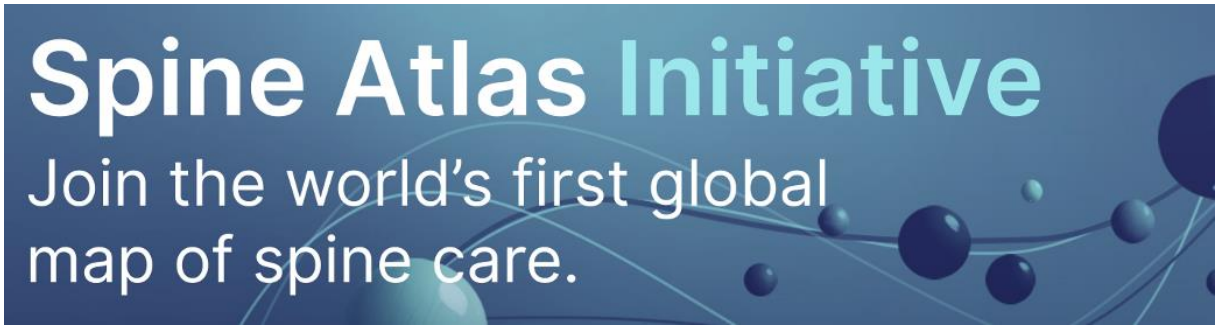

Protocol: Data Call 2026 on Degenerative Cervical Myelopathy (SAI-2026-DCM)

Treatment Variations in Degenerative Cervical Myelopathy (DCM)

Version 0.8; 28 Jan 2026

Authors:

- Christian Herrmann
- Emin Aghayev
- Tore Solberg
- Sabrina Donzelli
- SAI Steering Committee

Contents

1 Executive Summary 3

2 The Spine Atlas Initiative 3

2.1 Country lead investigators 3

3 Degenerative Cervical Myelopathy 4

4 Data call objectives 4

5 Study design, observation period and inclusion criteria 4

6 Data to be submitted 5

6.1 Data on patients 5

6.2 Mandatory parameters to collect 5

6.3 Optional parameters to collect 5

7 Ethics 6

8 Methods 6

8.1 Steering committee 6

8.2 Statistical analysis 6

9 Use of collected data 7

10 Benefits from and significance of this study 8

10.1 Hospitals 8

10.2 Overarching perspective 8

11 Contact 8

12 References 9

1 Executive Summary

The primary goal of the Spine Atlas Initiative (SAI) is to establish an approach for mapping spinal care services and variations in treatments of spinal pathologies across borders. The approach shall enable individual surgeons, hospitals, spinal registries and national societies (participants) worldwide to participate in international calls for epidemiological data, map their spine care service, benchmark them, and run epidemiological studies.

The data call 2026 focuses on Degenerative Cervical Myelopathy (DCM), the patient characteristics, treatment patterns and variations. The call aims to collect 9 mandatory and 6 optional data parameters on surgical and non-surgical treatments for DCM during the 4-month period from 1 February to 31 May 2026.

The data will be submitted by the participants of the initiative and combined for analysis by the SAI team. For data submission, participants may use a simple provided Excel template, the Spine Tango platform, or another existing registry. The data to be submitted will be required to follow specific definitions and formats. The collected data will be analysed, interpreted, and published by a large European network of hospitals and experts.

Each participant will benefit from group authorship (2 authors per participant), the visibility of their services, the network of spine experts and leading spine units, as well as from understanding the variation in DCM pathologies and their surgical treatment.

The initiative is supported by EANS, EUROSPINE and several national registries.

2 The Spine Atlas Initiative

The Spine Atlas Initiative (SAI) was founded in 2024 and had its first data call in 2025 for the surgical treatment of lumbar degenerative spondylolisthesis. Its goal is to enhance the understanding of spine care variations and inform healthcare practices through standardised international data calls and a visualisation framework. The SAI offers a collaborative, low-barrier approach to data collection, providing a platform for international research and comparison. All data calls, including this one, follow the general SAI protocol, see [1] (open access).

This protocol for the 2026 data call will only mention changes to the original protocol.

