

Failed Back Surgery Syndrome

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Recurrent herniated disc and symptomatic hypertrophic scar can produce similar low back symptoms and radiculopathy. Gradually increasing symptoms beginning a year or more after discectomy are considered more likely a result of scar radiculopathy, while a more abrupt onset at any interval after surgery is more likely due to recurrent herniated disc.

Failed back surgery syndrome is seen in 10-40 percent of patients who undergo back surgery. It is characterized by intractable pain and varying degrees of functional incapacitation occurring after spine surgery.

Epidural adhesions may occur with no previous treatment of low back pain or sciatica in some patients. Primary formation of epidural adhesions in the epidural space could explain why treatments sometimes fail and why surgery should be avoided in patients whose CT or myelograms are negative for nerve root compression.

The clinical features of lumbosacral spinal fibrosis are polymorphic. Lumbar pain and sciatica that become worse, even with minimal physical activities (seen in 60 percent of patients) are the main complaints. Nocturnal cramps and distal paresthesia are common. Twenty-five percent of patients have low back pain without radiculopathy. Ten percent show cauda equina syndrome with sphincter dysfunction and saddle hypesthesia. Lasegue's sign is positive in only 20 percent of the cases, but the absence of knee and ankle reflexes is frequent.

Case Presentation of a Postsurgical Failed Back

Complaint: A 43-year-old, white, single male was seen for the chief complaints of low back and right leg pain causing antalgic posture with occasional pain into the left leg as well. The patient had back surgery in 1990 for a laminectomy, and a spinal fusion in 1991. He noted that his back pain returned immediately following the surgeries. He had been seen at many clinics without any improvement.

Examination: Examination of the low back at this time revealed marked restriction of range-of-motion, flexion at 40 degrees, extension at five degrees, right and left lateral flexion at 10 degrees, and rotation at 20 degrees, all of which were accompanied by pain. Straight leg raising was bilaterally painful at 50 degrees, creating leg pains. The muscle power of the lower extremities was grade five of five bilaterally. The right ankle reflex was absent, while the remaining deep reflexes of the lower extremities were +2 bilaterally. No sensory changes were noted on pinwheel examination. The circulation was good.

Radiographic examination revealed the following: An extensive interlaminar fusion at the L4-S1 levels. Lateral projection revealed advanced degeneration of L4-L5 and L5-S1 disc spaces with the posterior fusion in place.

My impressions of this case were as follows:

A. Spinal fusion, interlaminar, at L4-L5 and the sacrum, with advanced degenerative disc disease at the L4-L5 and L5-S1 levels.

B. Possibility of postsurgical stenosis a L4-L5 and L5-S1.

C. Lumbosacral paraspinal myofascitis.

The lumbar spine was treated by goading of acupressure points B22 through B49 (gluteus), followed by a specific adjustment (L3-L4), that is with the fusion of L4 to the sacrum; all of the flexion, extension, and lateral bending motions have been transferred to L3-L4 level. I feel that maintaining complete range-of-motion with minimal stress can help to alleviate and prevent future degenerative changes at L3-L4 level. This will be the level of motion of this patient's spine for the rest of his life. In addition to this, we utilized tetanizing current (interferential), with moist heat to the paravertebral muscles of the lumbar spine and pelvis. The treatment of postsurgical backs can be extremely difficult, especially when sciatic pains are present.

This patient is still under my care and is seen bimonthly. He still has occasional soreness in his left gluteal region, but maintains that he can tolerate this.

According to Calodney,¹ the diagnosis and treatment of persistent pain in the previously operated low back patient is an increasingly common and complex problem. Over 300,000 laminectomies are performed in the United States each year, and as many as 10-40 percent of patients continue to experience symptoms over the long run.

Accurate diagnosis is mandatory for initiation of successful treatment. According to a study by Burton et al.,² the most common lesions accounting for surgical failure are recurrent or persistent disc herniation, arachnoiditis, epidural fibrosis, along with unidentified myofascial pain syndromes.

In summary, I have contacted the neurosurgeons and orthopedic surgeons in the area and encouraged their referral to the chiropractor's office instead of the usual physical therapist. The chiropractor can treat the joints of the spine above and below the fusion to prevent degenerative changes. We can also do soft tissue work to alleviate myofascial problems.

Surgeons understand that the failed back surgery syndrome is an iatrogenic disease. The best solution is prevention of unnecessary surgery.

References

1. Calodney A: *Failed Back Surgery Syndrome*.

2. Burton AK: *Prediction of the clinical source of low back trouble using multivariable modules. Spine, 16:7-14, 1991.*

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