identify those patients who require treatment with either surgery or radiotherapy.

2 **Policy scope**

The document provides best practice guidance for all Trust staff involved in the diagnosis and management of adult patients who present or are at risk of malignant spinal cord compression, in order to support the implementation of national standards (NICE 2008 / QST 2016).

For the purposes of this document adult patients are those individuals over the age of 18 years.

3 **Aim of policy**

This policy aims to outline and support the delivery of best practice advice on the care of patients at risk of, or with a diagnosis of malignant spinal cord compression within Gateshead Health NHS Foundation Trust.

4 **Duties - roles and responsibilities**

**Trust Board** has a responsibility to support the full implementation of this policy.

**Chief Executive** has overall responsibility for all aspects of this policy.

**Associate Directors and Heads of Services** have a duty to ensure compliance with Trust policy. Policies should be accessible to all staff. Divisional, Departmental and Ward Managers are responsible for ensuring that this is the case, bearing in mind that not all staff can easily access the Trust intranet.

**All staff** have a responsibility to adhere to Trust policy.

5 **Definitions**

For the purposes of this document the term ‘Metastatic Malignant Spinal Compression ’ (MSCC) is used to refer to a well recognised complication of cancer and is usually an oncological emergency. Metastases to the spinal column occur in 3–5% of all patients with cancer, MSCC occurs when there is pathological vertebral body collapse or direct tumour growth causing compression of the spinal cord or cauda equina, irreversible neurological damage can ensue with resulting paraplegia.
Policy for the diagnosis and management of Metastatic Spinal Cord Compression (MSCC)

6.1 Early detection and patient information

All patients at high risk of developing bone metastases (e.g. patients with myeloma, breast cancer, prostate cancer), patients with diagnosed bone metastases or patients with cancer who present with spinal pain must be informed about the symptoms of MSCC.

Patients diagnosed with spinal metastasis are to be provided by their key-worker with the cancer network patient information leaflet on early diagnosis of MSCC (Appendix 1). There is a section on the leaflet to include emergency contact numbers for that patient, as appropriate. The leaflet advises what to do and who to contact if the patient develops symptoms suggestive of MSCC. This leaflet has been distributed to all MDT leads within the Trust.

Symptoms suggestive of spinal metastases:
- Pain in the middle (thoracic) or upper (cervical) spine
- Progressive lower (lumbar) spinal pain
- Severe unremitting lower spinal pain
- Spinal pain aggravated by straining (for example at stool or when coughing or sneezing)
- Localized spinal tenderness
- Nocturnal spinal pain preventing sleep

Symptoms suggestive of MSCC with neurological symptoms and/or signs:
- Neurological symptoms including radicular pain
- Limb weakness,
- Difficulty in walking
- Sensory loss or bladder or bowel dysfunction
- Neurological signs of spinal cord or cauda equina compression

6.1.1 Diagnosis of impending or actual cauda equina compression

The diagnosis of impending or actual cauda equina compression cannot be made on clinical grounds alone, and requires an MRI scan. When cauda equina compression is suspected, in either Primary or Secondary Care, patients should undergo urgent assessment and MR scanning at their local hospital, prior to contacting the Neurosurgical Team at the RVI.

Following assessment and MR imaging, if these are consistent with cauda equina compression, then the neurosurgical team at the RVI should be contacted for advice on further management. Prior to contact, the MR scan should be uploaded to the NuTH PACS system.

If MR scanning is not available, the neurosurgical team can be contacted for advice. A clinical decision will be taken with regards to taking the patient to the RVI to be scanned. This decision is based upon the clinical picture of the individual patient and particularly, the speed of progression of their symptoms. If the clinical picture has not changed in the couple of days preceding the referral then the patient can wait to be scanned. If the patient’s symptoms have changed then they will be brought to the RVI for a scan. Care should not be compromised because the hospital does not have access to an MRI scanner out of hours.
Please contact the neurosurgical team at the RVI if you have any queries about this or require more information.