2.1 Country lead investigators

To increase participation and reduce hurdles, we are looking for country lead investigators. We are inviting national societies or participating hospitals/departments to act as a SAI country lead investigator. We aim in general for one such investigator per country, and they will be mentioned as such in the “lead investigators” section of SAI communications. The country lead investigators have the role to disseminate the information about the SAI data call within their countries, motivate the countries’ hospitals, institutions, and treatment specialists to participate and submit data, as well as support the SAI community in the interpretation of the countries’ and international results. Additionally, they are asked to help assess and identify any local regulations and clinical guidelines with regard to this data call and, if possible, to submit the index ethical approval (see ethics section below), to reduce participation hurdles for other units.

3 Degenerative Cervical Myelopathy

Degenerative Cervical Myelopathy (DCM) is the most common cause of spinal cord dysfunction in adults, resulting from degenerative changes (spondylosis), such as osteophyte formation, disc herniation, or ossification of the posterior longitudinal ligament.[2][3] DCM is a progressive condition characterised by cervical spinal stenosis and spinal cord compression, manifested by gait disturbance, hand clumsiness, sensory deficits, and, in advanced cases, significant motor impairment. [4] With an ageing global population, the incidence and prevalence of cervical myelopathy are expected to rise, making it a major public health concern.[5]

Despite its clinical significance, early diagnosis is often challenging due to the insidious onset and nonspecific initial symptoms. Delayed recognition and intervention are associated with poorer neurological outcomes, highlighting the importance of timely identification and management. [6] Current treatment strategies range from conservative care in mild cases to surgical decompression in patients with moderate to severe symptoms. Surgery has been shown to significantly improve patient-reported outcomes even in elderly populations, suggesting that age alone should not preclude operative treatment for DCM. [7]

Current literature does not provide sufficient evidence for a uniform classification of degenerative cervical myelopathy (DCM), for recommending a type of treatment or timing of surgical treatment. There is consistent, reasonably strong evidence that surgical decompression is the preferred treatment for moderate–severe or progressive DCM, but evidence is weaker or inconclusive for (a) whether early surgery is superior to watchful waiting in mild DCM, (b) which type surgical treatment and/or approach should be recommended, and (c) if non-surgical management could be an acceptable option in selected cases. Due to a small number of randomised trials, clinical guidelines will have to rely heavily on observational cohorts and expert consensus. [3]

4 Data call objectives

The specific objectives are to describe the patient population, to compare patient characteristics and variation in treatment practices across geographic areas.

5 Study design, observation period and inclusion criteria

The study design is an international cross-sectional study. The data will be reported and visualised for all participants' data in combination and for each individual country and/or provider with representative data.

All surgeries and non-surgical interventions for degenerative cervical myelopathy (DCM) performed between 1 February and 31 May 2026 are to be included.

Patients to be included must be 18 years of age or older.

Excluded are patients with myelopathy due to reasons other than DCM.

6 Data to be submitted

6.1 Data on patients

Only anonymised data will be accepted by the SAI team. The exact definitions and values of each parameter are outlined in the Codebook. The list of selected variables is based on the harmonisation work and core mandatory data set of the ISR working group, the SAI steering committee, the Spine Tango Committee, and the EUROSPINE Research Committee. It contains the most important information needed to describe the patient populations and interventions.

A few optional variables are included representing possible predictors of surgical outcome as described previously in the literature. Three additional questions on pathology and surgery are also available. Outcomes are not included in the variable list.

6.2 Mandatory parameters to collect

1. Patient age at therapy date (in whole years)
2. Patient gender
3. Surgery date/ Start of non-surgical treatment
4. Previous surgery at the same/adjacent level y/n
5. Duration of symptoms
6. Level of compression
7. Approach (anterior-lateral, posterior)
8. Pre-operative mJOA scores
    - Collected/not collected
    - Upper limb motor
    - Lower limb motor
    - Sensory (upper limbs)
    - Sphincter
    - Total
9. Treatment
    - (if any) Decompression type and level
    - (if any) Fusion type and level
    - (if any) Stabilisation rigid type and level
    - (if any) Other types of spine surgery and level
    - (if any) Non-surgical treatment

6.3 Optional parameters to collect

10. Additional spinal pathology
11. ASA status
12. Number of previous spine surgeries at the same or adjacent level
13. Height and weight (or alternatively BMI)
14. Smoking status
15. (if any) (a) Data on the implant manufacturer and (b) article number

7 Ethics

As outlined in the SAI protocol [1], each data contributor is responsible for following local rules and regulations, including obtaining patient consent and ethical clearance, if required.

