

BMJ "Failed back surgery syndrome"

Lina Talbot

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Contributors and sources: AP is head of the Public Health Policy Unit. She has researched and published widely on the NHS. DP is a political scientist who has collaborated with AP for several years, specifically on the use of private finance in the public sector and health care. ATS is currently a part time PhD student and has written with AP a guide to the structure and organisation of the new NHS. JM has researched into the history and development of the NHS and has collaborated with the unit on research into equity in the delivery of primary care. The article is based on publicly available government documents.

Competing interests: JM was a specialist adviser to the House of Commons Health Select Committee into Foundation Trusts during January-April 2003 but writes in a personal capacity.

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“Failed back surgery syndrome”

Lina Talbot

An inappropriate diagnostic label may exacerbate the discomfort of patients who develop persistent and disabling symptoms after back surgery

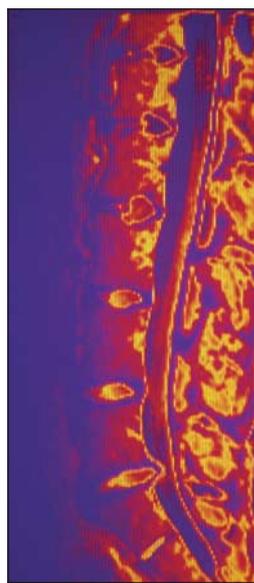
Every general practitioner has one—a patient who has had back surgery but hasn't improved. Around 2000 cases of failed back surgery syndrome are produced each year in the United Kingdom.¹⁻³ This is an uncomfortable statistic, and it is an uncomfortable condition to manage. Patients are often young and were previously active but now face chronic pain for years. They come from the surgeons but are no longer surgical candidates. They have been through the gamut of orthopaedic, neurological, and radiological opinions followed by physiotherapy, occupational therapy, and possibly clinical psychology, funnelling them inexorably towards the pain clinic. Unfortunately, they fare badly there too, with just over one in three patients achieving more than 30% pain relief.

I know about this dreary path at first hand. Nowadays, we may increasingly be questioning the advisability of surgery for prolapsed disc, but not operating can also produce long term disability. Comparison of the UK rate of spinal surgery with that in other countries shows that UK surgeons are not sharpening their scalpels to the ringing of cash tills. Yet 5–10% of patients who have back surgery return home without relief of their radicular pain.^{2,3} Worse still, after about six months, the pain may be showing an unpleasant whiff of neuropathy.

Personal view

I practised general medicine in both England and Germany. When the radicular pain returned after my

microdiscectomy, I battled for months to cope with ward work while seeking out an unoccupied bed in a quiet corner for periodic breaks. The availability of beds, in Germany at least, makes medicine seem the perfect occupation for someone with failed back surgery. I returned to the neurosurgeon, who did computed tomography,



False colour nuclear magnetic resonance image of prolapsed disc

pronounced that the prolapse had not recurred, and told me it would take more time. Despite twice weekly physiotherapy and utmost care with all physical activities, I gradually worsened and developed bladder problems.

Only after many consultations and investigations did I pick up a book and read about *Postdiskotomie-Syndrom*. I then began to understand that, although the nerve roots were not damaged directly by the surgery, they were now encased in a web of scar tissue causing pain and spasm every time this was tweaked enough by movements of the spine and legs.

Torquay, Devon
TQ1 3TB
Lina Talbot
general medicine
registrar, retired
llinaltalbot@aol.com

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Diagnosis

But I am also caught in a web myself, resulting from the lack of awareness of what is actually not such a rare condition. Having had access to the German diagnosis, I may have had a head start on my fellow sufferers in the United Kingdom. Here, a major difficulty is the uncritical use of the label “low back pain” to cover all patients with and without radicular pain, irrespective of possible aetiology. This confuses patients, therapists, and doctors alike. The impression is of a lack of precision in both diagnosis and treatment. But failed back surgery syndrome is also an unfortunate term, implying failure of the surgeon or possibly of the patient. In most cases, neither is true.

