Malignant Spinal Cord Compression (MSCC) Rehabilitation Guidelines
Version Control

This is a controlled document please destroy all previous versions on receipt of a new version.

Date Approved: March 2012  Review Date: March 2015

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<th>Version</th>
<th>Date Issued</th>
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<th>Owner’s Name</th>
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For the latest version of these guidelines please see the NEYHCA (Cancer) website
Please press control and click on the link below:

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/mscc.htm

Signature Sheet

Agreement of the NEYHCA (Cancer) MSCC Rehabilitation Guidelines 2012

<table>
<thead>
<tr>
<th>These guidelines have been agreed by:</th>
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<tbody>
<tr>
<td>Title</td>
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<tr>
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<tr>
<td>Chair of the MSCC Group</td>
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<tr>
<td>Chair of the Acute Oncology CEG</td>
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<tr>
<td>The MSCC Group have agreed these guidelines</td>
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1. MSCC Rehabilitation

Commence when MSCC is suspected/diagnosed, encompass the skills of various professionals as appropriate, having timely access to support services for assessment, advice and rehabilitation.

1.1 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 other MDT members to enable the patient to remain at home for as long as possible

1.2 Referrals

Referrals should be made to:
• Physiotherapy within 24hrs of admission.
• Occupational Therapy within 24-48 hrs of admission.

1.3 Multi-professional staff

Referrals should be considered to the following Multi Professional Staff:
• Social Worker
• Specialist Palliative Care Team
• Dietician
• Speech and Language Therapist
• Clinical Psychologist
• Oncology Health Centre
• Hospital Chaplain

Family members / friends (with patients’ permission) given opportunity to be involved in patient’s care e.g. personal hygiene, feeding, scheduling of medication.

Rehabilitation should focus on the patient’s goals and desired outcomes including functional independence, participation in normal activities of daily life and quality of life.

Goals should be short term and attainable to achieve the best quality of life possible.

To assist with goal setting it is important that the care team be honest with the patient from an early stage regarding the potential for improvement in mobility, whilst this may initially be distressing it encourages early adjustment and realistic rehabilitation expectations. A caution to this is if the patient is in denial about their primary cancer diagnosis.

Offer admission to a specialist rehabilitation unit to those patient’s most likely to benefit, e.g. those with a good prognosis, a high activity tolerance and strong rehabilitation potential.
2. Discharge Planning

- Due to the potentially complex nature of the discharge, discharge planning should commence as soon as possible following admission and diagnosis confirmation.

- Discharge planning will begin as an outcome of the initial assessment once realistic expectations have been discussed, patient and family wishes have been taken into consideration and initial objectives have been set. This will enable early liaison with community-based services for necessary adaptations or equipment, if required.

- May include transfers between hospitals or hospices depending on the treatment pathway assessed for each individual patient.

- Requires a multidisciplinary approach and therefore good communication between team members is crucial to facilitate discharge.

- Effective communication strategies between healthcare settings must be ensured to facilitate a seamless process to ensure an efficient and coordinated discharge and follow up care.

- The MDT should assist with psychological adjustment and goal setting related to loss of functional independence, self esteem and quality of life.

Cancer related distress is defined as an unpleasant emotional experience of a psychological, social or spiritual nature that may interfere with a patient’s ability to cope with cancer and its treatment. Factors identified as increasing patient risk of severe distress include, previous history of psychological problems, poor support network and ineffective coping strategies, substance abuse, financial strain, non-adult children, poor prognosis and symptoms of pain/fatigue etc.

Patients and their families should be provided with the opportunity to express their emotions. It is important that all healthcare professionals are alert to the potential psychological support needed, consider referral to psychological support services including the specialist palliative care team, clinical psychologist, psychiatrist, oncology health centre and chaplain.

- A home visit or access visit may be required, facilitated by the Occupational Therapist.

- Clear pathways should be established between hospitals and community based health and social services teams to ensure equipment and support is arranged in an efficient and coordinated manner.

- Involve patients and their relatives/carers to ensure their wishes are respected and discharge planning goals are realistic and achievable. Adequate support and training should be offered, such as the use of complex equipment.