The SAI team will ask their local ethics committee for specific approval of the data call 2026 protocol. The overall protocol was already reviewed by the ethics committee of Eastern Switzerland, confirming that no additional ethical approvals are required for anonymised data. BASEC submission no. AO_2024-00111.

Additionally, we ask the SAI country lead investigators to obtain an index ethical approval that can be used for other participants of that country.

8 Methods

Please consult [1] for details on SAI organisation, data submission, data retention and security, governance, estimated efforts of participants, representativeness of data, and use of collected data, among others.

8.1 Steering committee

The composition of the steering committee is variable and is published on the SAI website https://www.eurospine.org/spineatlas.

8.2 Statistical analysis

We will survey and describe the data collection in terms of data coverage, completeness, missing values, representativeness, and potential sources of bias. Then, the steering committee will decide, based on the participant survey, which countries have sufficient data representativeness to be included as a separate entity in the data analyses. Representativeness will also be assessed separately for single parameters.

With the mandatory parameters, we will describe the characteristics of the treated patient population (age and gender distribution), diagnoses and the performed treatments (type and involved levels). Descriptive statistics of the patient population overall and split by country, which have representative data, will be produced. Besides producing a map with the observed values, we also want to understand if there are country-wise patterns in patient populations, diagnoses and the treatment of myelopathy patients, such as:

- Is the distribution of age and gender the same among countries and regions, or do statistically different patterns arise?
- Does the distribution of diagnosis and treatment combinations differ among countries or regions (after standardisation by age and gender)?
- Is there within-country variability in patient management and treatments?

For each country, we will also assess the representativeness of the non-mandatory variables. We will perform a subgroup analysis for data that includes those variables. For this subgroup, we will further describe the patient population, including BMI, smoking status, the diagnoses, including pre-operative, mJOA scores, additional pathologies present, ASA status and number of previous spine surgeries. By comparing the distribution of mandatory variables among the submissions with optional data and those without, we will estimate if the data contributors with the additional

data may be significantly different to those without or if the additional data may be assumed to be representative of all participants and could be used for imputation. We will investigate the questions (all age and gender standardised):

- Can the optional parameters be imputed?
- Are the distributions of the ASA status, the number of previous spine surgeries, the duration of symptoms, the BMI, and the smoker status the same among countries and regions?
- Are there overall or country-specific patient clusters regarding the expanded patient characteristics?
- By including the optional variables, do different regional patterns arise compared to not including them?
- What is the variability of implants used?
- Does the severity of myelopathy differ by age, ASA status, no of operated levels and/or technique?
- Are there inequalities in the time to treatment (duration of symptoms) and what is there correlation with the risk factors?

To describe practice variation, we will use descriptive statistics to describe the distribution of treatment types per country and point estimates with 95% Confidence Intervals, or any other appropriate test to assess between-country variation. We will use logistic regressions or other appropriate models to identify predictors for each type of surgery and test if the country /region of treatment is a significant factor.

Any additional analyses will be defined by the SAI steering committee.

9 Use of collected data

The collected data could be used in numerous analyses for the assessment of different hypotheses.

The authorship group, as described in the SAI protocol [1], reserves the right to publish the first two main publications, one to describe the infrastructure and collected data, and one with the results of the data call 2026, as described in the study goals described above.

Subsequently, all involved hospitals and countries will have an equal right to use the pooled data for their research and publications. The standing steering committee (see SAI organisation) will review study proposals and control who does what to avoid duplication, maximise the use of the data and ensure high quality of the data usage. The Committee shall invite all interested colleagues from the Spine Atlas Working Group (SAWG) to participate, with a priori a maximum of one representative per country. The SAWG must be included as a contributing author.

The data pool of the data call will be made available to external researchers upon reasonable request. The time frame will be defined by the SAI team, depending on the volume of requests by participants and will be approximately 6-12 months after publication of the data call results.

