Appendix Definitions and terminology used in this guideline

Introduction
This guideline uses partly overlapping terms or terms that do not overlap at all, but that cover different things. For instance, spinal metastases also refer to spinal localisations of haematological malignancies, unless stated otherwise in the guideline text. The addendum defines the terminology we use to avoid any misunderstandings.

<table>
<tr><th>Term</th><th>Definition</th></tr>
<tr><td>Spinal metastases</td><td>All spinal metastases of systemic solid malignancies, with or without epidural spread and with or without compression of the spinal cord, cauda equina, or nerve roots. This definition also includes spinal localizations of multiple myeloma or malignant lymphoma, as their clinical presentation, diagnostic workup, complications, and management are similar. Deviations from this definition are explicitly stated in the guideline.</td></tr>
<tr><td>Spinal epidural metastases (SEM)</td><td>Spinal metastases, multiple myeloma, or malignant lymphoma with extension into the epidural space, which may or may not cause compression of the spinal cord, cauda equina, or nerve roots.</td></tr>
<tr><td>Metastatic epidural spinal cord compression (MESCC)</td><td>Spinal metastases, multiple myeloma, or malignant lymphoma causing compression of the spinal cord or cauda equina via epidural spread, with or without clinical signs of spinal cord injury or cauda equina syndrome. Radiological evidence of compression alone qualifies. If MESCC refers solely to spinal cord compression, this is explicitly stated. MESCC grade 2/3 is defined as high grade.</td></tr>
<tr><td>Complete spinal cord injury</td><td>Complete loss of motor and sensory function in sacral segments S4–S5 (ASIA score A)
ASIA score
<table>
<tr><td>A Complete</td><td>No motor or sensory function in the lowest sacral segment (S4-S5)</td></tr>
<tr><td>B Sensory - incomplete</td><td>Sensory function below neurologic level and in S4-S5, no motor function below neurologic level</td></tr>
<tr><td>C Motor - incomplete</td><td>Motor function is preserved below neurologic level and more than half of the key muscle groups below neurologic level have a muscle grade less than 3</td></tr>
<tr><td>D Motor - incomplete</td><td>Motor function is preserved below neurologic level and at least half of the key muscle groups below neurologic level have a muscle grade >3</td></tr>
<tr><td>E Normal</td><td>Sensory and motor function is normal</td></tr>
</table></td></tr>
<tr><td>Cauda (equina) compression</td><td>Compression of multiple cauda equina nerve roots, with or without pain or clinical signs of cauda equina syndrome. Radiological evidence alone qualifies.</td></tr>
<tr><td>Cauda equina syndrome</td><td>Pain and neurological deficits (paresis, sensory loss in the saddle area, or sphincter dysfunction) resulting from compression of multiple or all cauda equina roots.</td></tr>
<tr><td>Oligometastases/ oligometastasis</td><td>For the definitions/consensus used in clinical practice by tumor type, please refer to Table 1 in Module 4.1 Radiotherapy.</td></tr>
</table>

Radicular syndrome	Neurological deficit (sensory and/or motor) affecting one or more nerve roots in addition to pain. For a single nerve root, a maximum of one dermatome and one myotome are affected. Compression of the entire cauda equina is excluded.
Radicular pain	Pain caused by compression or damage to one or more nerve roots without neurological deficit.
Radicular deficit	Neurological deficit (sensory and/or motor) caused by compression or damage to one or more nerve roots.
Radiculopathy	Neurological deficit (sensory and/or motor) and/or pain caused by compression or damage to one or more nerve roots.
Vertebral instability	Structural instability of a vertebra due to tumor involvement, potentially causing progressive symptoms (e.g., pain). Diagnosis is based on clinical assessment and imaging.
Vertebral collapse	Loss of vertebral height. Typically occurs without compression or threat to the spinal cord or cauda equina, but may be associated with severe pain.
Specialized center	A regional center with 24/7 availability of spinal surgery, capable of reviewing and determining management in complex or uncertain cases, and specialized in the treatment of spinal metastases.
Coordinating clinician	The clinician who serves as the primary point of contact for the patient and other care providers, overseeing the management of patients with spinal metastases. Responsibilities may be delegated to an assistant physician or specialized nurse, depending on the clinical situation.
Spine surgeon	An orthopedic surgeon or neurosurgeon with specific expertise in spinal pathology.
Bilsky / MESCC grade	Bilsky grades 0–1c represent low grade MESCC, in which the tumor may extend into the epidural space but does not deform the thecal sac or compress the spinal cord or cauda equina. In contrast, high grade MESCC corresponds to Bilsky grades 2 and 3: grade 2 indicates deformation of the thecal sac with preserved CSF around the cord or cauda equina, while grade 3 represents complete effacement of CSF and true spinal cord or cauda equina compression (see module 1.2).
NOMS framework	The NOMS framework encompasses the four key components that systematically guide treatment decision-making: the (N)eurologic component, the (O)ncologic component, the (M)echanical component and the (S)ystemic component (see module 3.1).
Spinal Instability Neoplastic Score (SINS score)	The SINS score assesses whether spinal metastases cause stable, potentially unstable, or unstable spinal segments, helping decide if surgical evaluation is needed (see module 3.3).
The Karnofsky Performance Status (KPS) scale	The Karnofsky Performance Status (KPS) scale is a simple clinical tool that rates a patient's functional status from 100 to 0. 100 normal; 90 minor symptoms; 80 normal activity with effort; 70 able to care for self; 60 occasional assistance; 50 considerable assistance; 40 disabled, special care; 30 severely disabled, hospital indicated;

	20 very sick, active supportive care; 10 moribund; 0 dead. It reflects how well a patient can perform daily activities and how much assistance they need.
The WHO Performance Status (WHO PS)	The WHO Performance Status (WHO PS) is a simple 5-point scale (0–4) used to describe a patient's level of functioning and ability to carry out daily activities, especially in oncology. 0 Fully active, no restrictions; 1 Restricted in strenuous activity but ambulatory; 2 Ambulatory >50% of the day, unable to work; 3 Limited self-care; confined to bed/chair >50% of the day; 4 Completely disabled; totally bed- or chair-bound.
Multidisciplinary team meeting (MDO in Dutch)	A meeting where multiple specialists (at minimum with the organ specialist with oncology expertise, (intervention)radiologist, radiation oncologist, neurologist — if neurological deficits are present — and spinal surgeon) jointly decide on the best treatment strategy.
Cancer of Unknown Primary (CUP)	A situation where spinal metastases are found but the original tumor site is not yet identified.
Stereotactic Body Radiotherapy (SBRT)	Highly precise radiotherapy using high doses in a small number of sessions
Conventional (External Beam) Radiotherapy (cRT/cEBRT)	Standard radiotherapy
Vertebroplasty / Kyphoplasty	Minimally invasive procedures in which bone cement is injected into a vertebra (sometimes after inflating a balloon) to reduce pain and improve stability.
Separation surgery	Surgery that creates space between the tumor and spinal cord so radiation can be delivered safely. In this guidline this includes decompressive surgery as well.
Skeletal-Related Event (SRE)	A serious complication of spinal metastases, such as a spinal fracture.
International Classification of Functioning, Disability and Health (ICF)	A framework used to describe a patient's functional abilities, limitations, and participation in daily activities.
Health-Related Quality of Life (HR-QoL)	A measurement of how health problems affect a person's day-to-day well-being.