http://dx.doi.org/10.2106/JBJS.9520icl

TABLE E-1 Spine Instability Neoplastic Score*

Description	Score† *(points)*
I. Location‡ (3-point maximum)	
Junctional (Occ-C2, C-T, T-L, or L-S)	3
Midcervical (C3-C6) or lumbar (L2-L4)	2
Thoracic (T3-T9)	1
Sacroiliac	1
II. Pain (4-point maximum)	
Movement-related pain (VAS score of >5)§	4
Movement-related pain (VAS score of <5)	2
III. Bone response (2-point maximum)	
Lytic	2
Mixed	1
Other	0
IV. Radiographic features (6-point maximum)	
A. Alignment	6
Subluxation and/or translation (>3 mm)	2
De novo deformity (scoliosis and/or kyphosis)	
B. Bone involvement (lytic only)	2
Bilateral PLC involvement#	1
Unilateral PLC involvement#	1
Vertebral body lytic region of >50% (no collapse)	
C. Collapse and/or fracture (lytic only)	
Bilateral PLC involvement#	4
Unilateral PLC involvement#	3
Vertebral body collapse of ≥50%	3
Vertebral body collapse of <50%	2

*The table is reproduced, with modification, from: Fisher CG, DiPaola CP, Ryken TC, Bilsky MH, Shaffrey CI, Berven SH, Harrop JS, Fehlings MG, Boriani S, Chou D, Schmidt MH, Polly DW, Biagini R, Burch S, Dekutoski MB, Ganju A, Gerszten PC, Gokaslan ZL, Groff MW, Liebsch NJ, Mendel E, Okuno SH, Patel S, Rhines LD, Rose PS, Sciubba DM, Sundaresan N, Tomita K, Varga PP, Vialle LR, Vrionis FD, Yamada Y, Fourney DR. A novel classification system for spinal instability in neoplastic disease: an evidence-based approach and expert consensus from the Spine Oncology Study Group. Spine (Phila Pa 1976). 2010 Oct 15;35(22):E1221-9. Reproduced with permission. †The maximum score is 15 points. A score of <8 points indicates stability; 8 to 12 points, possible instability; and >12 points, instability. ‡Use the highest scoring region if lesion spans multiple regions. Occ = occiput, C-T = cervical to thoracic, T-L = thoracolumbar, and L-S = lumbosacral region. §Structural or neural pain, localized to the level of the tumor. VAS = visual analog scale. #PLC = posterolateral complex (includes occipital condyles, facets, pedicles, and costovertebral joints).

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TABLE E-2 Classification and Management of Acetabular Defects*

Acetabular Defect Type	Anatomic Description	Method of Reconstruction†
I	Lateral cortices and superior and medial Parts of wall are structurally intact	Conventional cemented total hip arthroplasty
II	Medial wall is deficient	Reconstruction of defect with PMMA and protrusio cup with cemented total hip arthroplasty
III	Superior and lateral walls are deficient	Reconstruction of defect with PMMA reinforced with screws, protrusio cup, and cemented total hip arthroplasty
IV	Pelvic discontinuity	Reconstruction of defect with PMMA reinforced with screws, protrusio cage with ischial fixation, and cemented total hip arthroplasty
V	Total acetabular destruction or resection for cure	Saddle prosthesis or durable reconstruction (structural allograft, custom prosthesis) if cure potential is high

*Reproduced, with permission, from: Quinn RH: Surgical management of lower extremity metastatic disease. In: Schwartz HS, editor. Orthopaedic knowledge update: musculoskeletal tumors 2. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2007. p 383-91. †PMMA = polymethylmethacrylate.