For this data call, regarding data security and privacy, we clarify that the data pool itself stays in the secure environment detailed in the protocol and will not be shared as is for further analysis by parties other than EUROSPINE and/or NEC software solutions. Study requests for further analysis shall detail the statistical analyses to be done, and only receive the results of those.

10 Benefits from and significance of this study

10.1 Hospitals

The hospitals will join a large network of European hospitals, which may lead to various research projects and collaborations. They can potentially co-author and/or participate in joint research projects, but also analyse and publish the data on their own under certain terms and conditions approved by the Steering Committee.

Each hospital and country will also receive a benchmarking report comparing their data with the pooled data of all other hospitals and countries.

The hospitals joining the Spine Tango platform may benefit from the platform for collecting additional data (physician-based as well as PROMs), receiving benchmarking reports, getting access to pooled international data, and thus, being empowered in quality assurance and research.

10.2 Overarching perspective

EUROSPINE and established Spine Registries advocate for the importance of disease registration in providing the necessary insight for the improvement of treatment strategy and quality insurance.

The collected data will be valuable for the planning and development of health structures as well as research. The data will give an overarching perspective to all key stakeholders on the treated study population and applied treatments, which is essential for their actions.

This data call provides a unique source of comparable treatment data for researchers worldwide. Each subsequent data call will facilitate the understanding of the evolving magnitude and patterns of spine pathologies in different regions/countries. A strict evaluation of the data quality will ensure comparability across different time periods and regions.

The data provides evidence for the origins of variability across regions, whether it be due to environmental, behavioural, societal, medical school, guideline, or other reasons, and may show potential for improvement across multiple factors.

11 Contact

SAI team to contact:

The Spine Atlas Initiative (SAI)
EUROSPINE, the Spine Society of Europe
c/o Pfister Treuhand
Bankstrasse 4
8610 Uster
Switzerland
spineatlas@eurospine.org

Principal Investigator:

Christian Herrmann, PhD
EUROSPINE, the Spine Society of Europe
herrmann@eurospine.org

12 References

[1] C. Herrmann *et al.*, "Mapping healthcare services and practice variations in spinal care across countries: The Spine Atlas Initiative," *Brain and Spine*, vol. 5, p. 105622, Jan. 2025, doi: 10.1016/J.BAS.2025.105622.

[2] A. Nouri, L. Tetreault, A. Singh, S. K. Karadimas, and M. G. Fehlings, "Degenerative Cervical Myelopathy: Epidemiology, Genetics, and Pathogenesis," *Spine (Phila Pa 1976)*, vol. 40, no. 12, pp. E675–E693, 2015, doi: 10.1097/BRS.0000000000000913.

[3] M. G. Fehlings *et al.*, "AO Spine Clinical Practice Recommendations for Diagnosis and Management of Degenerative Cervical Myelopathy: Evidence Based Decision Making - A Review of Cutting Edge Recent Literature Related to Degenerative Cervical Myelopathy," *Global Spine J*, vol. 15, no. 5, pp. 2585–2593, Jun. 2025, doi: 10.1177/21925682251331050/ASSET/EAAD6A5C-8558-43CF-9F69-4E20D7A83FAA/ASSETS/GRAPHIC/10.1177_21925682251331050-IMG1.PNG.

[4] J. Tu, J. V. Castillo, A. Das, and A. D. Diwan, "Degenerative Cervical Myelopathy: Insights into Its Pathobiology and Molecular Mechanisms," *J Clin Med*, vol. 10, no. 6, pp. 1–28, Mar. 2021, doi: 10.3390/JCM10061214.

[5] B. M. Davies, O. D. Mowforth, E. K. Smith, and M. R. N. Kotter, "Degenerative cervical myelopathy," *BMJ*, vol. 360, Feb. 2018, doi: 10.1136/BMJ.K186.

[6] G. Jannelli, A. Nouri, G. Molliqaj, G. Grasso, and E. Tessitore, "Degenerative Cervical Myelopathy: Review of Surgical Outcome Predictors and Need for Multimodal Approach," *World Neurosurg*, vol. 140, pp. 541–547, Aug. 2020, doi: 10.1016/J.WNEU.2020.04.233.