- Contact community staff already involved in the patient’s care and update on the patient’s status.

- Referral to the appropriate agency for timely equipment provision.

- Referral to community rehabilitation teams and support services to maximise patient’s quality of life.
• Due to the likely increase in physical disability a full benefits assessment must be considered. Consider application for Disability Living Allowance, Attendance Allowance, DS1500, Macmillan Grant, Disabled Parking badge etc.

• Patients may be discharged to a number of different locations; home; acute trust hospital; district general hospital; community hospital; hospice or care home depending on their needs, the degree of support required and the support networks available within their local community.

3. Networking
4. Approaching End of Life

- Recognise when end of life approaching, explore needs and adjust interventions accordingly
- Inform relevant team members
- Refer to local end of life policy
- Consider preferred place of care, review if needed and help to facilitate preferred place of care
- Provide carer support
- Supply or arrange collection of equipment as appropriate
- Advise on positioning and pressure management

5. Physiotherapy and Occupational Therapy

- At its simplest, the key outcome of therapy intervention is quality of life. For many people with cancer helped by therapists, one of the most important means to achieving this will be independence. However, for people who are receiving palliative care, this may not always be the first priority.
- Quality of life may have more to do with affirming life – providing people with physical, social and emotional opportunity, and a sense of control in their own lives.
- The short duration of treatment does not always facilitate this process but it is vital to address perceived and actual needs.
- Referral to Physiotherapy within 24 hrs of admission and physiotherapy assessment within 24-48hrs, unless there is no routine physiotherapy input e.g. at a weekend or if the patient’s condition makes it inappropriate.
- Referral to Occupational Therapy within 24-48 hours of admission to allow early screening for potential functional problems during admission and early investigation regarding discharge potential / needs.
- Access specialist therapist advice as appropriate.
- Provide patient / carer with information and reassurance.
- Introduction and explanation of the physiotherapy and occupational therapy role.
- Assume spine unstable until MDT decision made regarding stability. Advise flat bed rest with neutral spine alignment until confirmation of spinal stability. Stabilisation with a hard collar for patients with suspected cervical cord compression.
- Initial assessment following discussion with the senior medical team in relation to spinal stability. Spinal stability to be clearly documented in medical notes.
• The initial assessment is undertaken to establish details of current and previous level of functioning, home environment, life roles, life style, and the expectations and understanding of the person and their family as appropriate. It may be carried out over one or more sessions depending on the medical condition and tolerance of the patient.

• All patients to be re-assessed daily for any changes in their condition and treatment altered accordingly.

• Ensure adequate analgesia and explanation prior to assessment and treatment.

• Clearly explain any contraindications to the patient prior to movement / activity (increase in pain, altered sensation, increasing weakness) and the importance of returning to a position that does not exacerbate symptoms and spinal stability reassessed.

• Be aware of altered proprioception and how this may affect functional movement and positioning.

• Involvement in education of the patient / family / carers in relation to therapy management on discharge. This may involve moving and handling and positioning advice, guidance on use of aids and appliances, correct exercise and mobility / stairs technique, fatigue and pain management.

• Referral to the appropriate agency for equipment provision.

• Referral to local / community physiotherapy and occupational therapy services for ongoing therapy as indicated.

6. Assessment

6.1 Subjective assessment

Present Condition
Date of diagnosis, Stage of disease including location of any metastases

History of Present Condition
Include results of investigations

Past Medical History
Include treatment history of cancer including previous chemotherapy and radiotherapy

Drug History

Social History
Include outside support services (e.g. social services, district nurse, Macmillan nurse, Oncology Health), type of home, steps / stairs, location of bedroom, bathroom, toilet, aids and alterations, functional ability, family / friend support

Patients’ main problems
For each symptom, a symptom analysis should be carried out including: onset, duration, intensity, continuous or intermittent, precipitating or relieving factors, associated symptoms.

E.g. Pain: Use body chart, VAS (visual analogue score), easing and aggravating factors, behaviour / pattern.

