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PATIENT PRESENTATION

Suspected spinal cord compression (severe pain or abnormal findings on exam or neurologic complaints or incidental finding on imagingnot intended for traumatic injuries. If in Acute Cancer Care Center, triage patient as emergent.)



- Emergent treatment as follows:
- Dexamethasone² 10 mg IV STAT followed by 16 mg PO daily in divided doses (taper over 2 weeks)
- Obtain STAT MRI cervical thoracic lumbar spine with and without contrast (to be reviewed by Radiologist while patient is in MRI to evaluate for additional axial region of interest imaging if needed)
- Implement bed rest
- If cervical spine lesions suspected, place patient in Philadelphia Collar
- Baseline neurological exam followed by serial neurological exams after steroid treatment
- Initiate mechanical prophylaxis options for venous thromboembolism
- Initiate discussion with primary team to determine patient's prognosis, systemic disease progression and therapeutic options
- Initiate a Goal Concordant Care (GCC) conversation³ with the patient, or if clinically indicated, with the Patient Representative, and the Primary Oncologist/Primary Team/ Attending Physician. The Advance Care Planning (ACP) note should be used to document GCC discussion.

• Consider dexamethasone² 10 mg IV followed by 16 mg PO daily in divided doses (taper over 2 weeks)

• Obtain MRI cervical thoracic lumbar spine with and without contrast (to be reviewed by Radiologist while patient is in MRI to evaluate for additional axial region of interest imaging if needed)



¹Consider use of Frankel Classification or ASIA Impairment Scale to assist with patient's current status (see Appendix A)

- ²Use of steroids in undiagnosed lymphomas is not recommended
- ³Refer to the GCC home page (for internal use only).

⁴Consider use of Epidural Spinal Cord Compression (ESCC) Scale for cord compression assessment (see Appendix B)

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• Consider Infectious Disease consult if clinically indicated



PT = physical therapy; OT = occupational therapy

¹ Consider use of Epidural Spinal Cord Compression (ESCC) Scale for cord compression assessment (see Appendix B) ² Refer to the GCC home page (for internal use only). ³ For instances where patient is already receiving chemotherapy, the oncologist will advise on whether treatment should be continued/discontinued/delayed

⁴ Consider radiosensitivity of tumor

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APPENDIX A: Frankel Classification

Grade	Status	Sensory Function Below Level of Compression	Motor Function Below Level of Compression
А	Paraplegia	No sensation	Complete paralysis (no function)
В	Sensory function only	Some sensation	Complete paralysis (no function)
С	Non-ambulatory	-	Some motor function, but of no practical use to the patient
D	Ambulatory	-	Some motor function, but of no practical use to the patient
E	No neurologic signs or symptoms	Normal	Normal

ASIA Impairment Scale (AIS)

A = Complete. No sensory or motor function is preserved in the sacral segments S4-5.

B = Sensory Incomplete. Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-5 (light touch or pin prick at S4-5 or deep anal pressure) AND no motor function is preserved more than three levels below the motor level on either side of the body.

C = Motor Incomplete. Motor function is preserved at the most caudal sacral segments for voluntary anal contraction (VAC) OR the patient meets the criteria for sensory incomplete status (sensory function preserved at the most caudal sacral segments S4-5 by LT, PP or DAP), and has some sparing of motor function more than three levels below the ipsilateral motor level on either side of the body. (This includes key or non-key muscle functions to determine motor incomplete status.) For AIS C – less than half of key muscle functions below the single NLI have a muscle grade ≥ 3 .

D = Motor Incomplete. Motor incomplete status as defined above, with at least half (half or more) of key muscle functions below the single NLI having a muscle grade ≥ 3 .

E = Normal. If sensation and motor function as tested with the ISNCSCI are graded as normal in all segments, and the patient had prior deficits, then the AIS grade is E. Someone without an initial SCI does not receive an AIS grade.

Using ND (not determinable): To document the sensory, motor and NLI levels, the ASIA Impairment Scale grade, and/or the zone of partial preservation (ZPP) when they are unable to be determined based on the examination results.

From American Spinal Injury Association. (2019) International Standards for Neurological Classification of SCI (ISNCSCI) Worksheet. Retrieved from https://asia-spinalinjury.org/wp-content/uploads/2019/10/ASIA-ISCOS-Worksheet_10.2019_PRINT-Page-1-2.pdf. Adapted with permission.

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APPENDIX B: Epidural Spinal Cord Compression (ESCC) Scale



From "Reliability analysis of the epidural spinal cord compression scale," by M. H. Bilsky, I. Laufel, D. R. Fourney, M. Groff, M. H. Schmidt, P. P. Varga, ... T. R. Kuklo, (2010), Journal of Neurosurgery: Spine, 13, p. 325. Copyright 2010 by American Association of Neurological Surgeons. Adapted with permission.

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Department of Clinical Effectiveness V6 Approved by the Executive Committee of the Medical Staff on 06/20/2023



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