Spinal oncology referral form: evolution and rationale

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Anita Killingworth
Macmillan Spinal Oncology Advanced Nurse Practitioner

Alistair Stirling Spinal Surgeon
Lead Clinician NICE MSCC guideline

Introduction

- A referral form has been designed that records all the relevant information for initial decision making and planning of patient management and for the NICE MSCC guidelines (2008) implementation audit.
- It enables initial triage by the MSCC coordinator and facilitates senior professional advice and dialogue between Surgeons and Oncologists supporting prompt decision making.
- It should reduce the unnecessary transfer of patients who may not wish to undergo spinal surgery and / or who may not be medically fit for a procedure or require medical intervention prior to transfer.
- All the necessary contact information is included to facilitate obtaining further information and enhancing continuity of patient care.

Patient details

- Current complete patient details, contact numbers and location are necessary for patient registration and uploading of imaging onto PACS in the receiving hospital.
- Prompt liaison with referring staff is facilitated if the patient is in another unit.

Tumour presentation and prognosis

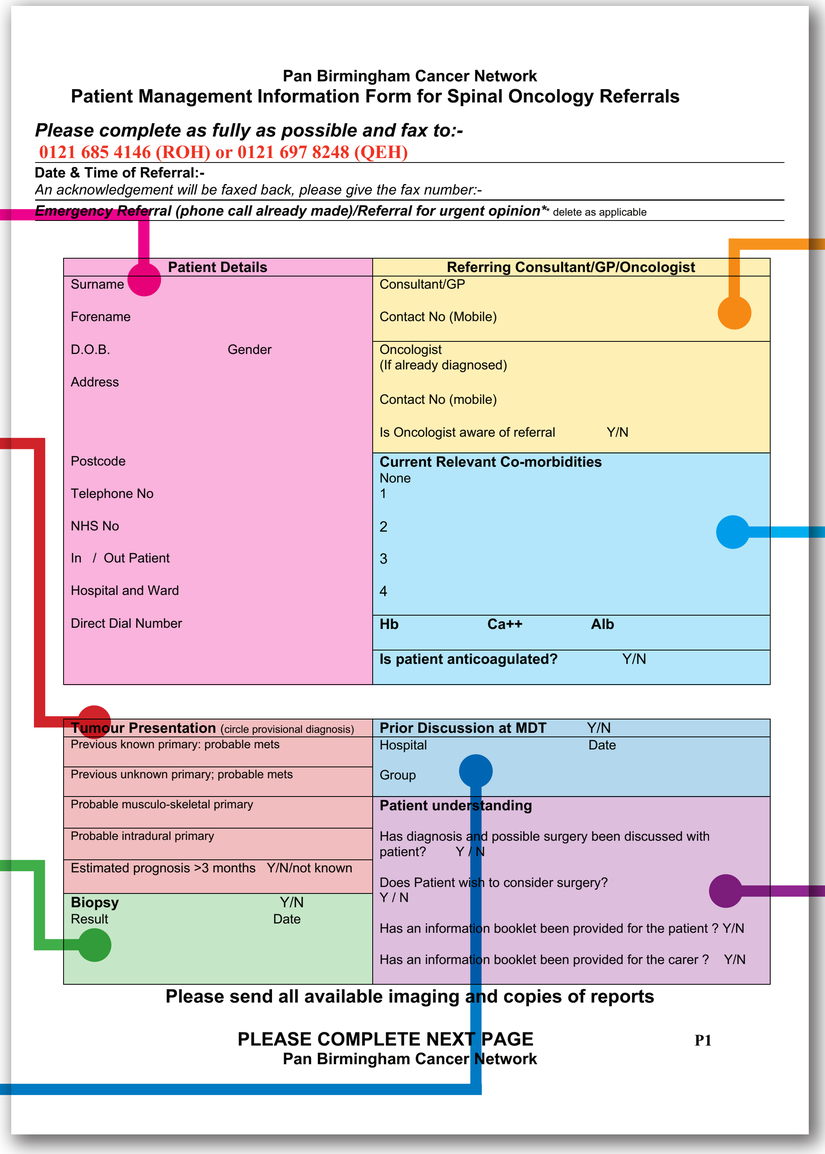
- Information about the generic presentation which may influence the decision about the most appropriate referral in that geographical region ie metastatic spinal disease and primary spinal tumours of osseoligamentous origin require spinal surgical referral. Primary neurological tumours require neurosurgical referral

Biopsy

- Metastases from a previously unknown primary or possible musculo-skeletal primary should have a biopsy prior to any more definitive procedure .
- Neo-adjuvant therapy prior to surgery and/or an en-bloc excision may sometimes be required.
- Metastases from an unknown renal tumour (and some primary tumours) may require embolisation prior to surgery to prevent exsanguinating haemorrhage .
- Biopsy where appearances suggest metastases from a previously known primary with a long disease free interval is suggested as these may be from a second primary requiring different management