SOB: At rest or on exertion, easing and aggravating factors, behaviour/pattern, how far can mobilise, able to use stairs, needing oxygen?

Secretions: Able / unable to clear and techniques used, how much and how often, colour and consistency, use of medication / inhalers / nebulisers.
6.2 Objective assessment

Observation
- General appearance, level of consciousness, colour, swelling, wasting, muscle bulk, scars
- Catheters, drips, drains, oxygen

Pain Assessment use of body chart, type of pain (burning, stabbing etc), pain score (use of visual analogue scale)
- **Localised pain**: pain over the area of the tumour, usually constant and generally increases in supine position.
- **Radicular pain**: pain from nerve root compression, follows distribution of involved segmental dermatome. Discomfort from a thoracic lesion often radiates in a band around the chest/abdomen almost always bilaterally. Radicular pain often worsened by activities such as coughing, sneezing, straining, straight leg raise and neck flexion.
- **Referred pain**: pain felt at a site other than where the cause is situated, such as pain from metastatic involvement of L1 causing pain over the sacroiliac joint.

Sensation
- Light touch
- Joint position sense – e.g. finger up/down, limb bent/straight with eyes closed, finger to nose with eyes closed
- Dermatomes
Range of Movement (ROM)
- Active
- Passive

Muscle Power
- Assess skeletal muscles for size and strength
- Oxford Scale
  - 0 = no movement
  - 1 = flicker
  - 2 = gravity eliminated
  - 3 = against gravity
  - 4 = against resistance
  - 5 = normal

- Myotomes
  **Upper limb**
  - C1 = occipital flexion
  - C2 = occipital extension
  - C3 = occipital side flexion
  - C4 = shoulder girdle elevation
  - C5 = shoulder abduction
  - C6 = elbow flexion
  - C7 = elbow extension
  - C8 = thumb extension
  - T1 = finger abduction/adduction

  **Lower limb**
  - L1 = hip flexion
  - L2 = hip flexion
  - L3 = knee extension
  - L4 = ankle dorsiflexion
  - L5 = 1st toe extension
  - S1 = Ankle plantarflexion
  - S2 = Knee flexion

Tone
- Use body chart e.g.
  - + Patient able to alter / low
  - ++ Therapist able to alter / moderate
  - +++ Unable to alter / high

Coordination
**Upper limb**
- Rapid pronation / supination (dysdiadochokinesia)
- Finger-nose (dysdiadochokinesia)
- Arm bounce – downward pressure & sudden release of outstretched arm causes excessive swinging
- Rebound – flex elbow against resistance, sudden release & hand strikes face as delay in triceps contraction
Lower limb
- Heel-shin (ataxia)
- Repeated foot tapping (dysdiadochokinesia)
- Romberg’s test
  (sway when eyes open or closed = cerebellar deficit / cerebellar ataxia)
  (sway only when eyes closed = proprioceptive deficit / sensory ataxia)

Reflexes
- Look for hyperactive deep tendon reflexes or absence of superficial reflexes
  **Upper limb**
  - C5 / 6 Biceps
  - C6 Brachioradialis
  - C7 Triceps
  - Hoffmann’s reflex (finger flexor reflex) tapping the nail or flicking the
terminal phalanx of the middle or ring finger, positive response is flexion of
the terminal phalanx of the thumb, indicates upper motor neurone lesion.

  **Lower limb**
  - L3 Quadriceps
  - S1 Achilles tendon
  - Babinski test – upper motor neuron lesion if big toe extends

Palpation

Balance
- Sitting and standing, static and dynamic

Mobility and function (Including gross and fine motor skills)
- This will identify if the patient requires assistance with regards:
  - Feeding, self care and toileting
  - Bed mobility
  - Transfers
  - With/without aid/assistance
  - Gait - step width/length, step to, reciprocal, wide based, scissoring, shuffling,
antalgic, high stepping, associated postural movements etc.

Steps / stairs
- With / without aid or assistance, use of rails, step to or reciprocal gait.

Bladder difficulties ask about urgency, initiating voiding, retention, overflow, incontinence.

