



The Ugly 5



FAILED BACK SPINE SURGERY (FBSS)

INVESTIGATION AND CLINICAL ASSESMENT

MAHALAPYE 2013

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PERSPECTIVE

As many as 50% of FBSS patients, on review of
original history
clinical assessment
diagnostic studies

have not met the generally accepted criteria for a primary
surgical procedure.

THERAPEUTIC GOALS

Pain relief

Neurological improvement

HISTORY

- Go back to beginning
- Chronologically piece the story together
- Approach as if your 1st contact with patient
- Acquire all the previous clinical notes/ op notes
- Make contact with the previous surgeon
- Input from the GP/physio/chiro, re analgesia usage
secondary gain

HISTORY

- Current complaints, relative to before surgery/ after surgery
- When the problems started
- What % of residual problem is still present

- Gain insight into pain behavior
 substance usage
 psycho-social issues

NB. NOT TO EXCLUDE FROM Rx

CLINICAL EXAMINATION

- Patient must undress
- Complete assessment of the patient
- No assumptions
- Expand the examination
- Compare findings

CLINICAL EXAMINATION

- Determine whether the patients problem is indeed spinal.
- Think about
gynecological
abdominal
vascular
orthopedic
systemic causes

PURPOSE OF THE INVESTIGATIONS

Residual of the previous problem

New problems assoc with the interventions or

Missed problems

Arachnoiditis

Fibrosis

Nonunion

Instrument failure

Infection

Flat back deformity

LIKELY DIAGNOSIS

ANATOMICAL

Difficult with 1st surgery

More complex with recurrent problems

LIKELY DIAGNOSIS

TIME OF PRESENTATION

Immediate

incorrect diagnosis
poor technique

Short term relief return of pain

? Infection

Medium term

re-herniation
fibrosis
arachnoiditis

Long term

instability
stenosis at adjacent level
ongoing degenerative change

- **66 yr female**

Myasthenia gravis

Chronic cortisone usage

Osteoporosis with compression fracture

Previous lumbar fusion

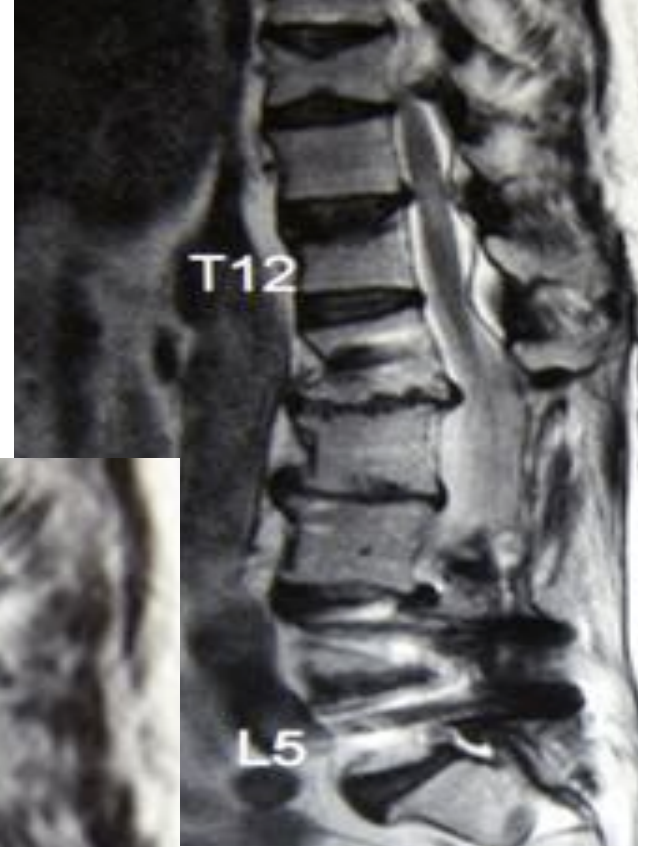
Referred as paraparetic

Back pain ++, and inability to walk

Power 5/5

Touch & pin prick normal

No myelopathy



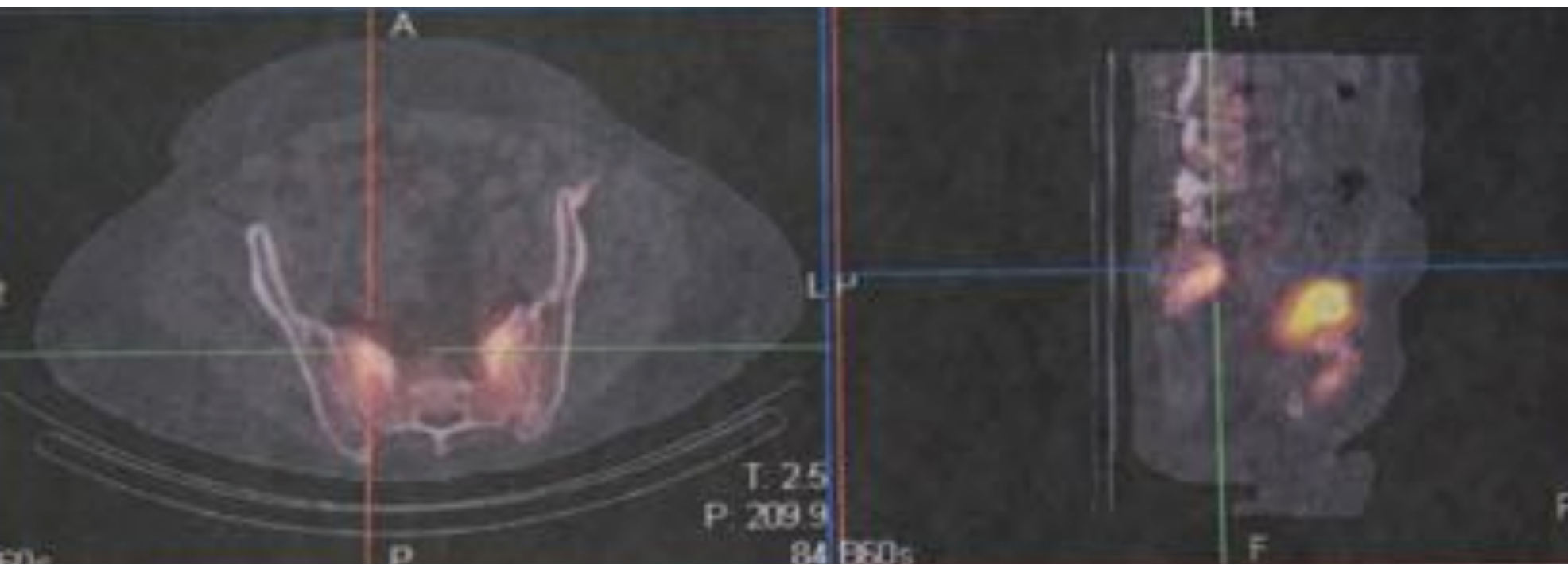
MANAGEMENT ??