6.2 **Pathway for those patients suspected of MSCC (Appendix 2 & 3)**

Clinicians who are concerned that an individual may have MSCC should contact the medical local (QEH) registrar on call via hospital switchboard, they act as the MSCC diagnostic pathway co-ordinator. They will facilitate rapid evaluation of the patient; if neurological symptoms are present hospital admission for assessment is mandated. After assessment appropriate suspected MSCC cases will be further escalated to MRI scanning within 24 hours.

MRI scanning will be arranged by the local MSCC diagnostic pathway co-ordinator; this will be performed in hours on site and arranged via the on call consultant radiologist. Out of hours they will liaise with the Northern Centre for Cancer Care (NCCC) regional MSCC co-ordinator at Newcastle who will organise MRI. The care of all patients with MRI proven MSCC will be escalated to the NCCC regional MSCC co-ordinator.

Unless contra-indicated, patients with MSCC should be initially treated with Dexamethasone 16mg daily while referral is underway, blood glucose levels should be monitored and the patient started on proton-pump inhibitors.

Patients with severe pain suggestive of spinal instability or any neurological symptoms or signs suggestive of MSCC must be nursed flat with neutral spine alignment and provided with analgesia. Thigh-length graduated compression/anti-embolism stockings (unless contraindicated) should be offered to patients with suspected MSCC on bed rest.

In addition offer low molecular weight heparin to patients with MSCC who are at high risk of venous thromboembolism (including those treated surgically). Individually assess the duration of thromboprophylaxis, based on risk factors, overall clinical condition and return to mobility.

6.3 **Role of the local MSCC Diagnostic Pathway Co-ordinator**

Acting as the first point of contact for clinicians who suspect that a patient may be developing metastatic spinal cord compression, they will assess and co-ordinate care for adult patients referred within normal working hours, or present at any time with suspected or proven MSCC, providing advice and guidance on the patients immediate care.

They will gather baseline information and ensure timely decision making and referral to the regional MSCC co-ordinating service, who will assess the most appropriate intervention, taking into account the patients:

- performance status
- the duration and severity of their neurological damage
- prognosis with respect to their underlying malignant disease
- personal preferences
- general health
- magnitude of surgery
- likelihood or complications
- fitness for general anaesthesia
- previous treatments
The onsite Acute Oncology service should be informed of the patients suspected MSCC by contacting the QE Acute Oncology Clinical Nurse Specialist (AO CNS). The AO CNS will act as key worker for those MSCC patients who are not known to a site specific CNS.

### 6.4 Newcastle Regional MSCC Co-ordinating Service

The service is accessed via the hospital switchboard on (0191) 2336161 and asking for the “MSCC Co-ordinator”. The rota for MSCC co-ordinator for referrals of patients with known cancer comprises the Neuro-oncology Clinical Nurse Specialists during working hours (Mon-Fri, 9am-5pm) and the On-call Oncology SpR out of hours and at weekends. The responsibilities of the regional MSCC co-ordinator will be to:

- co-ordinate care for patients who present with actual or potential MSCC and who require access to the specialist spinal oncology service
- perform an initial telephone triage by assessing requirement for, and urgency of, investigations, transfer, and treatment
- advise on the immediate care of the spinal cord and spine
- gather baseline information to aid decision-making and collate data for audit purposes
- identify the appropriate place for timely investigations and transfer if required, with agreement from other referring hospitals that the patient’s bed will be retained in case they need to be transferred back if MSCC is not proven or if urgent intervention is not required
- act as a co-coordinator of the pathway, facilitating multidisciplinary discussion between the MSCC senior clinical advisors
- liaise with the acute receiving team and organise admission where appropriate

### 6.5 MSCC Service Specification and Case Discussion Policy

The Newcastle Upon Tyne Trust provides a pathway for managing MSCC both within the Trust and for patients referred in to the Trust from surrounding hospitals (Northumbria Trust, Sunderland, Gateshead, South Tyneside, Durham).