Bowel difficulties ask about constipation, incontinence with loss of sphincter control, absence of
sensation or numbness in the rectum.

Fatigue and Endurance

Cognitive Function the impact of metastases, medication, toxicity or infection may lead to
temporary or long term cognitive impairment. If the patient has problems with memory,
perception, planning or spatial awareness, this may impact on their ability to carry out any
activity.

Psychological function includes emotions (state / feelings), coping techniques, self-identity, intra
and inter-personal relationships and possible impact of these on the patient’s performance.
Respiratory assessment

- Observation and palpation of chest – position, chest shape, chest expansion - paradoxical breathing, breathing pattern e.g. mouth breathing, chest movement e.g. accessory muscle use, cyanosis, wearing oxygen (delivery device and amount of oxygen) etc.
- Auscultation, Respiratory rate, Temperature, Heart rate and BP
- Oxygen saturation, CXR, ABG, Cough – technique, weak / fair / strong
- Sputum production – technique, amount, colour, smell, consistency
- Inhaler technique

7. Spinal Stability and Timing of Mobilisation

NICE recommends that a decision about spinal stability has to be made by the MDT, ideally including surgeon, radiologist, oncologist and physiotherapist and documented in the medical record. Assume the spine is unstable until investigations prove otherwise and MDT decision made

Most reliable indicators of spinal instability are radiological findings (MRI) and clinical features such as mechanical pain and changing neurological features (escalation of pain, peripheral tingling or numbness, muscle weakness).

Instability is likely to be present if any of the following are present:

- Severe pain at site of lesion, increasing on movement
- The tumour involves two or more adjacent vertebral bodies
- Both anterior and posterior elements at the same level are involved
- Involved vertebral bodies have collapsed to less than 50% of their original height
- The odontoid process has been destroyed leading to possible atlanto-axial subluxation (WOSCAN, West Of Scotland Cancer Network Guidelines for malignant spinal cord compression, 2007)

Retrospective audit of clinical practice shows wide variation in the timing of, and methods used to mobilise patients diagnosed with MSCC during treatment. In the past mobilisation has usually only been started only after radiotherapy or spinal stabilisation, or following an arbitrary period of bed rest. However there is no research evidence to support any of these approaches.

Once the spine is confirmed as stable, gentle mobilisation should be commenced as soon as possible, bearing in mind that this may be before, during or after definitive treatment. When pain is well controlled, gradual sitting should begin, from supine to 45° initially and if tolerated, the patient should be encouraged to progress to 60° and 90° if able. Pain levels and neurological signs / symptoms must be monitored during this process. If there is a significant worsening of any of these, patients should be returned to a position where these changes reverse and the stability of the spine reassessed.

(NICE, MSCC Guidelines, 2008)
7.1 Flow Chart for Decisions about timing and safety of mobilisation once MSCC suspected (NICE 2008)

Suspected MSCC

- Lie flat, neutral spine alignment and log roll

- Conduct and review MRI

Spine assessed as being unstable? (Bony or neurological instability)

- Yes: Are surgery and/or radiotherapy appropriate?
  - Yes: Medical management, Dexamethasone, surgery and/or radiotherapy as appropriate
  - No: Does spine remain stable?
    - Yes: Discharge planning
    - No: Graduated assessment of sitting once spinal shock settled or neurology stable (up to 60° over 4 hours)

- No: Significant increases in pain or neurological symptoms?
  - Yes: Ongoing assessment and rehabilitation in unsupported sitting, standing, walking and ADLs
  - No: Discharge planning
8. Respiratory care: Spinal cord compression