Despite the plethora of investigations that can be used for such a condition, the diagnosis remains essentially clinical. Magnetic resonance imaging and computed tomography are necessary to rule out lesions amenable to surgical intervention, but they cannot determine whether the intraspinal scarring is causing the symptoms. Neuropathic pain may not always have a burning quality, but other recognisable features are often present—for example, delayed summation of pain after provocation, the extension of pain perception beyond dermatomal boundaries, and allodynia (pain resulting from touch alone).

Support for patients

In many ways failed back surgery syndrome resembles multiple sclerosis: the conditions have the same range of symptoms of pain and numbness, weakness and spasm in the limbs, and bladder and bowel difficulties. But whereas some neurological units offer specialist expertise in treatment and lifestyle support for people with multiple sclerosis, patients with failed back surgery syndrome are left outside the door. In terms of numbers, there is roughly one person with failed back surgery syndrome for every two with multiple sclerosis.

After four years I still haven't found appropriate rehabilitative support in the United Kingdom. Pain management programmes, where well-intentioned

Summary points

Surgery for prolapsed disc fails to relieve pain in 5-10% of patients

Patients with failed back surgery syndrome face increasing disability as well as chronic pain

The condition has fallen into a no-man's land between surgery and medicine

Rehabilitative medicine is poorly developed, focusing mainly on pain relief

encouragement of generic measures is the rule, generally fail to take into account the real danger of further nerve damage and a permanent increase in symptoms. I have learnt to be wary of enthusiastic physiotherapists. Even in Germany, where I participated in a rehabilitation programme, this was very much batch processing, with little attention to variations between patients.

Patients with failed back surgery syndrome live with the constant anxiety of relapse and steady deterioration of a range of neurological symptoms, yet current medical management focuses narrowly on relieving pain. This is another strand in the web in which patients are caught: good pain relief brings the illusion of improved physical ability. However, for many patients, after a brief honeymoon period pain, spasm and weakness appear at a lower activity level, and the web tightens to immobilise the ensnared nerve roots (and patients) even more.

Competing interests: None declared.

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Commentary: label is unhelpful

Jos H Verbeek

Academic Medical Centre, Coronel Institute for Occupational and Environmental Health, PO Box 22700 Meibergdreef 15, Amsterdam, Netherlands
 Jos H Verbeek
occupational health physician
j.h.verbeek@amc.uva.nl

How useful is it to label a set of complaints as failed back surgery syndrome or post-discotomy syndrome? My view is that, far from improving a patient's condition, such a label may even play a part in its deterioration. Even the authors of articles who use these diagnostic terms admit that they are better avoided since they do not help to identify a cause or a treatment. After all, the only characteristics that these patients share are that they have been operated on for back pain and that non-specific back related complaints returned at some point after the operation.¹⁻³ I prefer the term non-specific back pain because this provides us with a sound starting point in our search for a diagnosis, treatment, and prognosis.⁴

How can we best help patients in a predicament like this? Operation on a herniated disc immediately relieves leg pain in some 80% of patients. Annoyingly, complaints return or remain after surgery in 10-40% of cases, regardless of the technique used. Unfortunately, we have not yet found a way of predicting this recurrence. In more than half of these patients, the reasons for the recurrence remain unclear. The most treatable causes are recurrence of the hernia and instability of the spine, although treatment of spinal instability is controversial.^{1,2} Epidural fibrosis (or scar tissue) is an often cited cause, but this does not seem to be linked directly with either pain or disability. Some evidence indicates that psychological factors such as anxiety or problems with work and disability have a major role.¹