1.conservative Mx

2.decompression T11 /T12

3.decompression T11 /T12 and fusion T11 /T12

4.other



LATERAL RECESS STENOSIS

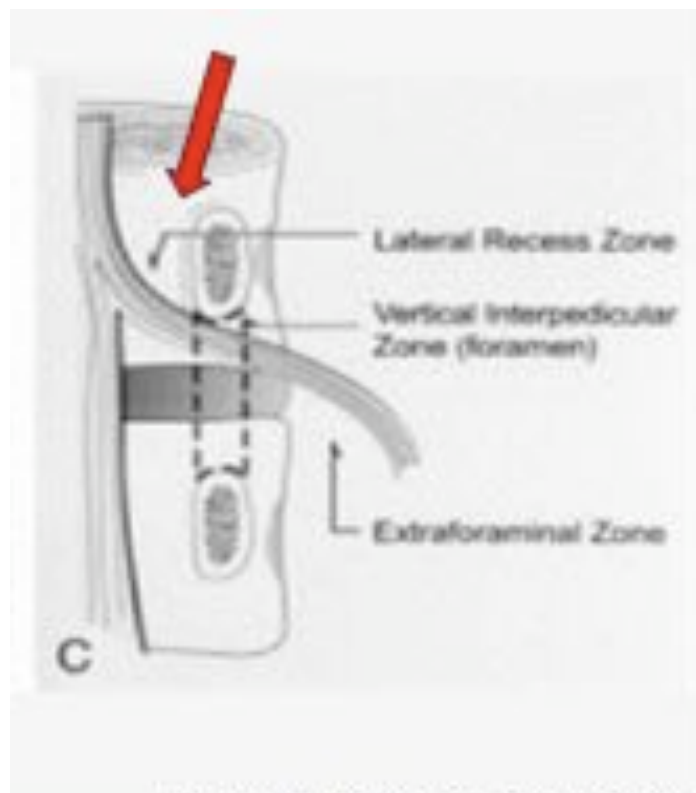
LATERAL RECESS STENOSIS

Verbiest 1940

Still remains the most common cause of "failed back syndrome"

failure to recognise the entity

failure to adequately decompress the recess



Courses obliquely downwards and laterally

LATERAL RECESS BORDERS

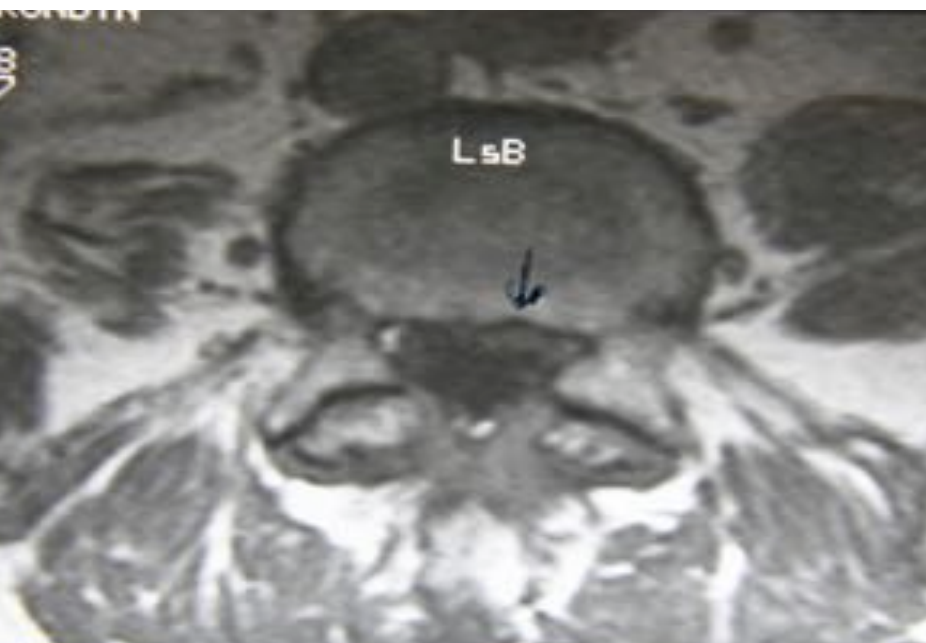
Lateral.	Pedicle
<u>Posteriorly</u>	Superior <u>articular</u> process
<u>Anteriorly</u>	Vertebral body
Medial	<u>Thecal</u> sac



INVESTIGATIONS

Xrays LUMBAR: AP , FLEX ,EXT
PELVIS : AP

BLOODS FBC, ESR, CRP ,Alk phos,+
other.