[7] T. O. Johansen *et al.*, "Surgery for degenerative cervical myelopathy in the elderly: a nationwide registry-based observational study with patient-reported outcomes," *Acta Neurochir (Wien)*, vol. 164, no. 9, pp. 2317–2326, Sep. 2022, doi: 10.1007/S00701-022-05282-Y/TABLES/4.

Appendix 1 Codebook

Type	Nr.	Parameter	Answer value	Answer text
Mandatory	1	Patient age at treatment date	[years]	-
	2	Patient gender	0	female
			1	male
			9	other
			99	unknown
	3	Surgery date/ Start of non-surgical treatment	[dd.mm.yyyy]	-
	4	Previous surgery at the same or adjacent level	0	no
			1	yes
			9	unknown
	5	Duration of symptoms	1	<3 months
			2	3-12 months
			3	>12 months
	6	Level of compression	0	C0/1
			1	C1/2
			2	C2/3
			3	C3/4
			4	C4/5
			5	C5/6
			6	C6/7
			7	C7/Th1
	7	Approach	1	anterior-lateral
			2	posterior
			3	both
	8a	Pre-operative mJOA (pmJOA) collected	0	Not collected
			1	collected
	8b	pmJOA score upper limb motor	[0-5]	
	8c	pmJOA score lower limb motor	[0-7]	
	8d	pmJOA score sensory (upper limbs)	[0-3]	
	8e	pmJOA score sphincter	[0-3]	
	8f	pmJOA score total	[0-17]	pmJOA* =18 excluded
	9a1	Decompression type	0	none
			1	discectomy partial/total
			2	sequestrectomy
			3	laminotomy
			4	hemi-laminectomy
			5	laminectomy
			6	foraminotomy/ uncoforaminotomy
			7	facet joint resection partial
			8	facet joint resection full
			9	other decompression (incl. laminoplasty)

Type	Nr.	Parameter	Answer value	Answer text
	9a2	Decompression level	0	C0/1
			1	C1/2
			2	C2/3
			3	C3/4
			4	C4/5
			5	C5/6
			6	C6/7
			7	C7/Th1
Mandatory	9b1	Fusion type	0	none
			1	anterior cervical interbody fusion/ ACDF
			2	posterolateral fusion
			3	posterior fusion
			4	corpectomy fusion
			9	other fusion
	9b2	Fusion level	0	C0/1
			1	C1/2
			2	C2/3
			3	C3/4
			4	C4/5
			5	C5/6
			6	C6/7
			7	C7/Th1
	9c1	Rigid stabilisation type	0	none
			1	cage
			2	transarticular screws C1-C2
			3	C2 pars/isthmic screws
			4	dens screws
			5	lateral mass screw
			6	laminar screws
			7	plates
			8	pedicle screw cemented
			9	pedicle screw uncemented
			99	other rigid stabilisation
	9c2	Rigid stabilisation level	0	C0/1
			1	C1/2
			2	C2/3
			3	C3/4
			4	C4/5
			5	C5/6
			6	C6/7
			7	C7/Th1
	9d1	Other type of spinal surgery	[free text]	-

Type	Nr.	Parameter	Answer value	Answer text
Mandatory	9d2	Other type of spinal surgery level	0	C0/1
			1	C1/2
			2	C2/3
			3	C3/4
			4	C4/5
			5	C5/6
			6	C6/7
			7	C7/Th1
	9e1	Non-surgical treatment	0	no
			1	yes
			9	Unknown
	9e2	Reason for choosing non-surgical treatment over surgical treatment	[free text]	
Optional	10	Additional pathology	0	none
			1	non-degenerative deformity
			2	traumatic fracture
			3	pathological fracture
			4	inflammation
			5	infection
			6	tumour
			7	repeat surgery
	11	ASA status	1	ASA 1 (no disturbance)
			2	ASA 2 (mild/moderate)
			3	ASA 3 (severe)
			4	ASA 4 (life threatening)
			5	ASA 5 (moribund)
	12	Number of previous spine surgeries at the same or adjacent level	0	0
			1	1
			2	2
			3	3
			4	>3
	13a	Height	[cm]	-
	13b	Weight	[kg]	-
	13c	BMI	[kg/m^2]	-
	14	Current smoker status	1	Currently non-smoker
			2	Currently smoker
			3	unknown
	15a	Manufacturer	[full name]	-
	15b	Article number	[full name]	-

Appendix 2 Participants survey

Version 0.5, CH, 11.12.2025

The purpose of this set of questions is to

1) identify the data delivery and country of origin
2) estimate the coverage of a particular country by the participants' data
3) identify and take potential biases in the data into account for analyses

The survey can be filled in with the knowledge currently available. The participants will be asked to update their answers when submitting their data.