Meeting patients' needs

Qualitative research among patients with chronic back pain shows that they have a great desire for an explanation, a diagnosis, instructions, referral to a specialist, and, above all, for their complaints to be taken seriously.⁵ Sadly, we do not offer much to fulfil these expectations. In most cases there is no real diagnosis and no specialist who can simply stop the pain, and a new operation is often counterproductive. In one patient series, almost 80% of the patients who had repeat surgery reported dissatisfaction with the results in the long term, despite apparent initial success.^{1 2}

Therefore, efforts have to be directed at restoring normal everyday life as far as possible. Contrary to the belief of many patients, conservative treatment or no treatment does not lead to more complications but to fewer. Our fear of paralysis and disability is usually based on an appealing but rather simplistic, mechanistic view of disc herniation: the disc has burst out of its packaging and the nerve root has become wedged between the disc fragment and the vertebra. However, many people have herniated discs without noticing any symptoms or signs.

Remaining active or doing physical exercises will not lead to a relapse or an increase in neurological symptoms. On the contrary, this can have significant beneficial effects.⁶ A customised rehabilitation programme led by a physiotherapist can build up self confidence. Although there is some evidence that exercise is an effective therapy after an operation on a herniated disc, I would prefer rehabilitation to be organised in a multidisciplinary setting with a specialist in back pain, a psychologist, and a physiotherapist working as a team.¹ Granted, no evidence is available that this is more effective than other rehabilitation measures, but the combined approach has the advantage of dealing with physical and mental issues at the same time.

Competing interests: None declared.

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Corrections and clarifications

Role of living liver donation in the United Kingdom

We mistyped a word in the summary points box of this Education and Debate article by James Neuberger and David Price (20 September, pp 676-9) and it slipped through our checking processes. In the third point, donors have a risk of morbidity [not mortality] of 40-60%. This should reassure potential donors.

Claim that smallpox vaccine protects against HIV is premature, say critics

In this news article by Jeanne Lenzer (27 September, p 699), we mistakenly said that the George Mason University had been criticised for announcing, before peer review, that the smallpox vaccine protected against HIV. We should have said that the university had been criticised for announcing, before peer review, that the vaccine might protect against HIV. We also incorrectly described the Soviet biowarfare programme, Biopreparat, as an "anti-Soviet" programme.

Quality improvement perspective and healthcare funding decisions

We inadvertently omitted to publish a figure in this Education and Debate article by Ashley Bloomfield and Robert Logan (23 August, pp 439-43). The figure (see bmj.com) shows the four distinct but interrelated levels of activity for quality improvement in the model developed by New Zealand's National Health Committee, and also the five dimensions of quality that are important in understanding, defining, and improving the quality of health care. The three principles of the Treaty of Waitangi underpin the model.

The reunion

Having qualified at the Welsh National School of Medicine in 1953, I am about to attend our 50th year reunion. I cannot say that I am looking forward to it. For a start, some of those of whom I have the fondest memories will not be there because of the Grim Reaper. Others with whom I was friendly have chosen not to come. No doubt we will hear of a few who are no longer oriented in time and space. For my own part, those long distant days were golden, but I have learnt that it is seldom possible to recapture a good time.

Of those that do attend, there will be those with whom I was never particularly friendly, nor they with me. Most will show ageing to a degree that will remind me just how much I have aged myself, and a few will look no older than they did 50 years ago, which is unforgivable. Others will boast of the incredible achievements of their children and grandchildren, and will be boring. Probably we will not find a great deal in common.

But then again, we were a heterogeneous year. Some of us were straight from school, whereas others had fought in the war. Also, the 1950s turmoil, when many sought posts abroad and others had to do their national service, meant very different subsequent lives and careers.

But I intend going to the reunion, if only to support the unquenchable enthusiasm of the person in our year who continues to believe that our six years of closely shared experiences so long ago are worthy of remembrance. He is probably right, particularly when one recalls that the year of 1953 first came together in 1948, the first year of the NHS. Come to think about it, we have more worth remembering than most.

David Crosby *honorary consultant surgeon, University Hospital of Wales, Cardiff*