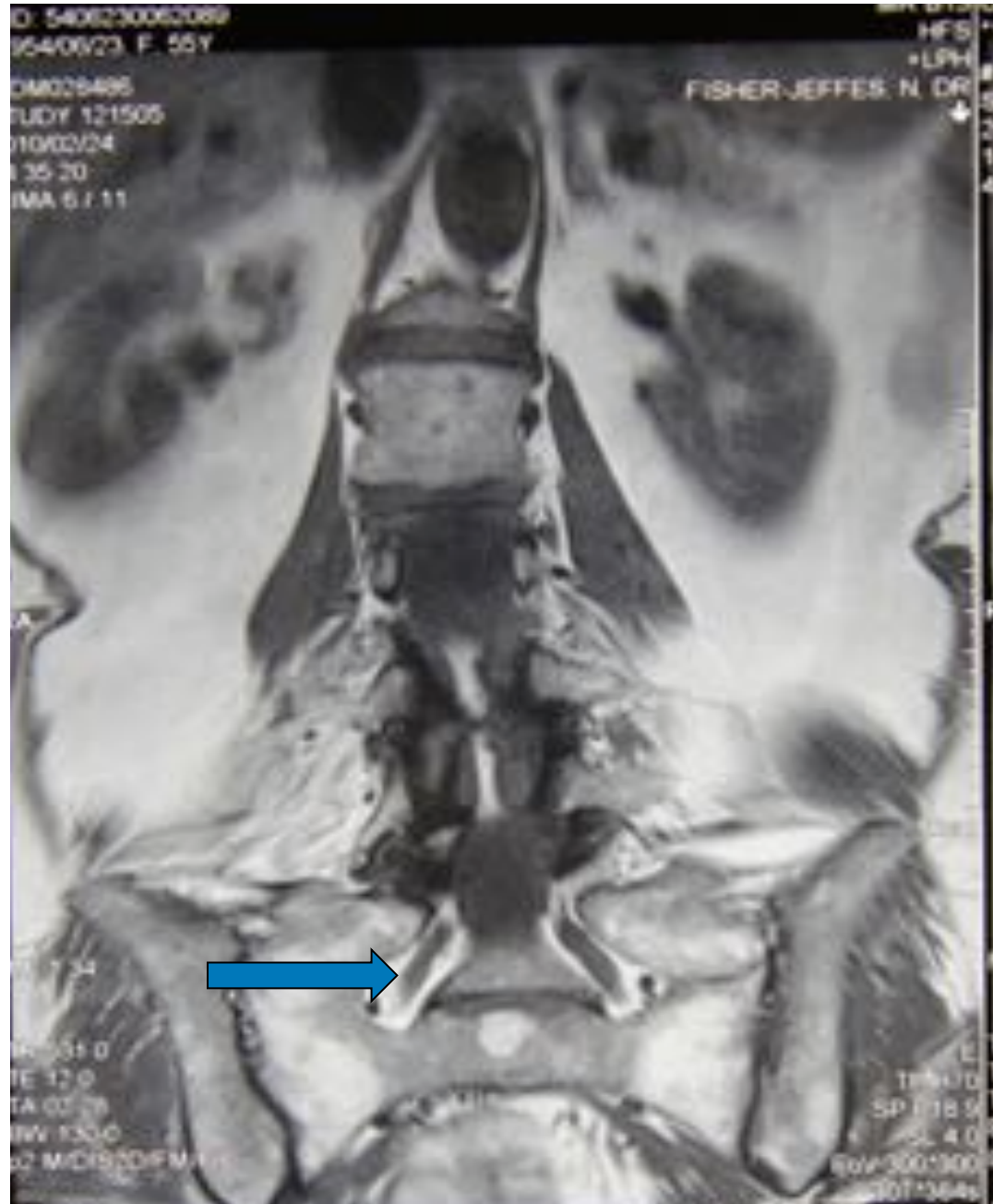


INVESTIGATIONS

MRI standard protocol
 use of coronal cuts

CT Myelogram

BONE SCAN for specific indications
 inflammatory\infective