<table>
<thead>
<tr>
<th>Above C3</th>
<th>Paralysis of diaphragm, intercostals and abdominals</th>
<th>Use sternocleidomastoid and trapezius</th>
<th>Normal chest care for ventilator dependent patients</th>
<th>Consider assisted cough</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required mechanical assistance, likely to be ventilator dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical compression Below C4</td>
<td>Partial or total diaphragmatic action and accessory muscles, no intercostals or abdominal activity</td>
<td>Need external compression for effective cough to increase positive intrathoracic pressure. Low vital capacity due to oedema and low tone. Paradoxical breathing. Unable to produce forced expiration</td>
<td>Consider assisted cough</td>
<td>Consider cough assist machine</td>
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<tr>
<td>Thoracic compression</td>
<td>Some preservation of intercostals but no abdominals</td>
<td>Impaired forced expiration</td>
<td>Consider use of abdominal binder</td>
<td>Consider assisted cough</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consider Cough assist machine</td>
<td></td>
</tr>
<tr>
<td>Below L1</td>
<td>Little effect on respiratory function</td>
<td></td>
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</table>

8.1 Effect of Spinal Lesion on Respiratory Muscles

8.11 Abdominal muscles

When the abdominal muscles are paralysed the abdominal contents fall downwards and forwards, the diaphragm descends lower into the abdominal cavity. When the diaphragm contracts the lower ribs are pulled inwards reducing the lateral diameter of the lower chest. Vital capacity may fall by as much as 45% in standing.

8.12 Intercostal muscles

When impaired the amount of muscle available for inspiration and expiration is reduced. When under stress the muscles used for inspiration are alternated. Inspiration may initially be caused by contraction of the diaphragm and then when it becomes fatigued the intercostals take over, until the diaphragm has had time to recover. Paradoxical inward movement of the intercostals spaces may occur if the intercostals muscles are paralysed.

8.13 The Diaphragm

If the diaphragm is paralysed or weak the negative intrathoracic pressure sucks the diaphragm up into the chest and the upper abdomen will move inwards during inspiration.
8.14 The Accessory muscles

In a complete lesion above C3 only the accessory muscles sternocleidomastoid and trapezius are available for inspiration. These muscles can sometimes produce a vital capacity of 700ml although they are usually incapable of providing long term ventilation. (Webber and Pryor, 1994)

8.2 Respiratory Physiotherapy for Patients with Spinal Cord Compression

- Patients are taught breathing exercises and provided with an incentive spirometer.
- Positioning for treatment needs to be considered and a supine or 15° head down position may be required.
- Some patients will require an assisted cough, particularly with cervical and thoracic cord compression.
- The Cough Assist and IPPB (The Bird) can be very beneficial for these patients, but be aware that positive intrathoracic pressure reduces venous return to the heart and can reduce cardiac output, therefore use with care in patients with an unstable cardiovascular system.
- Anxiety can adversely affect respiratory function so consider use of breathing control, anxiety management, pacing and fan therapy/open window and most importantly reassurance.

8.3 Respiratory Techniques

8.31 Manual Assisted Cough

The patient with partial or complete paralysis of the abdominal muscles will be unable to produce a forced expiration (cough). As therapists we can attempt to replace the function of the paralysed muscles by creating increased pressure underneath the working diaphragm.

Method

This can be done by one of two methods:

1. Hands should be placed so that one rests on the nearside of the thorax and the other on the opposite side of the thorax, with the forearm resting across the lower ribs. As the patient attempts to cough push inwards and upwards with your forearm and stabilise the thorax with the other hand.

2. The hands are positioned bilaterally over the lower thorax and with the elbows extended the physiotherapist pushes inwards and upwards evenly through the arms.

8.32 Cautions / Contraindications

Manual techniques

- Contraindicated if patient has rib metastases due to fracture risk
- Consideration of hand placement (not over tumour site / painful area)
- Consider platelet levels
- May not be appropriate to use with a terminal patient in respiratory distress
### Suction
- May not be appropriate in terminal care, as distressing
- Caution in head and neck cancers and upper airway tumours due to altered anatomy
- Consider platelet levels
- Awareness of infection risk

### Positioning
- Awareness of tumour site and potential to compress/cause discomfort

### Cough Assist / IPPB
- Caution in patients with bronchial tumour as potential for air trapping
- Consider platelet levels

### 8.33 Platelets
- Normal levels 150,000-400,000/microlitre reflects balance between production and destruction
- At 100,000/microlitre normal clotting still possible
- Patients need at least 50,000/microlitre for surgeons to perform procedures
- At 30,000-50,000/microlitre experience spontaneous bleeding after negligible trauma
- At 10,000-30,000/microlitre experience spontaneous bruising, menorrhagia, and prolonged bleeding with injury
- At <10,000/microlitre have mucosal bleeding (epistaxis, gastrointestinal, and genitourinary) and at risk for CNS bleeding.

