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Spine Surgeons' Role in Preventing Failed Back Syndrome

Written by Ralph F Rashbaum, MD (/author/44233/rashbaum)

SpineUniverse: ***Do all roads lead back to the operating room when it comes to failed back surgery?***

Dr. Rashbaum:
A failed back surgery implies that the patient had surgery, and then following that surgery, they come back with a situation where their symptoms persist or have gotten worse.

So here's the question: Is it from a surgical misadventure; in other words, was the nerve root brutalized or beaten in an effort to get the root out of the way to take the herniation out? This can happen at times, but let's not forget that these roots were sensitized by virtue of the process of herniating the disc (/conditions/herniated-disc/surgery-herniated-disc). The nerve roots swell and become hypersensitive.

If you bang your tibia, it becomes real sensitive; you don't want to touch it. Nerve roots respond in exactly the same way. Or, is failed back surgery brought on because a fragment of the disc that should have been removed wasn't? In other words, is surgeon error to blame?

(https://www.spineuniverse.com/sites/default/files/imagecache/gallery-large/wysiwyg_imageupload/3998/2018/08/10/surgeons_viewing%20images_93537110_ML.jpg)

Spine surgeons view their patient's pre-operative x-rays and MRIs.

SpineUniverse: ***What can surgeons do to decrease patient risk for failed back surgery?***

Dr. Rashbaum:
Surgical trauma is hard to avoid. Surgeon error, on the other hand, is certainly avoidable if the surgeon assesses and interprets the imaging pre-operatively. It's important that our imaging sophistication is such that we know what we're up against before we cut the skin. We have to know what to anticipate and what we're going to find before any incision is made.

For instance, if we suspect a disc herniation between the fourth and fifth lumbar vertebrae (L4-L5), and we do a laminotomy (/treatments/surgery/laminotomy-versus-laminectomy) without taking intraoperative images to confirm that we're in the right spot, and we find nothing, there are two reasons that may explain why. Number one, the interval time between the image and the surgery may have been sufficient so that the herniation has self-absorbed – we've seen that happen now by doing serial MRI – or, worse, you're at the wrong space. So you wind up doing ineffectual surgery, leaving the patient with the same herniation at L4-L5 because you were operating at L3-L4.

SpineUniverse: ***Are there cases in which a patients' anatomy makes a good outcome nearly impossible?***

Dr. Rashbaum:
Sure. If you're doing a disc procedure and you have to make a large bony window, and the bony window renders that segment susceptible to fracture, ultimately and predictably that patient will fracture and present with low back pain. So yes, we have to address structural concerns and how these affect surgical success.

Can that disc re-herniate? It certainly can, because we don't take the whole thing out, we just remove the herniation. That means that we still have disc material left. Why would we do that? Because we want to maintain a bumper, if you will, so that area can heal and stabilize.

A long time ago, when I had only been in practice for 4 years, we used to extirpate (remove) everything. Over the course of time, we began seeing a different kind of recurrence, one in which the endplate – which is cartilage – would roll up and extrude. So we started looking at simply taking out the herniation versus removing everything. When you remove only the herniation, there's an incidence of recurrent herniation between 5% and 20% during the first year. So the point is this: Even if you do masterful surgery, the body mechanics are such that you can create more problems. You can't address everything all at once.

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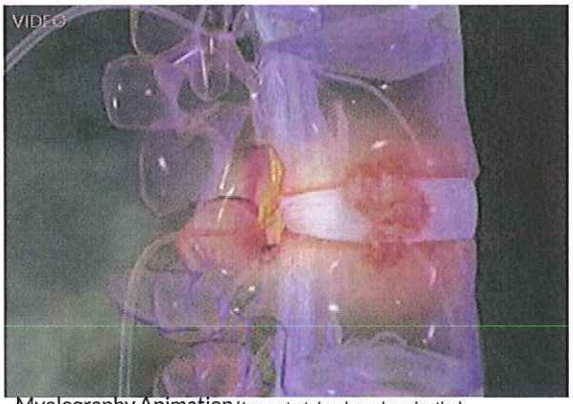

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