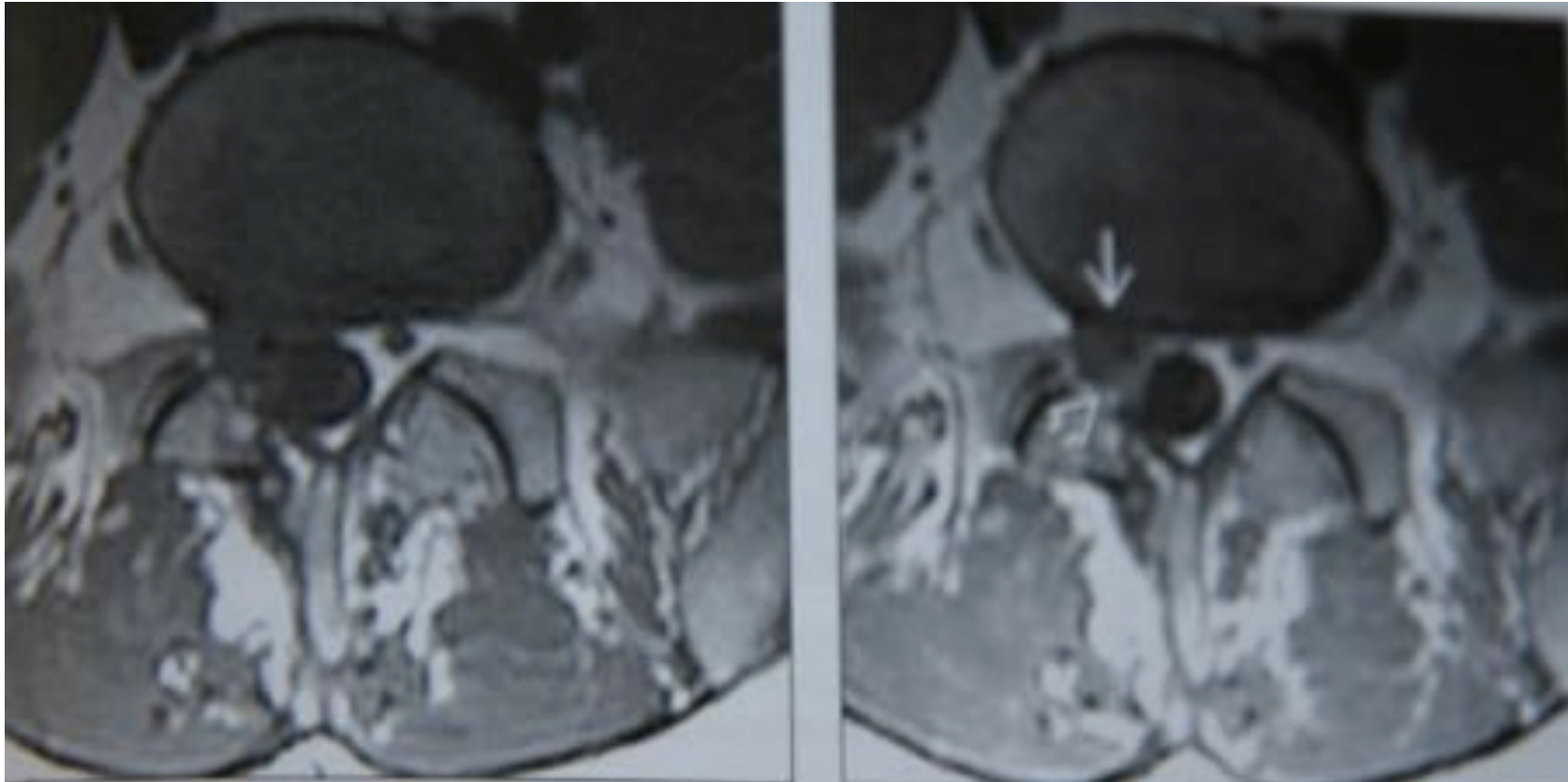


Precise correlation of history , clinical findings and investigations is necessary now more than ever; especially because of the sensitivity of MRI.

