PRIMARY CARE 10 TOP TIPS

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Spinal cord compression

1 It is important for all health professionals to have a high index of suspicion for possible malignant spinal cord compression (MSCC) because of the catastrophic consequences of a delay in diagnosis. Consider informing OOH's of those at risk with bony metastases.

2 MSCC is most common form in multiple myeloma is cancer of the breast, prostate and lung.

3 Consider in anyone with cancer who presents with back pain, weak legs, increased reflexes, a sensory level, urinary hesitancy or urinary retention.

4 Site of compression: thoracic 70%, lumbosacral 20%, cervical 10%.

5 A recent normal lumbar spine X-ray does not exclude MSCC, insist on following the NICE guidelines.

6 MSCC is an emergency, two questions need to be asked:
– Does the patient have a reasonable likelihood of having MSCC?
– Would the patient benefit from starting emergency investigation and treatment?
NICE guidelines recommend performing a whole spine MRI within 24hrs for back pain suggestive of spinal metastases accompanied by neurological signs and symptoms.

7 Lesions above L1 (lower end of spinal cord) may produce upper motor neurone signs and a sensory level, whereas lesions below L1 produce lower motor neurone signs and perianal numbness (cauda equine syndrome).

8 Where suspicion of MSCC is high it is often quicker to involve the oncological team that has been managing the patient or the acute oncological team if available. Avoid sending in via A&E. Familiarise yourself with the local pathway for dealing with suspected MSCC.

9 Commence dexamethasone 16mg daily orally and arrange urgent transfer. Prior to referral always consider the overall condition of the patient:
– Patients too frail for treatment.
– Patients already so disabled that cord compression will cause little additional disability.
– Patients with a very short life expectancy (few weeks).
– Patients already irradiated to tolerance, but unfit for surgery. Discuss with acute oncology team.

10 Treatment includes surgical decompression or radiotherapy. The earlier the treatment the better the prognosis. Overall 30% of patients with MSCC may survive for one year. Function will be retained in 70% of patients who were ambulant prior to treatment, but will return in only 5% of those who were paraplegic at the outset. Return of motor function is better in those with an incomplete block and particularly with partial lesions of the cauda equina. Loss of sphincter function is a bad prognostic sign. Patients with MSCC provide great challenges to the multidisciplinary team whose early involvement is vital for maintenance of function.

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