Patients with known cancer who present with true or suspected spinal cord compression will be discussed with the Trust MSCC co-ordinator, as described above. Within their responsibilities, the MSCC co-ordinator will advise on the immediate care of the spinal cord, timely imaging (usually MRI of whole spine) and, when imaging is available, initiate a discussion between the MSCC senior clinical advisors.

If referred from outside the Trust, the referring clinician or local MSCC co-ordinator will be responsible for ensuring that the Newcastle Upon Tyne MSCC co-ordination form is completed (appendix 4) and emailed along with any scan reports where applicable from an NHS.net account to tnu-tr.nuth.msccc@nhs.net. All local imaging should be transferred to the Newcastle Upon Tyne Hospital PACS system to enable the senior clinical advisors to view MRI scans at the time of discussion.

The Trust has 24 hour access to urgent MRI scanning for suspected MSCC. For patients with known cancer referred from surrounding hospitals who are unable to have an MRI scan within 24 hours of suspicion of MSCC (e.g. at weekends), temporary transfer to NCCC for urgent MRI scanning will be arranged. Implicit in this is that a bed is retained at the referring hospital so that the patient can be transferred back if the MRI scan does not show MSCC or if neurosurgical intervention and/or urgent radiotherapy are felt to be inappropriate following assessment by the MSCC senior clinical advisors. The QE onsite
Clinical Bed Managers should be made aware of patients transferred to Newcastle Trust so they can facilitate transfer back to an appropriate base ward.

The MSCC Senior Clinical Advisor rota will comprise the on-call rotas for Consultants in Neurosurgery (RVI), Neuro-radiology (RVI) and Oncology (FH). Where the on-call Consultant Oncologist is not a Clinical Oncologist, 2nd-on Consultant Clinical Oncologist support will be available.

A multi-disciplinary discussion between the MSCC Senior Clinical Advisors will assess the most appropriate intervention, taking into account:

- performance status
- the duration and severity of their neurological damage
- prognosis with respect to their underlying malignant disease

Following an assessment of these factors, the MSCC Senior Clinical Advisors may recommend urgent neurosurgery or radiotherapy. For patients referred from outside the Trust, appropriate admission will then be arranged through the regional MSCC coordinator.

6.6 Audit of the patient pathway.

The Northern Cancer Alliance, Acute Oncology Expert Advisory Group has obtained agreement to audit of the timeliness and outcome of definitive treatment of MSCC, being incorporated as part of the relevant regional Trust audit programmes, this includes the QEH. Within the Trust the Acute Oncology Steering Group will be responsible for the completion of this audit using the agreed audit proformas, they will feedback to all relevant Trust stakeholders and the NECN. The Northern Cancer Alliance, Acute Oncology Expert Advisory Group will discuss annually the results of the completed network audit project and agreed actions resulting from the audit with the relevant hospitals.

6.7 Rehabilitation and supportive care

Rehabilitation and supportive care should be initiated at the point of suspected diagnosis and continued through the diagnostic, triage and therapy pathways. MSCC rehabilitation encompasses the skills of various professionals as well as timely access and referral to support services for assessment, advice and rehabilitation.

The aim of rehabilitation:

- To promote quality of life for the person and their family for the remaining time of their illness
- Maintain or increase functional independence
- Prolong life by preventing complications
- Return the patient to the community wherever possible and support the patient, family and MDT members to enable the patient to remain at home for as long as possible.