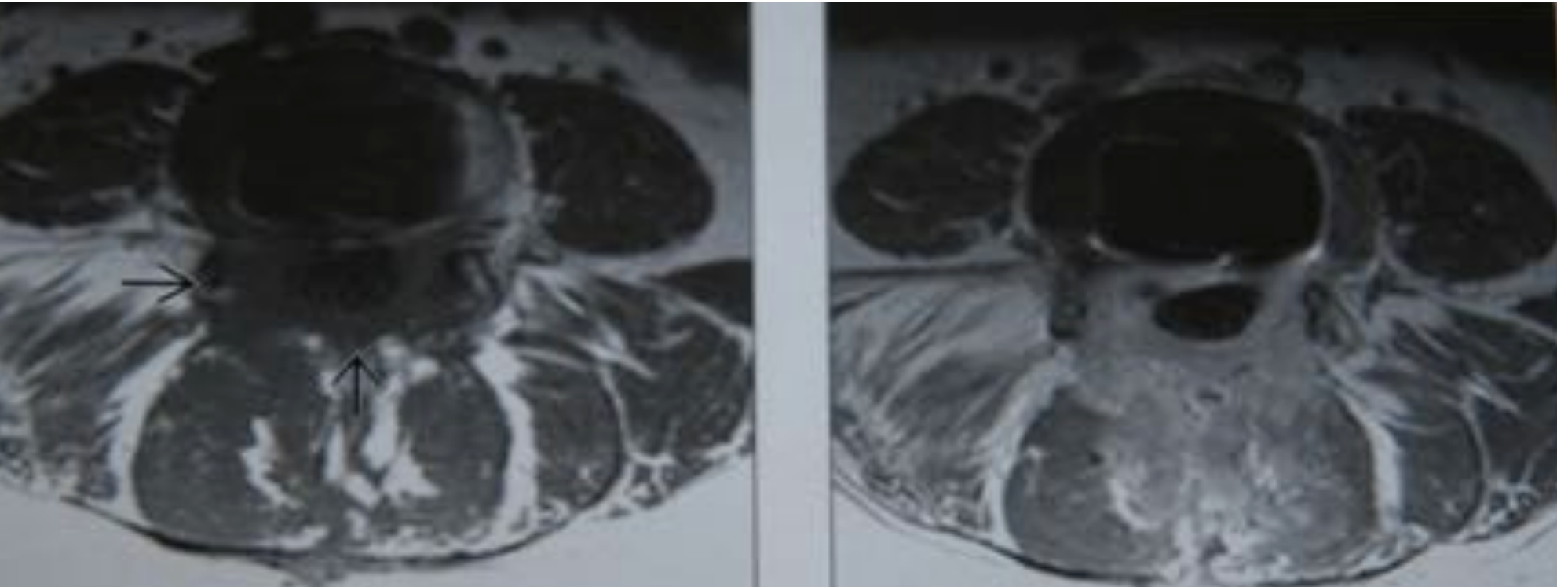
Non specific spondylotic changes often do not correlate with the patients symptoms, nor the need for surgery.

MRI should be used to **CONFIRM** the clinical diagnosis

RECURRENT DISC



PERIDURAL FIBROSIS



INVESTIGATIONS

ELECTROPHYSIOLOGY

Little value-----extremely valuable

Very operator dependent

Later the better

Differentiate; root; cauda equina; peripheral nerve

INVESTIGATIONS

PHYSIOLOGICAL TESTING

Discography	no credible evidence
Nerve root blocks	no credible evidence
Facet blocks	direct intra-articular

INVESTIGATIONS

- **Psychological testing**

no credible evidence to submit all patients to a battery of tests.

If clinicians concerned then refer to psychiatrist

22 years old football injury = onset LBP

25 years old declined admission to military due to back “issues”
neurosurgical & orthopaedic opinion , nonsurgical

28 years old Following intensive rehabilitation program = Fit for active Naval duty
later same year boat rammed in military action
LBP exacerbated

Different neurosurgeon consulted

Neurologically intact. Vague findings on spinogram
underwent left laminotomy L4/L5 L5/S1 [1]
Very slow recovery - ++ muscle spasm

+ - 1 Year later Returned to first surgeon who questioned *“indication for Sx without doing more sensitive investigations*

AP & Lateral x-rays - essentially normal , no degenerative disease,
no spondylosis, no lithesis.

Progressively worsening symptoms LBP ; conservative Mx with steroids , corset

37 years old

L5/S1 disc space collapsed; early osteophyte formation

Co-morbidity - Addison's disease

Medication - long term use corticosteroid

Surgical Intervention

Posterior fusion L5/S1 and left SIJ fusion - Wilson plate {2}

L5 Spinous process wire

No artificial disc (Fenstrom balls)

Stormy recovery UTI;

deep wound infection necessitating repeated packing and {3+4}
secondary closure

Rehabilitation followed with symptomatic treatment of muscle spasm & trigger points

3 Years later

Recurrent abscess of lumbar spine wound (Staph Aureus) {5}

4 years later

- Increasing dependence on amphetamines; steroid injections & alternate therapies
- Episodes of using crutches to walk.

5 years later – Change of physician

- consensus – **No more surgery**
- focus shift away from chemical management to water aerobics; strengthening & flexibility exercises
- use of external bracing corset
- getting on with life



“His continued, exceedingly high level of activity not only illustrates his personal determination but also serves as a notable demonstration that such patients can maintain a substantial functional status despite their physical incapacity.”