Platelets below 50,000-60,000/microlitre suction with extra care to avoid trauma, use manual techniques cautiously, discuss with medical team and get their consent

Below 20,000/microlitre avoid suction, manual techniques and manual hyperinflation consider Cough Assist at low pressures.

Patients may require platelet infusion to optimise levels prior to treatment.

These above values are a guide only, in each individual case discuss with the registrar/consultant and get documented consent

*(Zavadsky, 2001)*
9. Points to consider

- When treating oncology and haematology patients you need to be aware of the potential infection risk, as patients can have low white cell counts – ensure good hand washing technique, use of gloves, apron and mask (if indicated) and sterile technique if suction is needed.

- Patients fatigue easily and therefore may require shorter treatment sessions with rest periods, consider energy conservation and pacing advice.

- Patients can often become anxious exacerbating symptoms of breathlessness, reassurance and exploring the impact and meaning of the disease and its symptoms can be beneficial, consider breathing control and anxiety management, fan therapy and positioning to reduce breathlessness.

- For patients who are entering the terminal phase positioning, breathing control, reassurance and optimising medication (midazolam for agitation, hyoscine for excessive secretions, appropriate oxygen delivery) should be the main focus. It is not always appropriate to use manual techniques and suctioning.

10. References

NICE (2008) CG75: Metastatic Spinal Cord Compression: Diagnosis and Management of Patients at Risk of or with Metastatic Spinal Cord Compression


A.J Zavadsky. 2001 Platelet disorders and their implication on physical therapy intervention. Rehabilitation Oncology
## Appendix (i) MSCC Matrix of treatment / Rehabilitation

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>UNSTABLE SPINE PRIOR TO RADIOTHERAPY OR STABILISATION</th>
<th>STABLE SPINE PRIOR TO AND DURING RADIOTHERAPY</th>
<th>THERAPY POST RADIOTHERAPY +/- STABILISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General information</strong></td>
<td>Management pathway clearly documented and communicated</td>
<td>Management pathway clearly documented and communicated</td>
<td>Management pathway clearly documented and communicated</td>
</tr>
<tr>
<td></td>
<td>Patient nursed supine, one pillow, maintain neutral spine alignment, ‘log roll’, slipper pan and bottle/catheter, cot sides in place</td>
<td>MDT decision that spine appears stable</td>
<td>It must be acknowledged that completion of radiotherapy does not automatically indicate the spine is stable. The patient should be reviewed for signs of spinal instability, further scanning may be indicated and a decision made by the MDT regarding safety to mobilise.</td>
</tr>
<tr>
<td></td>
<td>Correct intervention for pressure relief</td>
<td>Gentle mobilisation ASAP, to complications of prolonged bed rest thought to contribute to increased morbidity &amp; early mortality, ensure well pain controlled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above knee TEDS to prevent thrombosis</td>
<td>Recommended that early mobilisation carried out by appropriately skilled therapist (liaise with therapists in Neurosurgery and in Oncology / Haematology)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immobilisation in hard collar if cervical lesion. Instruct patient, carers and nursing staff regarding fitting of collar, care and maintenance.</td>
<td>Spinal brace may be indicated for thoracic or lumbar lesions (liaise with consultant and neurosurgeons)</td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Bed rest until stabilisation achieved (this may be achieved by surgery or bracing) or Radiotherapy completed (It must be acknowledged that completion of radiotherapy does not automatically indicate the spine is stable. The patient should be reviewed for signs of spinal instability, further scanning may be indicated and a decision made by the MDT regarding safety to mobilise.)</td>
<td>Patient elevated in bed to 45° initially, if tolerated progress to 60° over 3-4 hrs if BP and pain / neurology stable &amp; then further elevation to 90° (If any significant deterioration in pain +/- neurological status to return to supine &amp; re-evaluated by doctor)</td>
<td>Bed mobility assessment May require monkey pole or cot sides to facilitate this</td>
</tr>
<tr>
<td></td>
<td>Bed mobility assessment May require monkey pole or cot sides to facilitate this</td>
<td>Mobilise as condition allows in consultation with consultant. If any significant deterioration in pain +/- Collar or brace?</td>
<td>Sitting up in bed Gradually elevate to 45°, then 60° over 3-4 hrs if BP, pain and neurology stable increase to 90°</td>
</tr>
<tr>
<td></td>
<td>Sitting up in bed</td>
<td>If pain limits patient’s mobility, consider</td>
<td></td>
</tr>
</tbody>
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Respiratory Function (see Respiratory section)
- Breathing exercises to increase air entry
- Use of incentive spirometer
- Autogenic drainage and active cycle of breathing to aid clearance of secretions
- Assisted coughing
- Suction as indicated