General questions (grey fields are already asked at registration)	
Name of participant in English	Name of organisation/institution/individual for which data will be delivered
Name of contact person	<text field>
Email-address of participant	Enter the email-address that should be used for main communication, either institutional or from representative
Other contact persons and email-addresses	Enter a list of persons that should receive information. Use format: "Name1" <email1>, "Name2" <email2> etc.
Country (participants spanning multiple countries: please submit data and the survey for each country separately)	Select out of a list of Countries, stored as ISO 3166-1 alpha-2 codes
Type of participant	Choose: - Health care professional - Surgeon - Department - Hospital - Region - National spine registry - National association for spine - National association for orthopaedics - National association for neurosurgery - Other national association - Research group - Other
Are you a current participant in a spine registry?	Choose: - No - Australian Spine Registry - Belgian Spine Registry

	- British Spine Registry - Danish Spine Registry - Finish Spine Registry - Norwegian Spine Registry - Swiss Implant Registry SIRIS - Spine Tango - Swedish Spine Registry - Other --> please specify
- Please specify if other:	<text field>
Which method of data collection and submission would you use?	Choose: - SAI Excel template, secure file transfer - Database format, following the SAI data definitions, secure file transfer - Spine Tango registry platform (existing user) - Spine Tango registry platform (new user) - unsure
Name of Author 1	<text field>
Affiliation of Author 1	<text field>
Email-of Author 1	<text field>
Name of Author 2	<text field>
Affiliation of Author 2	<text field>
Email-of Author 2	<text field>
Other authors (to be considered in a rotation system)	Enter a list of persons, affiliations and emails. Add a paragraph with instructions. Use format: "Name1", "Affiliation1", <email1> "Name2", "Affiliation2", <email2> etc.
Estimated annual average number of spine related surgeries performed by the participant	<text field>
Estimated annual number of degenerative cervical myelopathy (DCM) treated surgically by the participant	<text field>

Estimated annual number of DCM cases treated non-surgically by the participant	<text field>
Estimated percent coverage of country SURGICAL (in case of data containing multiple institutions and <100% national coverage please provide the SAI team spineatlas@eurospine.org with a list of institutions)	Please estimate how many DCM surgeries are performed by the participant in relation to the whole country. You may additionally state what percent of spinal surgeries are performed as a rough approximation.
Estimated percent coverage of country NON-SURGICAL (in case of data containing multiple institutions and <100% national coverage please provide the SAI team spineatlas@eurospine.org with a list of institutions)	Please estimate how many DCM non-surgical treatments are performed by the participant in relation to the whole country. You may additionally state what percent of spinal surgeries are performed as a rough approximation.
Questions regarding potential bias in the data	
May there be certain legislation, healthcare guidelines or practice recommendations in your country that might lead to different patient selection or treatment characteristics of patients with DCM than in other countries (like the recommendation to avoid fusion if possible)	Yes, No, Unknown
- If yes, please explain	<text field>
Do you estimate your patient demographics to be similar to the national average (consider age, gender, health status, affluence, insurance status)	Yes, Somewhat similar, No, Unknown
- Please explain if you believe that your patients may be different to the national average and some groups may be underrepresented	<text field>
Please explain, if and what data is missing, or you expect to be missing for certain patient groups	<text field>
Please estimate the proportion of submitted cases versus overall surgically treated cases for DCM in the reported period for the participant (please count patients without no informed patient consent as missing)	Please choose: - 95-100% completeness - 90-94% - 75-89% - 50-74% - less than 50% submitted

