**THIS PATIENT IS ON THE MSCC PATHWAY**

**INPATIENTS AT HIGH RISK OF MSCC (not yet confirmed)**

MSCC management guidelines located in Acute Oncology pages on Intranet. Also find link to patient information leaflet for MSCC **‘What it means and how it can be treated’**

|  |  |
| --- | --- |
| ***Patients Name :*** | ***Hospital No:*** |

 **IF** patient in A+E, sections 1-9 to be completed by **A+E staff**, sections 10-17 **ward staff**

**(Both medical and nursing staff can complete)**

|  |  |  |
| --- | --- | --- |
| **ACTION** | **Yes/No Rationale if NO** | **Signature** |
| 1. Flat bed rest |  |  |
| 2. Log rolling (until advised safe to stop) |  |  |
| 3. Dexamethasone 16mgs O/IV until excluded or treatment commenced. PPI Omeprazole 20mgs |  |  |
| 4. Urgent MRI **whole** spine (or CT **whole** spine if MRI contra-indicated with thin slices and saggital reconstruction) | Referral submitted? Y/N **(If OOH’s referral then managing team submits am)** | Date/Time………………… |
| 5. Analgesia, is the patient comfortable? |  |  |
| 6. Is this patient able to lie flat for MRI scan? The scan cannot be performed if unable to. |  |  |
| 7. Baseline BS check (Pt now on Dexamethasone), if >7, continue to monitor. |  |  |
| 8. Informed MSCC coordinator? **0161 446 3658 option 1**If OOH’s Christie clinical oncology SPR on call via switch **0161 446 3000**  | Name/Time………………………………………… |  |
| 9. Acute Oncology Team informed? Coordinator **78134 (answerphone OOH’s or online referral) BLEEP 3015 ROH/3016 FGH/3017 NMGH.**  | Name/Time …………………. |  |

**IT IS THE CLINICAL TEAM’S RESPONSIBILITY TO CHASE THIS SCAN ONCE COMPLETED**

**If no MSCC on scan do not delay mobilisation according to Stability Guidelines**

**(These are within MSCC guidelines on AO intranet page)**

**IF MSCC CONFIRMED ON SCAN**

|  |  |  |
| --- | --- | --- |
| **ACTION: WARD TEAM TO COMPLETE FROM HERE** | **YES/NO, RATIONALE IF NO** | **SIG** |
| 10. Patient should be referred to physio within 24 hours of presentation to assess pain and contribute to spinal stability decision/potential need for collar to ease pain Description of pain required, eg ‘Pain on movement’  | Description of pain required, eg ‘Pain at …. on movement’ from assessing physio |  |
| 11. SINS score (spinal stability table overleaf)Clinical team to calculate total score based on radiology scoring (A-E) and pain scoring (F) described in SINS table.**START GRADED SITTING IF STABLE/INDETERMINATE SINS SCORE**  | Total Score =If poor prognosis patient consider mobilisation even if “potentially unstable” or ”unstable” spine on SINS score: **provided patient understands neurology may deteriorate – this is to maintain quality of life** |  |
| 12. Discussed with radiologist if SINS score unavailable/difficult to establish | Name of radiologist……………………………………. |  |
| 13. Treatment decision Please circle | XRT/Spinal surgery/Chemotherapy/BSCIf no decision made after 3 days ensure MSCC coordinator informed. |  |
| 14. Discussed MSCC with patient? |  |  |
| 15. Is this patient on Clexane? |  |  |
| 16. Daily neurological assessment to assess any neurological deterioration. If acute deterioration whilst on the ward this should be discussed with Christie team immediately | Day 1Day 2Day 3  | Continue if clinically indicated |
| 17. **URGENT CT TAP** indicated if new primary or no restaging scan within last 3/12 | Time requested………………………………………. |  |
| 18. Does patient need to start reducing dose Dexamethasone | AO can advise |  |
|  **SINS SPINAL STABILITY NEOPLASTIC SCORE** |

**If multi-level disease SINS score must be reported for each individual lesion at risk of MSCC or confirmed MSCC.**

|  |  |
| --- | --- |
| **A Location**3 points: Junctional (C0-C2, C7-T2, T11-L1, L5-S1) 2 points: Mobile spine (C3-C6, L2-L4) 1 point: Semi-rigid (T3-T10) 0 points: Rigid (S2-S5) | **Score****………….** |
| **B Bone lesion (this may be assessed better on spinal Xray/CT films)**2 points: Lytic 1 point: Mixed (lytic/blastic) 0 points: Blastic | **Score****………….** |
| **C Radiographic spinal alignment**4 points: Subluxation / translation present 2 points: De novo deformity (kyphosis / scoliosis) 0 points: Normal alignment | **Score****………….** |
| **D Vertebral body collapse**3 points: >50% collapse 2 points: <50% collapse 1 point: No collapse with >50% body involved 0 points: None of the above | **Score****………....** |
| **E Posterolateral involvement of the spinal elements (facet, pedicle or costovertebral joint fracture or replacement with tumour**)3 points: Bilateral 1 point: Unilateral 0 points: None of the above  | **Score****……………** |
| **F Pain relief with recumbency and/or pain with movement/loading of the spine**3 points: Yes 1 point: No (occasional pain but not mechanical) 0 points: Pain free lesion | **Score****………..** |
| **Interpretation**sum score 0-6: stable sum score 7-12: indeterminate (possibly impending) instability sum score 13-18: instability SINS scores of 7 to 18 warrant surgical consultation. | **Total score**……………… |

**Reference: Fourney et al. SINS score: An analysis of reliability and validity from the Spine Oncology Study Group. J Clin Oncol 2011 29 (22):3072-3077**

**Weekend physio support is available for limited graded sitting / mobilisation.**The aim of rehabilitation is to improve quality of life, maintain or increase functional independence, prolong life by preventing complications and to return the patient to the community wherever possible. Early mobilisation may reduce complications.