Prior discussion at MDT

This may inform further Senior Professional advice, planning and management



Pan Birmingham Cancer Network
Patient Management Information Form for Spinal Oncology Referrals

Please complete as fully as possible and fax to:-
0121 685 4146 (ROH) or 0121 697 8248 (QEH)

Date & Time of Referral:-
An acknowledgement will be faxed back, please give the fax number:-

Emergency Referral (phone call already made)/Referral for urgent opinion* delete as applicable

Patient Details	Referring Consultant/GP/Oncologist
Surname	Consultant/GP
Forename	Contact No (Mobile)
D.O.B. Gender	Oncologist (If already diagnosed)
Address	Contact No (mobile)
	Is Oncologist aware of referral Y/N
Postcode	**Current Relevant Co-morbidities** None 1 2 3 4
Telephone No	
NHS No	
In / Out Patient	
Hospital and Ward	
Direct Dial Number	**Hb Ca++ Alb**
	Is patient anticoagulated? Y/N

Tumour Presentation (circle provisional diagnosis)	**Prior Discussion at MDT** Y/N
Previous known primary: probable mets	Hospital Date
Previous unknown primary; probable mets	Group
Probable musculo-skeletal primary	**Patient understanding**
Probable intradural primary	Has diagnosis and possible surgery been discussed with patient? Y / N
Estimated prognosis >3 months Y/N/not known	Does Patient wish to consider surgery? Y / N
Biopsy Y/N Result Date	Has an information booklet been provided for the patient ? Y/N
	Has an information booklet been provided for the carer ? Y/N

Please send all available imaging and copies of reports

PLEASE COMPLETE NEXT PAGE P1
Pan Birmingham Cancer Network

Referring Consultant/GP/Oncologist

- Further details may be required and senior professional discussion about appropriate management is recommended (NICE guideline) and should be facilitated through inclusion of the required contact information.

Current relevant co-morbidities

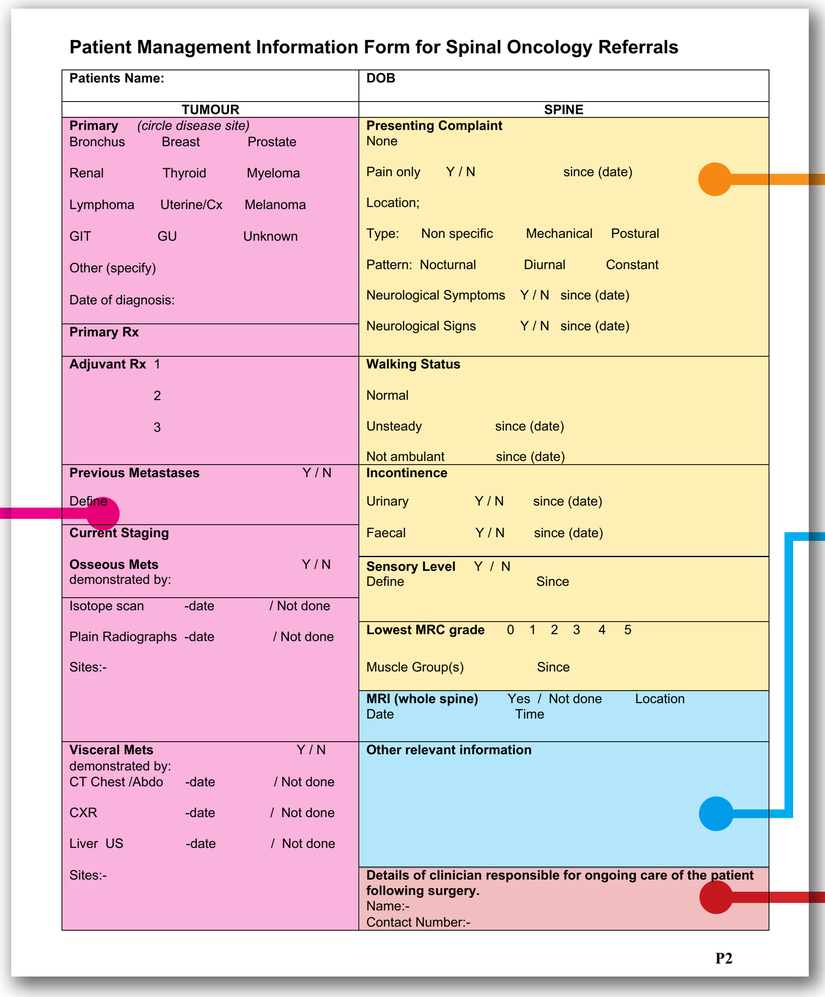
- The patient may not be medically fit for anaesthesia or surgery and may require medical opinion or intervention prior to transfer, particularly if anti-coagulated, hypercalcaemic or diabetic.
- This reduces the likelihood of inappropriate transfer and enhances awareness in the receiving hospital of likely treatment requirements

Patient understanding

- Confirmation that the patient understands the diagnosis and possible treatment options
- Understanding the patient's wishes and willingness to undergo surgery if indicated is important to avoid unnecessary transfers to surgical units.
- An information booklet on known bone metastases has been designed for patients and carers and recording its issue on the referral form prompts distribution. It is also one of the NICE MSCC audit criteria.