Please state the level of completeness within the data parameters and how correctness was ensured	Please select all applicable to your submission: ☐ Validity check by more than 1 person and/or audit and/or quality assurance ☐ Data entry and validity check by one person only ☐ Missing parameters were followed up and completed as much as possible ☐ Mandatory data parameters complete ☐ Mandatory data parameters incomplete ☐ No optional data parameters submitted ☐ Some optional data parameters submitted ☐ All optional data parameters submitted ☐ Unsure
- Please specify for which variables it was difficult/ impossible to collect data and submit	☐ Patient age at surgery date ☐ Patient gender ☐ Surgery date ☐ Duration of symptoms ☐ Approach ☐ Decompression type and level ☐ Fusion type and level ☐ Stabilisation rigid type and level ☐ Non-surgical treatment ☐ mJOA scores ☐ Additional pathology ☐ ASA status ☐ Number of previous spine surgeries at the same or adjacent level ☐ Height and weight/ BMI ☐ Current smoker status ☐ Data on the implant manufacturer and article number - Please specify: <text field>
Agreement	
Do you grant the SAI team permission to use the submitted data for the purposes stated in the SAI proposal, and that patient consent was retrieved -unless not required by local law. **Error! Reference source not found.** Participants can be assured that the submitted data will not be used for purposes other than those outlined above without the explicit permission of the individual participant.	Yes / No
-for non-Spine-Tango participants only- Do you agree to the Terms and Conditions below / in Appendix 1 of the SAI protocol?	Yes / No / Not applicable

To be included: Terms and Conditions for Non-Spine Tango users, Links to patient consent forms and Spine Tango terms and conditions

Appendix 3 Terms and Conditions applicable to the collection and submission of data under the Spine Atlas Initiative

1. Definitions

Spine Atlas Initiative (SAI) Participants are individuals, groups of individuals from academic institutions, or a legal entity primarily engaged in the fields of research, education, prevention and treatment of spinal disorders that have agreed to participate in the Spine Atlas project **that are not currently participating in the Spine Tango registry (the "Registry")**, nor have recently contributed data to the Registry.

The anonymised data to be submitted by the Participant includes all clinical data that will be submitted under the SAI in accordance with the terms and conditions and excludes all patient-identifiable personal data.

Steering Committee is the Spine Tango Working group approved board that steers the further development of the SAI and that reviews and approves requests for accessing, sharing and publishing the anonymized pooled data of the SAI for quality assurance and research purposes.

NEC Software Solutions ("Host") is the provider of IT, statistical and reporting services for the SAI.

2. Terms and conditions

1) The Participant shall ensure that all necessary agreements and approvals are obtained from their institution (and can be made available on demand) in respect to any local laws, guidelines, "best practices", ethical requirements, etc. In particular, the Participant is explicitly responsible for obtaining and documenting each patient's informed consent for the use of their data for purposes of the SAI;
2) The anonymized collected and pooled data will be provided solely for purposes of the SAI;
3) No patient-identifiable personal data may be collected or released;
4) Hospital-identifiable data may only be released upon prior consent of the releasing hospital;
5) Patient-level data without patient-identifiable personal data may only be collected if a data use agreement or equivalent arrangement is in place between the releasing hospital and Participant;
6) If patient-level data are not released, the Host will extract and analyse the data as specified in the SAI protocol;
7) Authorship shall be determined solely in accordance with the SAI proposal.

3. Intellectual property rights

The Participant acknowledges and agrees that it shall have no right to any intellectual property rights in the SAI pooled data, reports and results generated by the SAI, or data provided by EUROSPINE's Spine Tango registry or the Host. The foregoing intellectual property rights are protected by copyright laws and treaties around the world. All such rights shall be subject to the terms and conditions described in the SAI proposal, and reserved by the Host, and EUROSPINE.

4. Limited Trial Access to the Spine Tango Registry

The Project Participant shall be entitled to obtain full access subscription to the Spine Tango registry for a limited trial access by clicking and accepting the Spine Tango registry Terms and Conditions published at https://www.eurospine.org/fileadmin/Images/Research/Limited_Trial_to_the_Spine_Tango_Registry_General_Terms__Spine_Atlas_.pdf.

The trial period should commence upon accepting the Terms and Conditions and end 6 months from acceptance. The Project Participant shall be entitled at any time prior to the expiration of the trial period, to enter into a definitive agreement to participate in the Spine Tango registry.