Spinal Cord Compression

10 top tips

1 You can only make the diagnosis of malignant spinal cord compression (MSCC) if you think of it. A delay in diagnosis can have catastrophic consequences. Inform patients at high risk about the symptoms of MSCC. Offer information (for example, in the form of a leaflet) to patients and their families and carers which explains who to contact if symptomatic. Put a note highlighting the risk in your clinical system and share with out of hours services.

2 Too often MSCC is diagnosed late. Red flags in patients with bone metastases include spinal pain aggravated by straining (for example, at stool, or when coughing or sneezing), localised spinal tenderness or pain preventing sleep.

3 Consider in anyone with cancer who presents with back pain, weak legs, increased reflexes, a sensory level, urinary hesitancy or urinary retention. MSCC is most common in patients with breast, prostate and lung cancer.

4 Radicular pain: a band like pain ("like a belt tightening") is a common prodromal symptom of cord compression and will often precede neurological symptoms by weeks.

5 Familiarise yourself with the local pathway for dealing with suspected MSCC. Cancer Centres should have a designated MSCC Coordinator. Where suspicion of MSCC is high, liaise with the Coordinator or the Acute Oncology team first which may avoid sending in via A&E.

6 A recent normal lumbar spine X-ray does not exclude MSCC so don't be falsely reassured. NICE guidelines suggest an urgent whole spine MRI within 24 hours.

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 equina syndrome).

8 Give dexamethasone 16mg orally and arrange urgent transfer. Prior to referral, discuss the overall condition of the patient with the Acute Oncology team: Patients who have been pre-treated, are very frail or who are already rendered paraplegic are unlikely to benefit from hospital transfer and treatment.

9 Treatment includes surgical decompression and/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.

10 Patients with MSCC provide great challenges to the multidisciplinary team whose early involvement is vital for maintenance of function and subsequent rehabilitation. Patients with bone only disease (often with a better prognosis) may be suitable candidates for residential neuro-rehabilitation.

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