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The proper diagnosis of "discogenic" low back pain can be elusive

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Spinal News International asked Jeffrey A Goldstein, director of Spine Service, and associate professor of Orthopaedic Surgery, NYU Hospital for Joint Diseases for his opinion on operating for low back pain.

What is the background to operating on low back pain? Is this common practice?

Surgery for low back pain remains controversial. Since data show that 80% of the population may experience low back pain at some point in their life, we know that most patients do not require surgical intervention. While it is not common practice to operate for low back pain, we do know that for the appropriately selected patient who has failed non-operative treatment, that surgery can provide satisfactory pain relief, improvement in patient outcome scores, and improvement in quality of life.

One key problem has been that good radiographic results do not always correlate with satisfactory patient outcomes. The proper diagnosis of "discogenic" low back pain can be elusive. Further, common diagnostic modalities such as discography remain controversial and have newer evidence which suggests the test itself may have iatrogenic sequelae.



Jeffrey A Goldstein

What does the current evidence say on operating on low back pain?

There is now a wealth of Class I data which supports fusion surgery for appropriately selected patients. These studies include the LT-BMP-2 study. Fusion patients have been shown to surpass minimally important clinical difference in SF-36 and ODI after fusion. The US FDA trials for the ProDisc, Charite, Maverick, and Flexicore lumbar disc replacements not only show the benefit of artificial disc replacement for the appropriately selected patient population but also show the benefit of fusion. We see improvements in ODI, SF-36, and patient satisfaction. These improvements are maintained out to five years postoperatively. Further analysis of the data has demonstrated economic benefits of artificial disc replacement over fusion for this group of patients.

What is your view on this: Should we be operating on low back pain? What do you recommend?

The key is diagnostic specificity. In the patient with intractable pain with concordant imaging without non physiologic sources of pain, a good outcome can be supported by the literature. As surgeon physicians the onus is on us to support the interventions we provide our patients. There is Class I data which supports the role of surgery for low back pain in the appropriately selected patient. Further, the data supports the use of the resources being allocated to treat these patients. The challenge to surgeons is to continue to follow these patients in a prospective fashion over time.

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