Flowchart 1: Management of patients with cancer receiving palliative care who have suspected malignant spinal cord compression

Imaging	• Is the patient appropriate for imaging? (consider prognosis, performance status, duration of neurology) **If not proceed to flow chart 2**
Immediate management	• Commence steroids (dexamethasone 8 mg twice a day). • Consider gastroprotection, blood glucose monitoring, pain management, bowel management, urinary catheter, thromboprophylaxis. • Consider daily neurological examination. • Advise bed rest and admit for urgent MRI within 24 hours (CT if MRI contraindicated).
Surgical intervention	• If confirmed malignant spinal cord compression or cauda equina compression, consider discussion with neurosurgery. Use of the **SINS score** may be useful. • If suitable for spinal surgery, keep on flat bed rest, transfer to surgeons as soon as possible.
Oncology interventions	• If not appropriate for surgery discuss with the metastatic spinal cord compression co-ordinator, acute oncology or the on-call oncologist, to consider potential for radiotherapy (or less commonly systemic anticancer therapies (SACT)) and transfer to appropriate ward.
SINS score	• If the patient potentially has an unstable spine, and surgery has been ruled out (use of the **SINS score** may be useful), consider a referral to orthotics for a brace or collar. Advise to remain on bed rest until the device is fitted.
Orthotics	• If appropriate for an orthotic device, have a full discussion with the patient to see if this best meets their needs. Consider who will assist putting the brace on and off, prognosis, comfort, and who will follow this up.
Holistic care	• Ensure there is a holistic assessment of the patient's psychological and spiritual needs when considering symptom management. • Ensure a plan is in place for weaning off steroids and for pain management.
Next steps	• Once oncological treatment is complete, discuss as an MDT if ongoing rehabilitation is appropriate and discharge planning.