Post-treatment rehabilitation will be initiated at the treatment centre but continued at the referring hospital and subsequently the community. Rehabilitation and supportive needs will vary between patients based upon their neurological deficits post treatment, the anticipated likelihood of neurological improvement and anticipated overall survival (fitness for rehabilitation).
Specialist Palliative Care involvement should be sought for any patient with MSCC, whether undergoing rehabilitation or in whom definitive treatment was considered unsuitable, under the following circumstances:

- Significant pain or other symptoms not responsive to appropriate initial interventions
- Complex psychological issues related to diagnosis
- Hospice transfer is being considered for complex symptom management

7. Training

Adequate training and education is fundamental to the operational success of this policy. It is the responsibility of the Lead Clinician for Acute Oncology to ensure that relevant Trust staff whose normal duties are directly or indirectly concerned with that group of patients receive suitable and sufficient training, information and supervision on the care of that patient group. The organisation’s expectations in relation MSCC training for all staff groups are as follows:

- The local MSCC co-ordinators, identified on a rota as the Consultant Acute Physician on call and medical registrars, will be assessed as competent in the cancer network agreed additional training specific to the MSCC co-ordinator role.

- A&E consultants, and NCCG medical staff in the A&E as well as Consultant physicians and any NCCG medical staff, on the acute medical take rota should be trained according to the local cancer network induction training in the use of the acute oncology service, which incorporates information on in hours and out of hours MSCC management pathways.

- Contracted nurses of band 6 and above, in the A&E and medical admissions unit should be trained according to the local cancer network induction training in the use of the acute oncology service which incorporates information on in hours and out of hours MSCC management pathways.

- All Trust staff will have awareness of and access to this policy via the Trust Intranet page.

8. Diversity and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This policy aims to uphold the right of all staff to be treated fairly and consistently and adopts a human rights approach. This policy has been appropriately assessed.

9. Process(s) for monitoring compliance with the policy

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
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<td>Compliance with National Cancer peer review standards.</td>
<td>National Cancer Peer Review Standards for Acute Oncology 2014</td>
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10 **Consultation and review**

The Gateshead Acute Oncology Group will be responsible for reviewing this policy.

11 **Policy implementation (including awareness raising)**

All members of staff will be informed via e-mail, and other communication as and when the policy is implemented reviewed and re-implemented.

Any comments/suggestions about this policy or amendments required as part of a development should be made in writing to Mark Katory, Lead Cancer Clinician and Medical Director.

12 **References**

Equality Act (2010)


QST., (2016) *Acute Oncology Including metastatic Spinal Cord Compression (Formerly Peer Review).* References to relevant standards are bracketed in the contents list of this policy.

13 **Associated documentation**

Gateshead Acute Oncology Operational Policy 2015.
Appendix 1 - Network Information on Early Detection of MSCC

Contact telephone numbers

If you have any of the symptoms listed overleaf please contact

Further information and advice is available from:
North of England Cancer Network
0191 275 4608
www.necn.nhs.uk
Macmillan
0808 808 0000
http://www.macmillan.org.uk

Metastatic Spinal Cord Compression
Information for patients

Diagram of the spinal cord
Copyright © CancerHelp UK
Introduction
Sometimes when people have cancer it can spread to the spinal column and cause the spinal nerves to be squeezed. This leaflet is not intended to scare you but to help you recognise the important symptoms to report early so that tests and treatment may be done as soon as possible. When the spinal nerves are squeezed it can cause damage to the spinal cord to the point of complete paralysis from the neck, chest or waist down. This is called Metastatic Spinal Cord Compression (MSCC) and is quite rare and unlikely to affect you, but it is very important to pick it up quickly as the earlier treatments are started the better the result usually is.

MSCC only occurs in a small number of people.

