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Palliative Care Rounds: Update on Spinal Cord Compression for the Palliative Care Clinician

Marco Ferrone, Andrea Cheville, Tracy A. Balboni, Janet Abrahm

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Palliative Care Rounds: Update on Spinal Cord Compression for the Palliative Care Clinician
March 21, 2017

Marco Ferrone, Andrea Cheville, Tracy A. Balboni, Janet Abrahm

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Metastatic spinal cord compression (MSCC) is a devastating complication of cancer. Palliative care clinicians are often called to help manage the pain of such patients, and they can continue to assist the patient and family in choosing among treatment and rehabilitation options. The objectives of this case presentation are to alert palliative care providers to the subtle presentations of MSCC, the data on symptomatic therapy and the factors that enter into the decision for a recommendation of radiation therapy alone (RT) or surgery followed by RT, the newer RT and re-irradiation options, and the benefits of intensive rehabilitation therapy in select patients.

Case Description

Melanie is a 45 year-old graphic designer who was diagnosed with Stage 2, ER/PR positive, Her-2 negative breast cancer 5 years ago. She has a wife of 20 years, and three children, 7, 9, and 11. She completed adjuvant chemotherapy and continues taking adjuvant tamoxifen. Staging scans three months prior to her initial presentation to the ED showed no evidence of disease. She presented to the ED today with severe (10/10) mid-back pain with no radiation of pain. The pain is worse with Valsalva maneuver, straining at stool, or cough, and at night. It is not pleuritic. It is a deep, aching pain, without burning or electric shock. There is no tenderness to palpation at the site of the pain and no changes in the skin of the back. She takes acetaminophen with codeine without relief. The physical exam reveals normal strength, sensation and reflexes, and she has no bowel or bladder incontinence. Her laboratory studies are within normal limits except for a hemoglobin of 12. CT scans of her chest, abdomen and pelvis again show no evidence of metastatic disease.

MRI, however, shows a single lesion T7-T8 with epidural disease causing mild cord compression. The spine surgeon confirmed normal strength and reflexes but discovered subtle myelopathic features of gait instability. Melanie's pain became tolerable after a bolus of 10 mg of IV dexamethasone and 3 mg of IV morphine and her gait returned to normal. Her goals are to remain at home, be independent in her ADLs and IALDs, and work part-time. She begins 4 mg oral dexamethasone qid and she undergoes a biopsy of the thoracic spine lesion. The biopsy reveals metastatic breast cancer.

On the second hospital day, her case is presented to the Multidisciplinary Spinal Tumor Conference, attended by clinicians from palliative care, spine surgery, RT, diagnostic and interventional radiology and pathology. She does not have spinal instability (Spinal Instability Neoplastic Score (SINS) = 5 points)). Her prognosis is good (modified Bauer = 3 points). Her lesion is in the thoracic or semi rigid spine, and her surgery could be done from a single posterior

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