ROM Exercises & Positioning
- Exercises twice daily, encourage patient and family/carers to be independently involved with exercises
- Teach active/active assisted exercises, including static quadriceps and gluteal contractions and perform passive movements within pain limits of all joints
- Cervical lesions avoid movements that cause pain at the site of fracture/compression and no resisted arm movements
- Tendo Achilles stretches to prevent ankle contracture and hamstring stretches (consider frogging position)
- Hip flexion: lesions T10 and below restrict to 30°, move within pain free range

neurological status to return to supine and re-evaluated by medical team

Respiratory Function
Thoracic Expansion Exercises, use of incentive spirometer to increase air entry, Active Cycle of Breathing Technique, autogenic drainage to aid clearance of secretions, assisted coughing, suction as indicated

ROM Exercises & Positioning
Active / Active-Assisted / Passive exercises involving all muscle groups depending on patient’s ability to maintain ROM and muscle power

the use of a brace, liaise with consultant and neurosurgical team

Respiratory function
See previous table

ROM Exercises & Positioning
Sitting balance assessment and re-education
Once able to sit upright in bed, modified log roll technique to move from supine to sitting

Sit-Stand assessment and re-education
If patient has independent sitting balance and grade 3 and above muscle power

Standing balance assessment and re-education
Patients with grade 3 and above lower limb strength

Transfers
- If no sitting balance use full hoist
- If sitting balance but unable to stand consider sliding board use. Be aware of any sensory deficit and pressure areas.

<table>
<thead>
<tr>
<th>Anxiety management</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Advice, education, relaxation techniques</td>
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</tr>
</tbody>
</table>

- If sitting balance and grade 3 or above lower limb strength consider facilitated transfer +/- aid

**Gait re-education**
- Appropriate walking aids and stair mobility as appropriate

**Sitting out of bed**
- Assessment of suitable seating and pressure relief including frequent position change to reduce sores, initially to sit out for 1 hr closely monitoring BP and pain/neurological function, then increase as able/indicated
- Liaison with OT for provision of wheelchair and pressure relieving cushion,