Symptoms to watch out for:
- Back pain in areas of your spine that is severe, distressing or different from your usual pain (especially if it affects the upper spine or neck)
- Severe increasing pain in the spine that changes when:
  - lying down or standing up
  - lifting or straining
  - it wakes you at night or prevents sleep
- Pain which starts in the spine and goes around the chest or abdomen
- Pain down the leg or arm
- A new feeling of clumsiness or weakness of the arms or legs or difficulty walking

• Numbness in the arms / hands or legs / feet
• Difficulty with urinating (not being able to pass urine or being aware that you have passed urine) or problems with controlling bowel function

If you have any of these symptoms:
• Speak with a doctor / health professional as soon as is practical (certainly within 24 hours)
• Tell them that you have cancer, are worried about your spine and would like to see a doctor
• Show the doctor / health professional this leaflet
• Try to bend your back as little as possible

The earlier MSCC is diagnosed, the better the chances of the treatment being effective.

What will happen next?
If your doctor / health professional is concerned that your spinal nerves are being squeezed (spinal cord compression) he or she will usually send you straight to hospital, so that you can have an urgent scan and start the right treatment.
Appendix 2

In Hours Metastatic Spinal Cord Compression High level Pathway

Information pack for patients

Known cancer patient (aware of risk)

Patient attends GP

Cancer patient unaware of the risk (undiagnosed)

Admission via A&E or Medical Admissions Unit

Co-ordinator (collate clinical information)

MRI (local/central)

Coordinator link with local / centre Oncologist

Oncology / Surgery - patient discussion

Supportive / Palliative care

Key worker

Transfer patient to Centre for definitive treatment

Discharge

Rehab Centre (local unless otherwise agreed)

Key worker

Not appropriate for admission / active treatment

GP informed (+/- D.N.A. / Primary Care Team)

Discharge

EOL

Member of Primary Care Team
Appendix 3

Out of Hours Metastatic Spinal Cord Compression High Level Pathway
# Appendix 4

Newcastle Upon Tyne Hospitals MSCC Co-ordination Form

Please complete for patients with suspicion of or with confirmed Metastatic Spinal Cord Compression (please see referral pathway for information). We require all of this information in order to make a timely management plan. Once complete please RING 0191 2336161 and ask for the MSCC Co-ordinator and email this form with scan reports if applicable (from an NHS net account) to tnu-tr.nuth.msc@nhs.net. If the patient has had scans please ensure they are sent via PACS.

<table>
<thead>
<tr>
<th>Patient Details Affix Addressograph or complete details</th>
<th>Date and time of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname:</td>
<td>Pt ID No</td>
</tr>
<tr>
<td>Forename:</td>
<td>D.O.B</td>
</tr>
<tr>
<td>Sex: M/F</td>
<td>NHS No:</td>
</tr>
<tr>
<td>Address:</td>
<td>Referring clinician</td>
</tr>
<tr>
<td>Patients current location</td>
<td>Contact Number</td>
</tr>
</tbody>
</table>

## Known cancer type

## Current treatment for cancer or not on active treatment

## Oncologist

## Known metastatic disease? Sites

## Known vertebral metastases

## Previous treatment for MSCC? If yes details:

## WHO Performance status: 0 = normal – 4 = completely disabled

<table>
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<tr>
<th>Pre onset MSCC</th>
<th>Present</th>
</tr>
</thead>
</table>

## Presentation

<table>
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<tr>
<th>Pain</th>
<th>Level of mobility</th>
</tr>
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<tbody>
<tr>
<td>Thoracic or cervical spine pain</td>
<td>Normal</td>
</tr>
<tr>
<td>Progressive lumbar spinal pain</td>
<td>Reduced</td>
</tr>
<tr>
<td>Severe unremitting lower spinal pain</td>
<td>Mobile only with walking aids</td>
</tr>
<tr>
<td>Spinal pain aggravated by straining</td>
<td>Transferring only</td>
</tr>
<tr>
<td>Localised spinal tenderness</td>
<td>Immobile more than 24 hours</td>
</tr>
<tr>
<td>Nocturnal spinal pain preventing sleep</td>
<td>Immobile less than 24 hours</td>
</tr>
<tr>
<td>Radiating pain</td>
<td>Date last walked (if applicable)</td>
</tr>
<tr>
<td>Duration of symptoms</td>
<td>Duration of symptoms</td>
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</tbody>
</table>