Tumour information

- Primary tumour type, the stage at diagnosis, initial treatment and interval to metastases, location of metastases (visceral, osseous, extraspinal) and extent are all important determinants of outcome contributing to prognostic scoring (Tokuhashi 2005) and may directly influence other measures eg. pre-operative embolisation is advised for renal metastases to minimise intra-operative bleeding.
- Patients on adjuvant therapy potentially requiring spinal surgery may need a planned interval before surgery to minimise complications. There will be some tumours for which chemotherapy is the preferred neo-adjuvant treatment and if clinically possible surgery will be planned once a number of cycles of chemotherapy have been administered.
- Information on staging and metastases is required to make decisions as to the purpose and nature of surgery. Urgent staging often has to be arranged at the time of referral and needs to be done promptly and in the most appropriate location for the patient.



Patient Management Information Form for Spinal Oncology Referrals

Patients Name:	**DOB**
TUMOUR	**SPINE**
Primary *(circle disease site)* Bronchus Breast Prostate	**Presenting Complaint** None
Renal Thyroid Myeloma	Pain only Y / N since (date)
Lymphoma Uterine/Cx Melanoma	Location;
GIT GU Unknown	Type: Non specific Mechanical Postural
Other (specify)	Pattern: Nocturnal Diurnal Constant
Date of diagnosis:	Neurological Symptoms Y / N since (date)
Primary Rx	Neurological Signs Y / N since (date)
Adjuvant Rx 1 2 3	**Walking Status** Normal
	Unsteady since (date)
	Not ambulant since (date)
Previous Metastases Y / N Define	**Incontinence** Urinary Y / N since (date)
Current Staging	Faecal Y / N since (date)
Osseous Mets Y / N demonstrated by:	**Sensory Level** Y / N Define Since
Isotope scan -date / Not done	**Lowest MRC grade** 0 1 2 3 4 5
Plain Radiographs -date / Not done	Muscle Group(s) Since
Sites:-	**MRI (whole spine)** Yes / Not done Location Date Time
Visceral Mets Y / N demonstrated by:	**Other relevant information**
CT Chest /Abdo -date / Not done	
CXR -date / Not done	
Liver US -date / Not done	
Sites:-	**Details of clinician responsible for ongoing care of the patient following surgery.** Name:- Contact Number:-

P2

Spine information

- The referrer is guided through a systematic review of the patient's symptoms in terms of the evolution of the presenting complaint, sensory, motor and sphincter symptoms and signs. This information informs the surgical team on the urgency of the referral and further management (eg whether steroid therapy should be commenced.)

MRI

- Whole spine MRI (as recommended in the NICE Guideline, 2008) is required as there may be multiple levels of spinal disease and \or cord compression. Incomplete studies will require repetition.

Clinician responsible for ongoing care

- This identifies the key clinician to enable effective forward planning as the patient may require input from rehabilitation as well as oncological management. To effectively manage the next stage of the pathway following surgery the patient may require transfer to a speciality in a different hospital and identification of the responsible clinician prevents delays.

Conclusion

- This referral form enables referrers to efficiently record and relay the relevant clinical information to MSCC coordinators to permit initial triage and inform Senior Professional Advisors so that care can be managed and coordinated effectively.
- Its use as a clinical management tool should reduce delays for patients at risk (of MSCC) and will support co-ordinated patient care and impact on patient outcomes.
- It acts as an educational tool for junior medical staff and reminder to senior medical staff of the relevant information for decision making in MSCC.
- This is the paper representation of an e-referral form that downloads into a linked purpose designed database (see adjacent poster – DATABASE) that also generates prognostic scores (Tokuhashi 2005 as recommended in NICE 2008 guideline) and avoids duplication of data entry.

References

NICE (November 2008) Metastatic Spinal Cord Compression. Diagnosis and management of adults at risk of and with metastatic spinal cord compression www.nice.org.uk

NICE (March 2006) Improving Outcomes for People with Sarcoma www.nice.org.uk

GD09_49787 b) Designed and printed by Medical Illustration 0121 204 1514