**Exercises / Positioning**
- Strengthen unaffected muscle groups, taking care not to increase spasticity or cause muscle imbalance
- Exercises and functional activities to aid recovery in weak muscles, passive movements if unable to exercise actively
- Control spasticity if present, positioning, splinting, muscle relaxants
- Increase exercise tolerance and reduce fatigue, graded ex programme and pacing
<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>As for unstable / stabilisation and ...</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Introductions to patient and relatives, and commence initial interview</td>
<td>Psychological support to enable adjustment to loss of function</td>
<td>Joint assessment with Physiotherapist</td>
</tr>
<tr>
<td>Assessment of cognitive functioning</td>
<td>Functional assessment</td>
<td>Assess trunk postural stability, level of mobility</td>
</tr>
<tr>
<td>Assessment of psychological functioning</td>
<td>Assess for communication deficit</td>
<td>- walking aid</td>
</tr>
<tr>
<td>Feeding &amp; drinking whilst flat bed rest</td>
<td>Assessment for wheelchair (intermediate) if sitting balance (as appropriate)</td>
<td>- assisted transfer</td>
</tr>
<tr>
<td>Self care and leisure activities whilst on flat bed rest</td>
<td>Assess transfer method (hoist / transfer boards etc.)</td>
<td>- wheelchair needs</td>
</tr>
<tr>
<td>Management of environment as independent as possible</td>
<td>Pressure care assessment (liaison with staff nurse)</td>
<td>Method of transfer</td>
</tr>
<tr>
<td>Clarification of understanding of MSCC</td>
<td>PADL or purposeful activity to increase ROM and active sitting balance/standing balance</td>
<td>- transfer board</td>
</tr>
<tr>
<td>Psychological support to enable adjustment to loss, encouraging realistic expectations and enabling early choices</td>
<td>Assessment for temporary wheelchair</td>
<td>- standing hoist</td>
</tr>
<tr>
<td>Anxiety management</td>
<td>Wheelchair practice (dependent on ability/site of SCC / known metastases)</td>
<td>- full hoist</td>
</tr>
<tr>
<td>Advice and support to carers</td>
<td>Functional mobility within ADLs as able</td>
<td>Wheelchair assessment and prescription (as appropriate)</td>
</tr>
<tr>
<td>Acquisition of specialist equipment – chair / wheelchair / hoist which may be needed for rehab phase</td>
<td>Access visit as appropriate</td>
<td>Acquisition of specialist equipment related to discharge</td>
</tr>
<tr>
<td>Discussions around goal setting with patient / carers</td>
<td>Liaison with patient and carers, look at goal setting towards end of RT</td>
<td>Activity practice (PADL, purposeful activities, meal prep, home management, leisure and social – as appropriate) – techniques such as backward chaining can be useful to gain confidence</td>
</tr>
<tr>
<td>Possible initial access visit</td>
<td>Liaison with S/S OT teams / local rehab teams/OT teams</td>
<td>Compensatory approach to increase independence</td>
</tr>
<tr>
<td>Liaison with MDT re particular issues e.g. social worker and housing, palliative care team and pain</td>
<td>Liaison with D/N (specific issues)</td>
<td>Additional activity for fatigue / balance / confidence</td>
</tr>
<tr>
<td>Encourage self care with pain and ROM precautions</td>
<td>Access visit as appropriate</td>
<td>Fatigue management including advice and education on energy conservation techniques</td>
</tr>
<tr>
<td>Liaison with nursing team re moving and handling</td>
<td>Liaison with patient and carers, look at goal setting towards end of RT</td>
<td>Progressively increase graded activities.</td>
</tr>
<tr>
<td>Joint assessment with Physiotherapist</td>
<td>Liaison with S/S OT teams</td>
<td>Liaison with MDT</td>
</tr>
<tr>
<td>Liaison with S/S OT teams (as appropriate)</td>
<td>Liaison with S/S OT teams/ local rehab teams / OT teams</td>
<td>- advice</td>
</tr>
<tr>
<td></td>
<td>Liaison with D/N (specific issues)</td>
<td>- benefits</td>
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<tr>
<td></td>
<td>Access visit as appropriate</td>
<td>- symptom control</td>
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<tr>
<td></td>
<td></td>
<td>Liaison with carers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Achievable goals – plans to achieve goals with patient / carers / MDT</td>
</tr>
</tbody>
</table>
- Goal setting with patient, small manageable goals to completion or as progressive to larger long term goal
- Liaison with D/N (specific issues – as appropriate)
- Liaison with community rehab palliative therapy services.
- Liaison with next place of care if to be transferred

- Domestic hoist assessment if to go directly home (as required)
- Home visit / Access visits
- Environmental adaptations – refer to appropriate resource
- Assess with adaptations, referral to community teams, liaison with out of area OTs for access visits
- Demo (& training) of equipment with carers
- Re-housing reports
- Advice to patient / carers re privately funded equipment
- Referral to community agencies for support
- Facilitation of Stair lifts provision
- Splinting as appropriate
- Liaison with D/N (specific issues)