## Neurological Symptoms

<table>
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<tr>
<th>Any limb weakness, if yes MRC Grade motor power 1 2 3 4 5 of affected limbs</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>R arm L arm</td>
<td>Urinary incontinence</td>
</tr>
<tr>
<td>R leg L leg</td>
<td>Dual incontinence</td>
</tr>
<tr>
<td>Difficulty in walking</td>
<td>Urinary Retention</td>
</tr>
<tr>
<td>Sensory loss, if yes details</td>
<td>Constipation</td>
</tr>
<tr>
<td>Neurological signs of spinal cord or cauda equina compression</td>
<td>Sphincter function normal</td>
</tr>
<tr>
<td></td>
<td>Peri anal sensation normal</td>
</tr>
</tbody>
</table>

## Bladder and bowel function

<table>
<thead>
<tr>
<th>Duration of symptoms</th>
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</thead>
</table>

## Initial management of MSCC (After discussion with co-ordinator)

| Dexamethasone 16mg od (Ensure PPI) | Nurse flat, neutral spine alignment |

Policy for the diagnosis and management of Metastatic Spinal Cord Compression (MSCC) v1 15
## Investigation of MSCC

### Has the patient already had imaging on referral?

<table>
<thead>
<tr>
<th>YES</th>
<th>What imaging modality already performed?</th>
<th>Date and time prior imaging requested?</th>
<th>Date and time prior imaging performed?</th>
<th>Is the report available? (faxed or on ICE)</th>
<th>Findings</th>
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<tbody>
<tr>
<td>NO</td>
<td>Date and time imaging requested</td>
<td>Imaging modality requested: MRI whole spine, or other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>For good prognosis patients a CT chest, abdo and pelvis with contrast, within the last 3-months is essential</td>
<td></td>
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### MSCC Senior clinical advisors involved in discussion (For co-ordinator to complete)

<table>
<thead>
<tr>
<th>Oncologist</th>
<th>Contact number</th>
<th>Date and time discussed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal/Neurosurgeon</td>
<td>Contact number</td>
<td>Date and time discussed:</td>
</tr>
<tr>
<td>Neuro-radiology</td>
<td>Contact number</td>
<td>Date and time discussed:</td>
</tr>
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</table>

Further information:
Dear Colleague,

The specialised commissioning team has been made aware of some concerns in relation to the process for the referral of patients presenting at local hospitals with suspected cauda equina to the Royal Victoria Infirmary (RVI) neurosurgery department. Therefore, I am writing to confirm the process which has been clarified with Newcastle Hospitals.

The diagnosis of impending or actual cauda equina compression cannot be made on clinical grounds alone, and requires an MRI scan.

If cauda equina compression is suspected, in either Primary or Secondary Care, patients should undergo urgent assessment and MR scanning at their local hospital, prior to contacting the Neurosurgical Team at the RVI.

Following assessment and MR imaging, if these are consistent with cauda equina compression, then the neurosurgical team at the RVI should be contacted for advice on further management. Prior to contact, the MR scan should be uploaded to the NuTH PACS system.

If MR scanning is not available, the neurosurgical team can be contacted for advice. A clinical decision will be taken with regards to taking the patient to the RVI to be scanned. This decision is based upon the clinical picture of the individual patient and particularly, the speed of progression of their symptoms.

If the clinical picture has not changed in the couple of days preceding the referral then the patient can wait to be scanned. If the patient’s symptoms have changed then they will be brought to the RVI for a scan.

Care should not be compromised because a hospital does not have access to an MRI scanner out of hours.

If you have any queries about this you can contact the neurosurgical team at the RVI for more information.

Yours sincerely

Lisa Jordan
Local Service Specialist
Specialised Commissioning Team

Cc Alistair Blair
Mike Prentice
Helen Byworth
Hannah Powell