Robert A Hart. The Orthopaedic Forum, JBJS, 2006

Inappropriate patient selection

Neurologically intact, however based on an air spinogram underwent left sided laminotomy L4/L5 and discectomy L5/S1

Addison's disease

Family pressure to run for congress

Incorrect pre op diagnosis /Inadequate work up

Normal Xrays.limited investigations

Unrealistic patient expectation

Immediate return to work,congress ,senate,president

Reported hectic social life

Surgical complications

Very slow recovery / spasms, UTI, wound infection

INVESTIGATE EARLY

Establish accurate diagnosis early, and propose and institute Rx and Mx program before the pain and behavior becomes fixed.

The patient must retain confidence in their surgeon

INVESTIGATE EARLY

Advise and guide your patient

- Inappropriate surgery
- Inappropriate alternative interventions
- Financial implications

Recognize the limitations and benefits of surgical intervention.

If there is not a neural compressive problem, or a mechanical instability problem ,

then surgery will contribute to the devastating
FBSS

THANK YOU

Cure your spine problem within 20 min.



Mrs. Nirupamma had a sudden fall while walking and was immediately hospitalized. She was diagnosed as Acute Lumber discs prolapse between third and fourth vertebra with paralysis of left knee muscles

were impossible to perform when she suffered the fall. In three days she started walking normally and her paralysis disappeared.

Dr. Prasham Shah is the First Indian Orthopaedic Surgeon to bring Iliizarov technique (Russian) and Ozone therapy in INDIA. On our correspondent inquiring about the safety of this procedure, Dr. Shah said, "since Ozone is made up of three molecules of Oxygen, injecting it in the disc has No side effect at all. As a matter of fact the third molecule takes away the water content of disc which is 80% of the total disc, thus collapsing the disc & relieving the pressure on the spinal cord.

Even **MULTIPLE DISCS CAN BE TREATED WITH OZONE INJECTION**, enabling the patient to avoid going through the trauma of surgery and spinal

instrumentation. Spinal canal stenosis can also be treated with ozone injection in Epidural space claims 'Dr. Shah.



Needle in the offending Disc

**Dr. Shah
H A S
TREATED**

MANY PATIENTS WHO HAVE PREVIOUSLY FAILED SPINAL SURGERY, simply by introducing ozone in disc and epidural space. In more than 600 patients treated with Ozone, he claims 85 to 90% success rate. He also added there were other multiple uses of Ozone in Orthopaedic conditions like **RHEUMATOID ARTHRITIS, OSTEO ARTHRITIS, AVASCULAR NECROSIS, DIABETIC & ALCOHOLIC NEURITIS** Etc.

For Further information, Contact:
304, Doctor Centre,
Next To Shalimar Hotel,
August Kranti Marg,
Kemps Corner, Mumbai - 400036



Disc blasted with Ozone injection Displacing Dye

**No Rest &
No Surgery
for
Slipped Disc**

Inadequate work up

- **Nov 1944** - returned to first surgeon who questioned *“indication for Sx without doing more sensitive Pantoque myelogram”*
- Did not follow up on what had previously been done / decided

Incorrect preoperative diagnosis

- AP & Lateral x-rays - essentially normal
no degenerative disease, spondylosis,
spondylolisthesis

Unrealistic patient expectations

- SX 1944 - Immediate return to work – ran for Congress 1945
- Surgery 1954 - Serving senator 1953 to 1957
- Ran for President 1960
- Reports of hectic social life

Surgical complications

- 1944 - Very slow recovery - ++ muscle spasm
- 1954 – Infection and UTI

Comorbidities

- Co-morbidity - Addison's disease
- Medication - long term use corticosteroids
 - no evidence osteoporosis

Psycho-socio-economic factors*

- Personal / other pressure to continue regardless
- Unrealistic expectations
- Dependency on cortisone and amphetamines
- Failure to adapt lifestyle to back

Previous surgery

- 1944 - Left sided laminotomy L4/L5 and discectomy L5/S1
- October 1954 - Posterior fusion L5/S1 and left SIJ fusion

Previous infection

- 1954 - Deep wound infection necessitating repeated packing and secondary closure
- 1957 – Recurrent abscess of lumbar spine wound (Staph Aureas)